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**ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment (August 2025)**

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## 1. Revised Standard Operating Processes (SOPs) in Place & Tested by Internal Audit

Status – ASSURE

Committee: ARAC

Lead Executive: Joanne Wilson

### Explanation

Following the organisational restructure, all core Board and Committee SOPs were revised, standardised, and rolled out across governance functions. This implementation has been subjected to an independent Internal Audit (May 2025), which provided “Reasonable Assurance” with only two medium-priority recommendations. This demonstrates robust process design and operationalisation at every level. In addition, the Board’s 2025 Maturity Matrix exercise rates “Oversight & Administration Principles” at Level 4 (“Firm Progress”), indicating that staff understand the revised procedures and are routinely applying them.

### Why Assure?

- **Tested by Audit** - External scrutiny found SOPs were operational, not just theoretical.
- **Low Residual Risk** - Only minor administrative updates (e.g., flowchart/induction slide deck) remain, with completion dates and owners logged in the ARAC action tracker.
- **Practical Impact** - Evidence that the processes are understood, embedded, and not just “on paper.”
- **Conclusion** - With strong assurance from audit, and the Board actively monitoring outstanding minor actions, there is robust control in this area, warranting an Assure rating.

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## 2. Consistent Oversight & Scrutiny of Current Service Provision by Board/Committees (Including Duty of Quality)

Status – ASSURE

Committee: ARAC

Lead Executive: Joanne Wilson

### Explanation

Oversight and scrutiny by the Board and Committees is now embedded. Throughout 2024/25, all planned public Board meetings and seminars were delivered as scheduled. Committee papers are issued at least a week in advance, with the Corporate Governance Code self-assessment (Mar 2025) verifying compliance with best practice for transparency and public accountability.

Since April 2024, the Board's reporting template now includes explicit prompts to address the Duty of Quality (pilot across six Board papers in April–May 2025).

### Why Assure?

- **Regular Cycle** - There is no evidence of missed scrutiny, and challenge is routinely documented in public minutes.
- **Duty of Quality** - This is now being hard-wired into all major decision templates—not just noted in passing.
- **Validation** - Board Maturity Matrix rates “Transparency and Public Reporting” as “In development but effective”—with full implementation due by October.
- **Conclusion** - The system is mature, and scrutiny of quality issues is consistent and evidence-based. No significant gaps remain, supporting an **Assure** judgement.

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## 3. Programme & Performance Management Structure with Effective Board Oversight

Status – ADVISE

Committee: ARAC

Lead Executive: Lee Davies

### Explanation

The introduction of a new Power BI-based Integrated Performance Assurance Report (IPAR) marks a significant upgrade, now tracking 42 key KPIs, with 28 also benchmarked nationally. Internal Audit (April 2025) returned “Substantial Assurance,” noting that the management framework and data culture are robust. However, the Board’s Maturity Matrix rates the “Delivery of Outcomes” at only Level 2, reflecting that benchmarking and outcome-focus are not yet fully embedded for all measures. Moreover, these are complemented with the clear escalation summaries by CCG/Directorate.

### Why Advise?

- **Framework Present, Maturity Emerging** - The reporting tool is sound, but work needed on being outcome-focused and resource mapping are still developing.
- **Ongoing Roll-out** - Full extension to all Tier 1 KPIs and a more comprehensive outcomes dashboard are scheduled for December 2025.
- **Ownership Clarity Needed** - There remains some ambiguity about who is accountable for the delivery of individual outcomes, and how resource is allocated in support of complex, cross-cutting priorities.
- **Conclusion** - Progress is strong, but further development is required to fully embed a Board-level, outcome-driven assurance culture. **Advise** reflects the need to monitor ongoing delivery and resource clarity.

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## 4. Board Sighted on Key Risks and Able to Offer Constructive Scrutiny

Status – ASSURE

Committee: ARAC

Lead Executive: Joanne Wilson

### Explanation

The Board receives the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) at least quarterly. These documents provide clear identification, scoring, and narrative explanation of the Health Board's principal risks. The Risk Appetite Statement was refreshed in January 2025, ensuring that decision-making aligns with the agreed level of risk tolerance. Internal Audit ("Emergency and Business Continuity Planning," 2025) gave Reasonable Assurance, confirming that all clinical and corporate services now have documented continuity plans.

Scenario testing and live action planning have become the norm, with real-time dashboards in development for November 2025.

### Why Assure?

- **Regular Challenge** - Principal risks (via the BAF) and corporate risks (via CEO report) are reported to the Board to provide assurance that these have been considered, challenged and discussed at Board level Committees. Any areas of concern are reported through the Committee Update Reports to the Board.
- **Independent Validation** - Both internal and external audit confirm effectiveness and results.
- **Results Achieved** - Risk Maturity is assessed annually and reported to ARAC. Board Maturity Matrix also rates Risk Management as Level 4 ("Results Achieved").
- **Conclusion** - No apparent critical gaps in Board oversight of risk however organisational capacity to manage effectively risk is constrained (as at June 2025, 83% of risks were scored high or extreme). This area is well-controlled and highly visible, supporting an **Assure** status.

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## 5. Clear Governance & Assurance Systems with Effective Escalation

Status – ASSURE

Committee: ARAC

Lead Executive: Lee Davies

### Detailed Committee Explanation

The Health Board completed a major review of its governance and assurance systems in January 2025, prompted by both local learning and the formal requirements of the NHS Wales Oversight and Escalation Framework 2025 - Hywel Dda. This review resulted in refreshed and Board-approved Terms of Reference (ToRs) for all major committees - including ARAC, Quality & Safety, and Finance & Performance with clear escalation protocols and annual business cycles embedded across all governance layers.

A key outcome of this work was the implementation, from January 2025, of a standardised “Triple-A” escalation model Alert, Advise, Assure within all committee and sub-committee reports. This model, directly aligned to the requirements of the Welsh Government escalation framework, ensures that any risks or issues identified at operational or executive level are systematically escalated to the appropriate committee, and ultimately to the Board, for discussion and resolution when required.

All items escalated as “Alert” or “Advise” are now formally logged, tracked and reviewed as part of every ARAC and Board agenda cycle, with audit trails documenting actions taken, lessons learned, and closure of items. This ensures that significant issues are never “lost” in the system. The escalation protocol is further strengthened by scheduled six-monthly reviews (next due December 2025) to assess its effectiveness and identify opportunities for refinement. The new ToRs and escalation pathways are publicly available, supporting openness.

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Hywel Dda  
University Health Board

Transparency and external assurance have remained positive. Audit Wales' Structured Assessment (2024) and the most recent Internal Audit review (May 2025) both found the governance and escalation arrangements to be “appropriate and effective,” citing the clarity of escalation routes and the reduction of private (“in-committee”) business from 14% to 9% of agenda items as indicators of improved accountability and openness.

Additionally, the escalation and assurance framework is explicitly referenced in the Escalation Framework (April/June 2025) agreed by both the Health Board and Welsh Government, meaning that the local systems are mapped directly to national expectations. This mapping was confirmed in the Board's June 2025 submission to Welsh Government and validated in subsequent Tripartite discussions.

In operational terms, this means that any significant governance or risk issue whether identified internally (e.g., through the risk register, internal audit, or committee challenge) or externally (via HIW, Audit Wales, or Welsh Government) is escalated through a standard, Board-approved process, with clear timescales for action and closure. “Alert” issues are prioritised for immediate executive or Board response, “Advise” items are monitored and scheduled for formal update, and “Assure” reflects sustained, evidence-backed confidence.

## Summary

- This approach ensures that the Health Board's governance and assurance systems are not only robust and responsive to internal risks but are also fully compliant with the NHS Wales Escalation Framework and external regulatory requirements. The combination of standardised protocols, transparent tracking, regular external validation, and scheduled review means ARAC can be confident in providing a strong ASSURE rating for this criterion.

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Hywel Dda  
University Health Board

## 6. Self-assessment Against Governance & Leadership Maturity Matrix

Status – ASSURE

Committee: ARAC

Lead Executive: Joanne Wilson

### Explanation

The Board undertook a detailed self-assessment against the Central Government Good Practice Code and an updated Governance/Leadership Maturity Matrix at a Board seminar in April 2025. The process was externally validated by Welsh Government, then formally received and endorsed by ARAC in May 2025. Welsh Government has acknowledged this and is “content with the processes in place”.

### Why Assure?

- **Full Cycle Completed** - Assessment, external validation, ARAC review.
- **Board Endorsement** - Explicit Board/Committee acceptance.
- **WG Content** - Formal recognition from regulator.
- **Conclusion** - Robust, documented, and endorsed—supports **Assure**.

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## 7. Board Acts on and Addresses Concerns Raised by Regulators (HIW, Audit Wales, etc.)

Status – ALERT

Committee: ARAC

Lead Executive: Sharon Daniel

### Overview

This criterion requires the Board not only to respond promptly to regulatory concerns, but also to demonstrate *systematic closure and learning* from recommendations raised by external bodies such as Health Inspectorate Wales (HIW), Audit Wales, and the Royal Colleges. A credible “Assure” position depends on being able to evidence both immediate action on critical risks and timely, sustainable delivery of all improvement actions.

### Current Position (as of July/August 2025)

- **Some Improvement - but not yet assurance** - The Health Board has made progress in recent months in closing overdue HIW actions. The number of outstanding or overdue recommendations has dropped from 51 (Feb 2024) to 17 (July 2025), which reflects better operational grip and focus.
- **Ongoing Monitoring** - Updates on HIW recommendations continue to be reported through the regular Quality Assurance Report to QSEC, with an overview of compliance reported 3 times to ARAC. Issues are also picked up via our internal escalation framework.
- **Process improvements** - Dedicated service leads have been assigned to HIW action plans, and the Board receives summary updates through 3As reports from Committees.

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Hywel Dda  
University Health Board

## Welsh Government amendment – new HIW Governance & Leadership criterion (July 2025)

In July 2025 Welsh Government updated the NHS Wales Oversight & Escalation Framework, adding a specific Governance & Leadership requirement: “Boards must evidence robust escalation, tracking, closure and organisational learning from HIW recommendations.”

This new national criterion sits alongside the existing ARAC measures and requires clear assurance that recommendations are:

- Clarified at draft stage if unclear or undeliverable.
- Resourced (people, time, budget) before acceptance.
- Delivered to risk-based deadlines, with evidence of embedding and thematic learning.

## Key Issues/Concerns

- **Persisting delays on high-risk items** - Of the 17 outstanding actions, several relate to services with a history of regulatory and safety concern, such as maternity, critical care, ward safety, and elements of medical workforce. The risks here are not just administrative - unresolved HIW recommendations often indicate deeper underlying workforce, culture, or patient safety issues.
- **Regulatory perception** - HIW and Welsh Government have flagged (in correspondence and in meetings) that although progress has been made, the pace of closure is still “too slow,” particularly for high-risk recommendations. This is a reputational risk to the organisation and can undermine public and stakeholder confidence.
- **Learning and assurance** - Delays in adopting recommendations increase the risk that “lessons identified” are not truly “lessons learned,” which may result in repeated incidents or missed opportunities to improve care. External reviews highlight that some actions have remained open for over a year due to system, cultural, or resource barriers, not just technical delay.
- **Action closure vs. evidence** - There is ongoing tension between closing recommendations quickly and being able to demonstrate that underlying changes are embedded and sustainable. In some cases, HIW has asked for additional evidence or follow-up before accepting actions as complete, which can further slow the process. In these examples, a longer period of the action being open is reasonable as the key here is to ensure lessons are learnt and embedded.

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Hywel Dda  
University Health Board

## Why this Remains an ALERT

- **Volume of open recommendations** - Even at 17 outstanding, the number is high, and the Board remains under closer regulatory scrutiny as a result i.e. this was specifically added to the escalation
- **Nature of open actions** - Some overdue items relate directly to patient safety, workforce, or statutory compliance, increasing the seriousness of the risk if left unresolved.
- **HIW and WG concern** - Ongoing correspondence and oversight meetings indicate that regulators are not yet satisfied with the pace or depth of response.
- **Board and ARAC oversight** - ARAC, QSEC and the Board need to receive assurance that there is robust oversight and challenge of closure of recommendations and sustainable change, that can be evidenced.

## What Needs to Happen Next

- Prioritise the closure of the highest-risk recommendations, with Board-level ownership and clear timescales.
- Provide QSEC with assurance around clear targeted recovery plans for areas that are not progressing.
- Work with HIW and WG to clarify evidence requirements for action closure.
- Ensure that lessons learned from HIW recommendations are systematically embedded, and that thematic analysis is used to prevent recurrence.

## Summary

- While the Board continues to have clear processes for managing and reporting HIW and regulatory actions, the number and nature of overdue recommendations remain a cause for external concern. Until all high-risk HIW recommendations are closed (with clear evidence of sustained improvement), and the Health Board can demonstrate a move from reactive to proactive assurance, this criterion must remain at ALERT.

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Hywel Dda  
University Health Board

## Recommendation

The recent amendment by Welsh Government to our Escalation Framework explicitly places greater emphasis on the governance and leadership arrangements regarding HIW recommendations. ARAC has previously acknowledged that our governance processes around regulatory actions are robust. This assurance is supported by external validation from Audit Wales and Internal Audit. However, it is recommended that to drive further assurance that:

ARAC formally notes the need to strengthen professional and operational responses to ensure consistent adherence to established HIW processes, particularly concerning resource allocation, capacity, and realistic timeframe setting. Progress and effectiveness should be tracked through our internal escalation framework and reported back to ARAC via future reports.

**Health, Social Care and Early Years Group  
Welsh Government**

**Hywel Dda University Health Board**

**Escalation Framework**

**April 2025**



Llywodraeth Cymru  
Welsh Government

**Contents**

1. Introduction .....	2
2. Escalation history .....	3
3. NHS Wales oversight and escalation framework .....	4
4. Roles and responsibilities .....	5
5. Finance, strategy and planning .....	6
5.1 Finance – level 4 .....	6
5.2 Strategy and planning – level 4 .....	9
6. Clinical services – level 4.....	10
7. Performance and outcomes.....	11
7.1 Urgent and emergency care – level 4.....	11
7.2 Cancer – level 4.....	12
7.3 Quality of care related to HCAs - level 4.....	13
7.4 Planned care – level 3 .....	14
7.5 Children and adolescence mental health services – level 3 .....	16
8. Governance and leadership – level 3.....	17
9. Document control.....	19

## 1. Introduction

Following an assessment against the NHS Wales oversight and escalation framework in February 2025, Hywel Dda Bay University Health Board escalation levels are as follows:

- Level 4 for finance, strategy and planning, performance and outcomes related to urgent and emergency care, cancer and quality of care related to HCAs and fragile services
- Level 3 for performance and outcomes related to planned care, CAMHS and leadership and governance

Level 4 (targeted intervention) is the second highest level of escalation within the NHS oversight and escalation framework. It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support. The Welsh Government will take and co-ordinate action and direct intervention to support the health board to strengthen its capability and capacity to drive improvement. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. The interventions will normally be undertaken by the NHS Wales Executive directed by Welsh Government. If appropriate, external support will be agreed with the organisation.

Level 3 (enhanced monitoring) occurs when Welsh Government has identified serious concerns related to the NHS organisation. Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular interactions and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data. The NHS organisation will need to demonstrate that it is taking a proactive response to the escalation and will need to put in place effective processes to address the issue(s) and drive improvement itself. Welsh Government will co-ordinate activity to closely monitor, challenge and review progress.

## **2. Escalation history**

In September 2022, the health board was escalated to targeted intervention from enhanced monitoring for finance and planning. Quality and performance remained in enhanced monitoring following concerns around urgent and emergency care, planned care including cancer, neurodevelopment and child and adolescent mental health services.

In January 2024, the health board was escalated to level 4 (targeted Intervention). The escalation of the whole organisation into level 4 reflected escalating concerns across all the domains within the oversight and escalation framework.

In March 2025, the health board was de-escalated to level 3 for performance and outcomes relating to planned care and CAMHS and for leadership and governance.

### 3. NHS Wales oversight and escalation framework

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed.

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools, guidance.
- Impact focussed - we will examine and seek assurance and evidence how organisations are obtaining assurance over delivery and impact of actions.
- Be undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

*Whilst in escalation:*

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery Board (IQPD) and Joint Executive Team (JET) meetings.
- Quarterly escalation meetings will be chaired by the Director General of the Health, Social Care and Early Years Group / Chief Executive NHS Wales – these will cover both the level 4 and 3 progress, but with a greater scrutiny on level 4 actions and impact.
- Finance, strategy and planning level 4 touchpoint meetings will be agreed with the Finance, Planning and Delivery team within NHS Executive - these will examine progress made against the action log, review evidence and agree outputs for inclusion at the Welsh Government led escalation meetings.
- The monthly IQPD meetings led by Welsh Government will be utilised to ensure effective ongoing oversight against the concerns related to performance and outcomes domain.

#### **4. Roles and responsibilities**

##### Welsh Government

1. Support a formal structure for reviewing and reporting progress.
2. Signpost relevant best practice guidance and frameworks.
3. Act as a critical friend and sounding board on existing practices and new developments.
4. Review and provide feedback on action plans.
5. Undertake and share relevant analysis and deep dives of national data.
6. Enable shared approaches to key national issues across Welsh organisations and promote shared learning.
7. Direct the NHS Executive to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
8. Work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

##### Hywel Dda University Health Board

1. Appoint an SRO(s) for all areas of escalation.
2. Ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
3. To produce an enhanced monitoring/targeted interventions plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.
4. Provide progress reports and evidence against the escalation plan to Welsh Government.
5. Give assurance that there are formal review mechanisms in place within the health board to monitor and deliver the required improvements.

## 5. Finance, strategy and planning

### 5.1 Finance – level 4

The finance intervention and focus whilst in level 4 covers the following areas and the health board will be required to:

- Demonstrate financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness by undertaking a review of the financial management arrangements in place against an appropriate best practice framework(s) and developing and implementing an action plan to address any gaps in approach.
- Clearly articulate the drivers of the current deficit to inform a triangulated approach to identify and deliver actions that will improve efficiency, sustainably reduce costs, and maximise the sustainable use of resources.
- Demonstrate clear policies and processes supporting the identification, delivery and monitoring of all savings schemes and opportunities. This should include having a clear and robust opportunities framework (and pipeline) that contains realistic opportunities to support and manage the short-term challenges being faced, as well as driving the larger-scale transformational changes that will support long-term sustainability.
- Demonstrate and evidence an integrated planning approach and strategy to deliver as a minimum the target control total set for the health board, with a clear roadmap and key milestones for delivery of a breakeven plan over the medium term. This should include clear and realistic planning assumptions, which triangulates with the organisation's longer-term strategic objectives around service delivery, workforce, infrastructure, etc.
- Stress-test and challenge the health board's plan submission for 2025/26 and identifying opportunities for improvement.
- Evidence delivery of an improving financial trajectory in line with the organisation's Board approved plans, including significant progress towards delivery of the target control total; improved grip and control of the existing financial and operational pressures; and further progress around identification and delivery of opportunities.

#### Financial governance and control environment

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and addresses key risks.
- Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
- Financial controls at the health board are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews or other control reviews.

- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Budget holders and managers are held to account for delivering their financial plans.
- That as a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

#### Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.
- The drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored through the Integrated Performance Report.
- The integrated performance reports clearly identify and monitor metrics against key activity cost drivers.
- Triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

#### Development and realisation of opportunities

- Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.
- Development of a comprehensive opportunities framework with a constant pipeline of opportunities, and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

#### Clear financial plan and strategy

- An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
- A clear engagement plan to communicate the necessity for financial improvement across the organisation.

#### Delivery of Plan

- It is delivering clear improvement in the planned financial trajectory for 2025/26 (significant progress towards delivery of the target control total), including further progress around identification and delivery of recurring opportunities.

### De-escalation criteria

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

## 5.2 Strategy and planning – level 4

The strategy and planning intervention and focus whilst in level 4 escalation covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

### Submission and delivery of an approvable plan

- Improved integrated planning evident across the organisation to develop an approvable IMTP, providing a route map towards the health board's longer-term ambition.
- Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
- Make good progress in delivering the ministerial targets, delivery expectations and enabling actions (as set out in the NHS Wales Planning framework 2025-28), accountability criteria and the level 4 requirements.

### Clinical strategy

- Clearly agreed refreshed clinical strategy and development of a clinical plan to lead future planning and investment decisions.
- Demonstrate how the clinical strategy and plan are driving decision making across the organisation.

### Regional planning

- Ensure the delivery of key objectives are made through the Joint Committee with Swansea Bay University Health Board, demonstrating improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services, including orthopaedics and ophthalmology.

### De-escalation criteria

1. Submission of an acceptable annual plan in line with the current planning framework.
2. Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.
3. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.
4. Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.
5. Progress made with regional planning in relation to orthopaedics, ophthalmology, stroke services, urology, and upper GI services in 2025/26.

## 6. Clinical services – level 4

The fragile services intervention and focus whilst in level 4 will alter over time in response to workforce and estate challenges. At this point the focus will be on the nine clinical areas identified in the clinical services plan as follows:

- Critical care
- Dermatology
- Elective orthopaedics
- Ophthalmology
- Urology
- Emergency general surgery
- Stroke
- Endoscopy
- Radiology

For each service, the health board will be expected to produce a summary document setting out the issues of concern, and action plans with agreed outcomes and access targets.

### De-escalation criteria

1. Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.
2. Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.
3. Progress is being made towards key performance metrics
4. Evidence that all recommendations from the Royal Colleges, 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.
5. Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.
6. 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.

## 7. Performance and outcomes

### 7.1 Urgent and emergency care – level 4

The performance and outcomes intervention and focus for urgent and emergency care (UEC) covers the following areas and the health board will be required to action and demonstrate:

#### Sustainable services

- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.
- Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

#### Work with national programmes and respond to external reviews

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care, Six Goals for Emergency Care and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities.
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

#### Communications and engagement

- Ensure that patients are clear where they can and should access support, signposting away from emergency services.

#### De-escalation criteria

- A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on agreed baseline).
- Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.
- Continuous improvement in the median time from arrival at an emergency department to assessment by a clinical decision maker to achieve a maximum of 60 minutes.
- A continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months and then maintained (based on agreed baseline).
- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC. Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.

## **7.2 Cancer – level 4**

The performance and outcomes intervention and focus for cancer covers the following areas and the health board will be required to action and demonstrate:

### Sustainable services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Ensure compliance with all aspects of the NOPs
- Maintain cancer performance in line with the agreed standards and ensure that the backlog of patients waiting over 62 and 104 days is kept to a minimum agreed level.

### Work with national programmes and respond to external reviews

- Work with and implement the recommendations from the Cancer Recovery Programme
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

### Communications and engagement

- Effective and meaningful engagement with patients related to the potential urgency of their condition, waiting times policies and the provision of appropriate support that keep patients well whilst waiting
- Ensure effective communication and engagement with general practice in relation to referral management

### **De-escalation criteria**

- 60% performance maintained for 3 months against the SCP target.

### **7.3 Quality of care related to HCAs - level 4**

The performance and outcomes intervention and focus for quality of care related to HCAs covers the following areas and the health board will be required to action and demonstrate:

#### Sustainable services

- Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board.

#### Governance and Leadership

- The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAs
- Clear and effective response mechanisms in place to respond to outbreaks reporting directly to Board

#### De-escalation criteria

- C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month)
- Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month)
- E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month)

## **7.4 Planned care – level 3**

The performance and outcomes intervention and focus for planned care covers the following areas and the health board will be required to action and demonstrate:

### Sustainable planned care services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Improved access to planned care with reduced waiting times in line with the de-escalation criteria.
- Delivery of the enabling actions in the 2025/28 planning guidance.
- Implementation of an outpatient's transformation plan in line with the requirements of the planned care programme.
- Impact of regional working arrangements.

### Work with national programmes and respond to external reviews

- Work with and implement the recommendations from national programmes including but not limited to Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, the CIN optimisation programmes and related national improvement recommendations.
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendations, developing and completing action plans that demonstrate sustainable evidence.

### Communications and engagement

- Effective and meaningful engagement with patients related to service changes, waiting times policies and the provision of appropriate support that keep patients well whilst waiting.
- Ensure that patients are clear where they can and should access support.
- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

### De-escalation criteria

- 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
- Continuous improvement towards 75% of all open outpatient pathways waiting less than 26 weeks.
- 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
- Continuous improvement towards 80% of all open pathways waiting less than 36 weeks.
- 12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2024 baseline.)
- 85% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.

- 85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
- 85% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
- 90% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.
- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.

### **7.5 Children and adolescence mental health services – level 3**

The performance and outcomes intervention and focus for CAMHS covers the following areas and the health board will be required to action and demonstrate:

#### Sustainable services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Maintain CAMHS performance in line with the standards set out in the Mental Health Act and Mental Health (Wales) Measure, for adult and children's services.

#### Work with national programmes and respond to external reviews

- Work with and implement the recommendations from the Inpatient Safety Programme
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

#### Communications and engagement

- Effective and meaningful engagement with patients related to service changes, waiting times policies and the provision of appropriate support that keep patients well whilst waiting and that they are able to access the appropriate levels of support

#### De-escalation criteria

- 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.
- 70% of therapeutic interventions started within 28 days following an assessment by LPMHSS.
- 85% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan.
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s.
- Improved patient and family feedback.

## **8. Governance and leadership – level 3**

The governance and leadership intervention and focus covers the following areas and the health board will be required to action and demonstrate:

### Governance

- That all parts of the organisation are clear on accountability and expectations at all levels to ensure successful delivery.
- Effective decision making that supports financial management, performance improvement, safe, timely and quality care.
- Revised standard operating processes are in place following the organisational restructure.
- Effective programme management, which defines objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; effective, open and transparent reporting, with effective strategic Board oversight.
- Ensuring the health board is a data-driven organisation that ensures data is understood and utilised in decision making at all levels.
- Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committees.
- Succession and development plans in place to ensure operational efficiency at all times.

### Leadership

- Demonstrate through delivery, leadership that enables the organisation to implement national strategic programme objectives.
- Lead the improvement in sustainable service delivery with increased focus on the short and medium term.
- Ongoing development of leadership and management skills at all levels / professions to strengthen management maturity.
- The organisation is focussed on all aspects of strategic workforce planning and maximising the skills of its current staff.
- Continuation of embedding / demonstrating lived values and behaviours throughout the organisation.
- Clinical leadership is visible and effective.
- There is evidence of positive shifts in culture in key areas such as multidisciplinary working.
- Senior leaders set the desired culture and tone for the organisation which promotes equality, inclusivity, openness and transparency.
- A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including patient outcomes, user and staff feedback.

### Board Self-Assessment

- Review strategic risks and ensure that risk management is aligned with the health board's risk appetite.

- Ensure an appropriate governance framework is in place, particularly with regards to providing appropriate scrutiny of performance, leadership style and practice.
- Regular self-assessment against an agreed maturity matrix.
- Responding to the outcome of self-assessments and external assessments and observations by setting objectives that will improve effectiveness.

#### De-escalation criteria

1. Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit.
2. Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making.
3. Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement.
4. 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.
5. Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes.
6. 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.
7. Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity.
8. Positive staff engagement in NHS Wales surveys.
9. Self-assessment against the governance and leadership maturity matrix with evidence the agreed level.
10. The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

## 9. Document control

<b>Date</b>	<b>Comments</b>
April 2025	New framework following changes in in escalation status in March 2025.
15 May 2025	Amended following comments from health board
12 June 2025	Amended governance de-escalation criteria
30 June 2025	Agreed by Hywel Dda UHB

Project ID	Project Name	Start Date	End Date	Project Manager	Project Sponsor	Project Description	Project Status	Project Phase	Project Budget	Project Risk	Project Complexity	Project Location	Project Team	Project Lead	Project Contact	Project Email	Project Phone	Project Fax	Project Website	Project URL	Project Notes	
Project 001	Project Name 001	2023-01-01	2023-03-31	John Doe	John Doe	Project Description 001	Completed	Phase 1	\$1,000,000	Low	Medium	USA	John Doe	John Doe	john.doe@company.com	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	Project 001 Notes	
Project 002	Project Name 002	2023-04-01	2023-06-30	Jane Smith	Jane Smith	Project Description 002	In Progress	Phase 2	\$2,000,000	Medium	High	USA	Jane Smith	Jane Smith	jane.smith@company.com	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	Project 002 Notes
Project 003	Project Name 003	2023-07-01	2023-09-30	Mike Johnson	Mike Johnson	Project Description 003	On Hold	Phase 1	\$500,000	Low	Low	USA	Mike Johnson	Mike Johnson	mike.johnson@company.com	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	Project 003 Notes
Project 004	Project Name 004	2023-10-01	2023-12-31	Sarah Lee	Sarah Lee	Project Description 004	Planned	Phase 1	\$3,000,000	High	Very High	USA	Sarah Lee	Sarah Lee	sarah.lee@company.com	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	555-555-5555	Project 004 Notes

# Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee - Action plan

Inspection origin: Targeted intervention


Date of inspection: 12/08/2025

Inspection lead: Shaun Ayres

Inspection team: Katrina Davies, Shaun Ayres


Date action plan generated: 30th July 2025

## Recommendations & actions

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/55 8/MD1		Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete


Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/55 8/MD1/1	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
The review of the Executive Team Governance was concluded by Internal Audit and reported to ARAC in May 2025. The IA review of the new operational governance arrangements has been included in the IA plan for 2025/26 - to take place in Q2/Q3. This plan was agreed by ARAC in April 2025.	None	None	2	


Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD2		Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD2/1	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
<p>Regular reports provided to Board and Committees include IPAR, Risk Register, Q&amp;S Dashboard, Clinical Services Plan Updates, Deep Dive reports on specific issues, updates on GIRFT reports. A number of reports to Board requesting decisions on service changes demonstrate the impact on quality has been considered. Finance paper to Board in July 2025 demonstrates the impact to quality. Fragile Services Framework paper to Board in July 2025.</p> <p>Furthermore, the Targeted Intervention (TI) pack undergoes thorough scrutiny at committee level, with robust and regular discussions across relevant committees. Significant progress has been made to ensure that each committee focuses on the de-escalation criteria relevant to its remit, particularly within the Audit and Risk Assurance Committee, People, Organisational Development and Culture Committee, Quality, Safety and Experience Committee, Finance and Performance Committee and the Strategy and Planning Committee.</p> <p>Following feedback from independent members at ARAC meetings, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing have been addressed (see Feb25 TI update to ARAC). Standardised reporting on TI taking place across the Health Board's committees.</p> <p>The new Clinical Care Group (CCG) model was implemented in April 2025 to strengthen governance through Integrated Governance Groups (IGGs) that meets fortnightly to examine planning, performance, Finance, people, quality, health and safety matters. This was a planned transition from the previous directorate-based approach. While this transition represents a significant organisational change that will require time to fully embed, it is designed to provide greater cohesion across related clinical services and strengthen local ownership of care pathways while maintaining robust Health Board-wide oversight. In Internal Audit review is planned for Q4 of 2025/26, with further AW review on quality governance arrangements to take place in 2026. Structured Assessment 2025 will also provide a high level feedback on implementation so far.</p> <p>AW Structured Assessment 2024 concluded that whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.</p>	None	None	19	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD3		Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement.	Must do	Mr Lee Davies	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress


Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD3/1	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue
Comments/Updates		Risks	Barriers	Number of uploaded evidence		Reject reason (if applicable)	
None		None	None	0			

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD4		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.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD4/1	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. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)


Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
<p>The Board receives the Board Assurance Framework (BAF) and Corporate Risk Register on a quarterly basis, ensuring regular oversight of principal and corporate risks. The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines through our formal governance structure. This allows the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services and to fulfil its role, not only in terms of monitoring, but also in challenging and supporting the development of mitigation strategies. AW Structured Assessment 2024 provided assurance that the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements. The Risk Appetite Statement was refreshed in January 2025 and has been operationalised throughout the year, this informs decisions on 'accepting' risks'.</p> <p>The Health Board undertakes a review of its risk maturity annually against The Orange Book Risk Management Standard, which then informs the objectives set out its Risk Management Strategy, and agreed by the Board. The Board approved its Risk Management Strategy in March 2024. This is supported by an up-to-date risk management framework and procedure - both the Risk Management Strategy and Framework have been reviewed and will be presented to the Board for approval in September 2025.</p> <p>The Board's approach to risk management was also rated at Level 4 ("Results Achieved") in the Board Maturity Matrix in April 2025, reflecting the positive impact of scenario testing and action planning.</p> <p>The implementation of the Clinical Care Group model from April 2025 has strengthened risk management by integrating risk identification and management at service level. Each CCG's fortnightly Integrated Governance Group meetings are designed to ensure emerging risks are identified and addressed promptly, with clear escalation routes to the Integrated Quality, Finance &amp; Performance Delivery Group where needed. This is intended to address the previously identified gap between risk identification and active mitigation, creating more responsive risk management closer to service delivery.</p> <p>Operational oversight has also improved through internal escalation processes, however challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation. It has been observed that while risks are being systematically recorded, there is sometimes a lack of capacity to manage the risks and the actionable plans tied to these risks. This gap is being addressed by focusing on the development of risk management plans that contain specific deliverables, measurable milestones, and clearly assigned responsibilities (subject to capacity) that are linked to the Health Board's agreed objectives, as set out in the Health Board's Annual Plan. Strengthening these aspects will enhance the link between risk identification and tangible mitigation outcomes, promoting a more cohesive approach to risk management across the Health Board.</p> <p>No critical gaps are identified; residual risk remains low.</p>	None	None	10	




Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD5		Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes.	Must do	Mr Lee Davies	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD5/1	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue
Comments/Updates		Risks	Barriers	Number of uploaded evidence		Reject reason (if applicable)	
None		None	None	0			



Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD6		Self-assessment against the governance and leadership maturity matrix with evidence the agreed level.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD6/1	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue
Comments/Updates		Risks	Barriers	Number of uploaded evidence		Reject reason (if applicable)	
None		None	None	0			

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD7		The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.	Must do	Ms Sharon Daniel	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress



Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD7/1	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Ms Sharon Daniel	11/07/2025	22/07/2025	Overdue
Comments/Updates		Risks	Barriers	Number of uploaded evidence		Reject reason (if applicable)	
None		None	None	0			

