PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 October 2024
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 Termau: 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 criteria set, 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 against each recommendation, with evidence requested to be uploaded to demonstrate their progress and full implementation.

AMaT allows services to directly to update progress against all recommendations via one central system, which promotes consistency in approach with regards to processes and reporting, improvement in transparency and accountability, supports services with their governance, and improves 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 (*AMAT Status: Complete and awaiting approval / Fully Complete*)
Amber	Recommendation is currently in progress, and within the agreed **original** timeframe for implementation (*AMAT Status: Partially Complete / In Progress*)
Red	Recommendation is in progress, but has exceeded its agreed **original** timeframe for implementation (i.e. overdue) (*AMAT Status: Overdue / Partially Complete (Overdue)*)
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. (*AMAT Status: In Progress*)

The Assurance and Risk team and Quality, Assurance and Safety Team (QAST) liaise directly with services and review the status of reports monitored to support the provision 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. Where service leads have not yet received training on AMaT, the Assurance and Risk Team continue to provide support via email and review meetings.

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

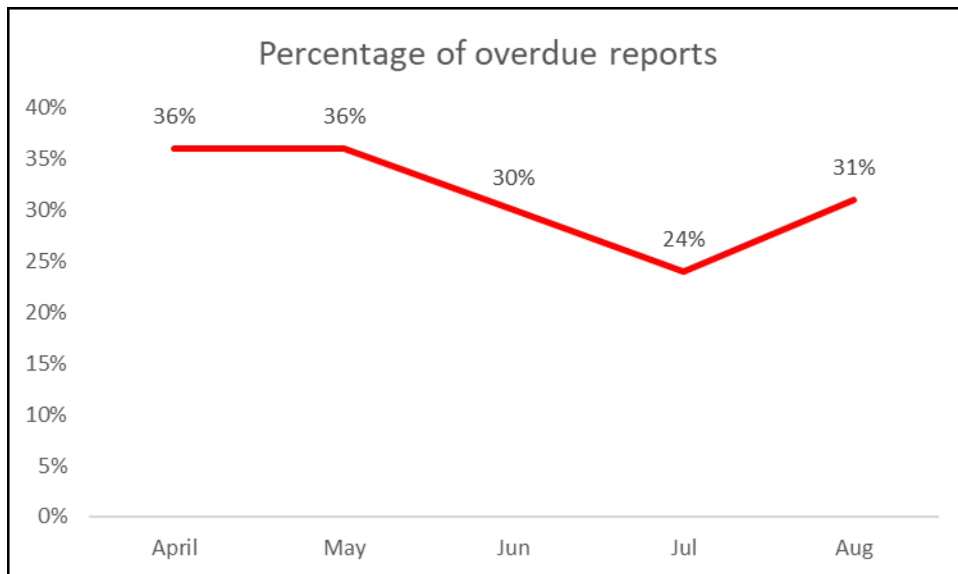
	June 2024	August 2024	Trend
Total number of reports	158	174	↑
Number of overdue reports	62	54	↓
Total number of recommendations	1408	1499	↑
Number of Green recommendations (completed)	832	840	↑
Number of open recommendations	576	611	↑
Number of Amber recommendations (in progress and in line with original timescales)	275	369	↑
Number of Red (overdue) recommendations	250	242	↓
Number of recommendations overdue by more than 6 months	116	121	↑
Number of recommendations classified as 'External'	51	48	↓
Number of recommendations without revised timescales (N/K)	108	106	↓

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

Inspectorate / Regulator	Open reports as at month- end July 2024	New reports as at month-end July 24	Closed reports as at month-end July 24	Open reports as at month-end August 24	Open reports which are overdue	Red recommendations	Red recommendations overdue by more than 6 months
Audit Wales (AW)	9	2	1	10	6	8	7
Care Inspectorate Wales (CIW)	2	0	0	2	2	9	1
Health Education and Improvement Wales (HEIW)	3	0	0	3	1	7	2
Health Inspectorate Wales (HIW)	16	1	3	14	7	53	48
Human Tissue Authority (HTA)	1	0	0	1	0	2	0
Internal Audit	31	1	4	29	13	34	9
Llais	4	0	0	4	3	8	8
Mid and West Wales Fire and Rescue Service (MWWFRS)	61	17	0	78	5	8	0
NHS Wales Cyber Resilience Unit	1	0	0	1	0	0	0
NHS Wales Executive	8	0	0	8	2	11	5
Peer Reviews	10	1	0	11	9	81	36
Public Services Ombudsman for Wales (PSOW) – S21	5	2	2	5	2	10	0
Public Health Wales	1	0	0	1	1	0	0
Royal Colleges	1	0	0	1	1	2	2
Shared Services Partnership	0	1	0	1	0	3	0
Welsh Risk Pool (WRP)	2	0	0	2	1	3	2
Welsh Language Commissioner (WLC)	1	0	0	1	1	0	0
Welsh Government	2	0	0	2	0	3	1
TOTAL	**158**	**25**	**10**	**174**	**54**	**242**	**121**

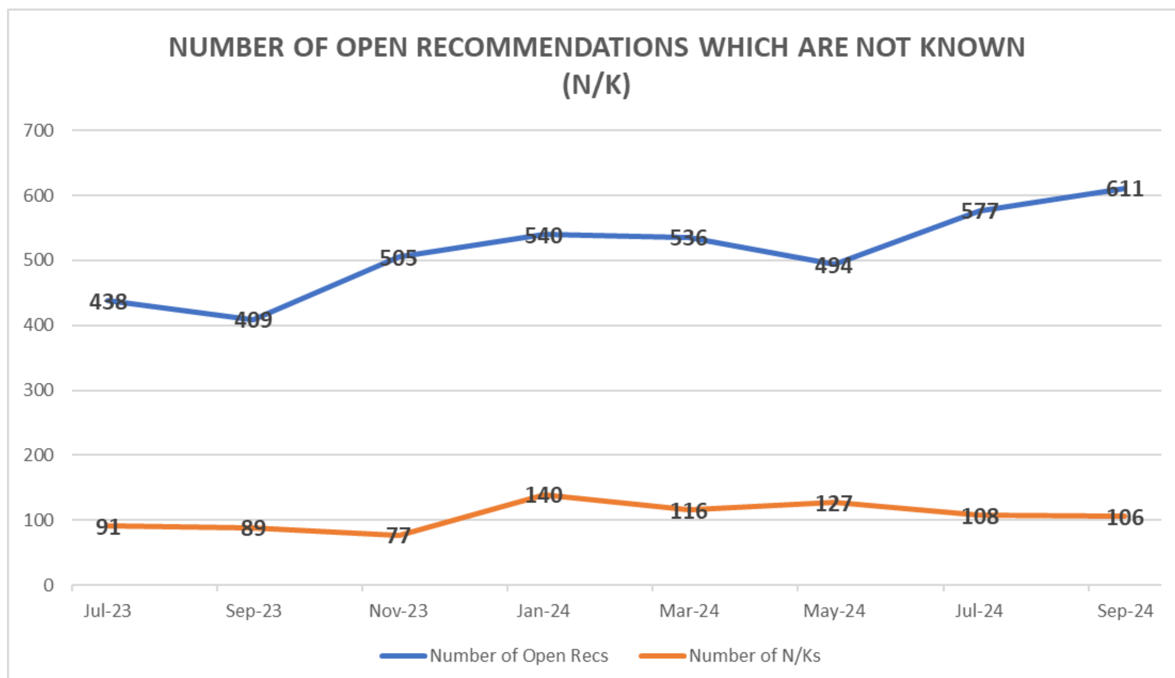
Overdue reports

There has been an overall reduction in the number of overdue reports since April 2024, as demonstrated in the trend graph overleaf. Whilst it is noted that there has been an increase between July and August 2024, this may be as a result of operational pressures and capacity over the summer months, there is an overall positive trajectory over the first six months of 2024/25.



Recommendations without revised timescales

There were 106 recommendations without revised timescales as at August 2024, representing 7% of all recommendations. While this is an improving position, as highlighted by the trend graph below, work to obtain progress updates and revised dates continues.



Recommendations without revised timescales are mainly attributed to the following:

- Implementation is reliant on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems;
- Recommendations previously noted as 'complete' that have been re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;

- Recommendations with completion dates of July 2024 which have not been updated with a revised completion date during August;
- Directorates have reviewed recommendations however have not provided a revised completion date. This may be due to specific barriers such as financial challenges / resource and capacity challenges which require resolution; and
- Recommendations have not been reviewed by services on AMaT.

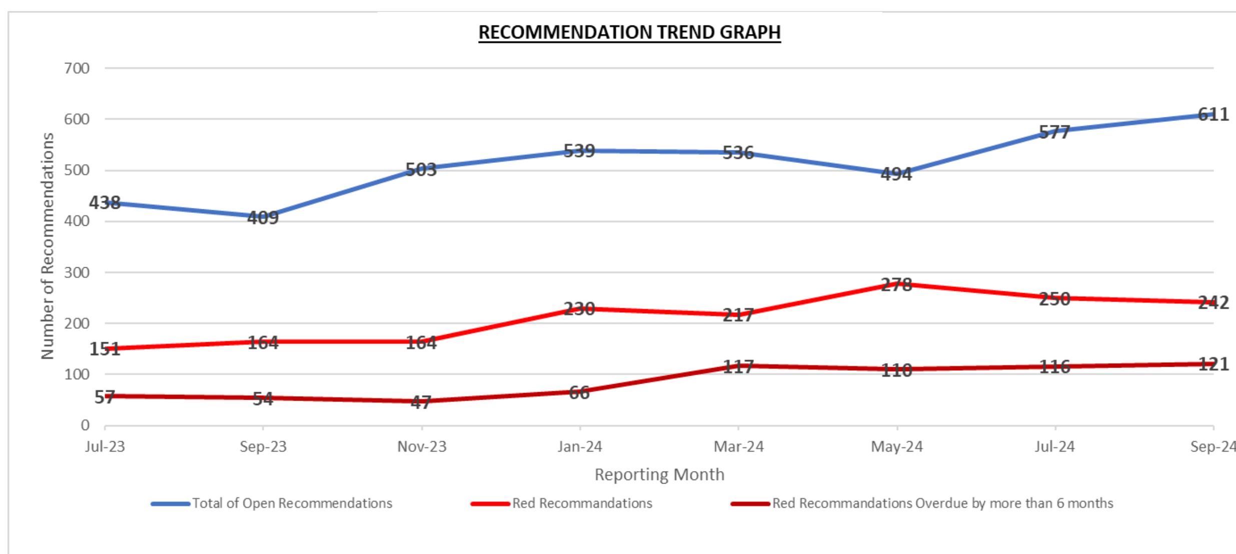
Directorates are able to note on AMaT the specific barriers to the full implementation of recommendation. Training materials and sessions include the requirement for recommendation owners to include revised completion dates where appropriate when providing progress updates. Additional guidance is being developed for the Assurance and Risk's Sharepoint site relating to required information when providing progress updates on AMaT, allowing staff across the Health Board to access from a central resource point, and supporting the content of existing training materials.

The Assurance and Risk Team review recommendations which have not had progress updates, 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 PowerBI 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.

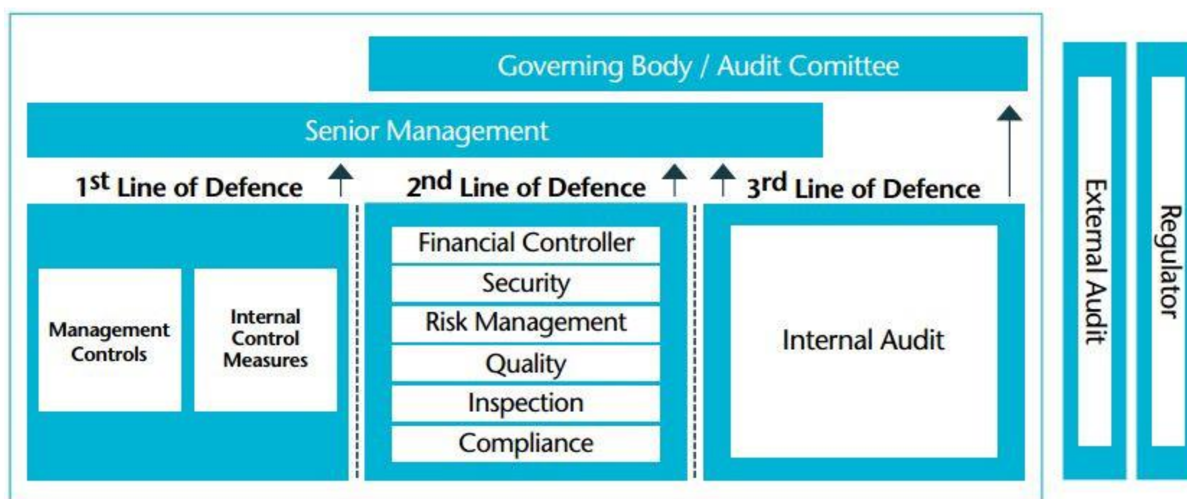
Overdue recommendations

The graph below illustrates the trend in the number of overdue recommendations, and the number of recommendations overdue by more than 6 months over the previous year. Whilst the number of overdue recommendations is showing an improving trend, the number of recommendations that are overdue by 6 months has not improved since March 2024. 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.



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 risks and recommendations, with operational staff responsible for maintaining internal controls such as processes, procedures, and identifying risks and addressing as required.

Progress on implementation of recommendations are discussed by services and directorates via quality governance meetings for operational areas, or senior management meetings for corporate functions. The frequency of these meetings vary but are either monthly or bi-monthly. Local governance arrangements are considered when awarding the escalation status for Governance. For operational services, an overview of progress made against recommendations is also reported to the Chief Operating

Officer's monthly Operational Performance, Governance and Planning (OPGP) meetings, and to the Acute Leadership Group (ALG) chaired by the Director of Operational Performance and Delivery.

Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are still provided to management and service leads 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 August month end 2024	Total number of recommendations as at August 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 *(including Central Operations, Acute Service, and USC: Health Board wide)*	6	60	14	9	1
Facilities	88	674	40	8	29
Mental Health and Learning Disabilities	13	164	54	39	35
Oncology	2	11	1	0	0
Pathology	2	26	5	1	5
Radiology	3	30	3	1	3
Planned Care *(including Audiology & Endoscopy)*	10	177	67	21	8
Unscheduled Care: Bronglais General Hospital	1	3	1	1	0
Unscheduled Care: Withybush General Hospital (*including Stroke and COTE)*	2	53	1	0	1
Unscheduled Care: Prince Philip Hospital (*including Diabetes and Respiratory)*	1	1	1	1	1
Unscheduled Care: Glangwili General Hospital *(including Cardiology, Gastro and Renal)*	0	0	0	0	0
Women and Children	4	45	21	19	7
Director of Primary, Community and Long Term Care					
Ceredigion *(including Palliative Care)*	1	5	5	5	5
Carmarthenshire	0	0	0	0	0
Pembrokeshire	0	0	0	0	0
Medicines Management	2	35	0	0	0
Primary Care Management *(Long Term Care and Chronic Conditions)*	1	4	1	0	1
Primary Care *(All other Primary Care services)*	3	8	0	0	0
Director of Finance					
Finance	3	13	0	0	0
Digital	3	18	4	1	0
Performance	0	0	0	0	0

Area	Total number of reports as at August month end 2024	Total number of recommendations as at August 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 Nursing					
Nursing	10	60	7	6	6
Director of Public Health					
Public Health	1	3	0	0	0
Director of Strategy and Planning					
Strategic Planning	7	42	4	2	1
Director of Therapies and Health Sciences					
Therapies	0	0	0	0	0
Director of Workforce and Organisational Development					
Workforce and Organisational Development	2	9	0	0	0
Medical Director					
Medical	7	47	10	5	3
Corporate Services					
Governance	2	11	3	2	0
CEO Directorate	0	0	0	0	0
Total:	**174**	**1499**	**242**	**121**	**106**

Of the 1499 recommendations arising from the 174 open reports reportable at month-end August 2024, which include completed recommendations, 242 (16%) of these are noted as ‘overdue’ as they have passed their **original timescales** for completion, with 121 of these being overdue by more than 6 months (8%), and 106 with unknown timescales for completion (7%).

The use of AMaT to update reports and recommendations has been rolled out across the Health Board, and the improving performance trend in the reduction of both overdue reports and recommendations suggests improved engagement from services. This improvement has also been supported by the implementation of the Health Board’s internal Escalation Framework since April 2024, further detail of which can be found later in the report.

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.

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 which are awarded a level 3 for Governance, but are not awarded an overall Alert status, the Director of Corporate Governance will meet with relevant service leads to discuss concerns, and determine next steps for de-escalation.

The internal escalation framework arrangements came in to force in April 2024, with five rounds of review and escalation undertaken as at the time of writing this report. The Assurance and Risk Team provide focussed support for those Directorates at level 3, to aid their de-escalation, and to prevent those awarded level 2 status being escalated. A summary of each Directorate’s performance for the Governance domain since April 2024 can be found in the following table:

Service	April 2024	May 2024	June 2024	July 2024	August 2024
Director of Operations	1	1	3	3	3
Facilities	3	3	3	3	2
Mental Health & Learning Disabilities	2	2	2	3	3
Cancer & Oncology	2	2	2	2	2*
Pathology	2	2	1	1	1
Radiology	2	2	1	1	1
Planned Care (incl. Audiology and Endoscopy)	2	2	3	3	3
Bronglais Hospital	2	2	2	2	1
Glangwili Hospital	2	2	1	1	1
Prince Philip Hospital	2	2	1	1	1
Withybush Hospital	3	3	2	1	1
Women & Children	3	3	3	3	3
Carmarthenshire County	1	1	1	1	1
Ceredigion County	2	2	2	2	1
Pembrokeshire County	1	1	1	1	1
Primary Care	2	2	1	1	1
Primary Care Management	N/A	N/A	2	2	1
Medicines Management	3	3	1	1	1
Director of Therapies and Health Sciences	2	2	1	1	1
Director of Finance	2	2	2	2	2*
Director of Nursing	2	2	2	2	2*
Director of Public Health	2	2	1	1	1
Director of Strategy and Planning	2	2	1	1	1
Director of Workforce & OD	1	1	1	1	1
Medical Directorate	2	2	2	2	1
Corporate Services	2	2	1	1	1

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

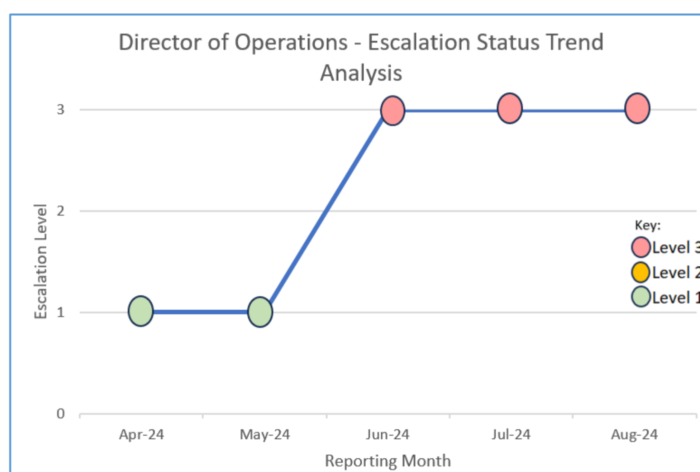
Along with risk management, the implementation of external recommendations has been the dominant factor in assessing Directorate's escalation level. The minimum requirement for a service to be de-escalated is that 90% of audit and inspection recommendations are implemented within agreed timescales.

Detailed analysis of those Directorates who have been awarded either Level 3 or 2 status as at the August 2024 month end position is provided below, based on the implementation of recommendations:

Level 3: Alert Status - Services with No Assurance

Director of Operations

As at 31 August 2024, the Directorate had 6 open reports with 14 recommendations noted as overdue (23%), of which 9 were overdue by more than 6 months (15%). In addition, there was one recommendation without a revised completion date. 7 of the overdue recommendations relate to the Out of Hours Peer Review undertaken in April 2023, and the service is being supported by colleagues in Primary Care in the ongoing management and monitoring of these recommendations. The barrier to the full implementation of these recommendations are strategic in nature and pending the embedding of the operational restructure.



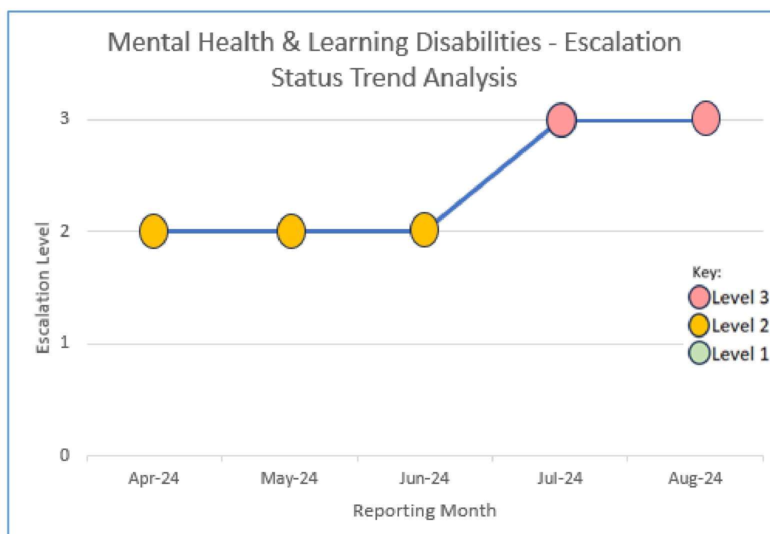
Escalation meetings have been held between the Chief Operating Officer, Director of Corporate Governance and the Assistant Director of Assurance and Risk in both August and September 2024 to discuss the outstanding recommendations, with actions generated and monitored via the internal escalation framework structures, and the Head of Assurance and Risk is supporting the implementation of these actions with relevant report leads.

The Assistant Director of Assurance and Risk attends monthly OPGP meetings which is chaired by the Chief Operating Officer, whereby a summary position of the audit tracker is provided for information and highlighting any key areas of concerns for all services within his remit. 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 their remit. 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 August 2024**,** MH&LD had 13 open reports, with 54 (33%) overdue recommendations, 39 of which by more than 6 months. 35 (21%) of their recommendations were without revised completion dates.

At the time of writing this report, 6 reports have been closed and confirmed as 'completed'' on AMaT. The number of overdue recommendations remains unchanged.



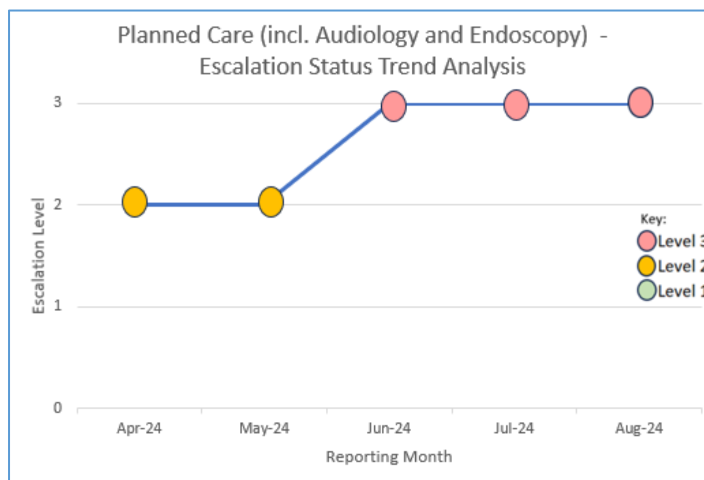
Barriers to the full implementation of recommendations include:

- provision of supporting evidence to enable formal approval of closure;
- inability to recruit staff into posts due to funding;
- 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, such as Facilities;
- 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. An additional meeting has been scheduled with the Assistant Director of Nursing MH&LD to review the overdue recommendations.

There is frequent communication and regular meetings with the Assistant Director of Nursing MH&LD to review risks and recommendations. Response rate to queries can vary across the Directorate and this has prompted additional meetings to be scheduled in October to strengthen communication with those individuals who require support from the Assurance and Risk Officer.

Planned Care *(including Audiology & Endoscopy)*



As at 31 August 2024**,** 67 (38%) of recommendations were overdue, 41 of which relate to the Getting It Right First Time (GIRFT) report on Ophthalmology. Whilst there has been a decrease in the number of overdue recommendations since the implementation of the internal escalation framework due to the progress made and closure of recommendations in the GIRFT reports on General Surgery and Orthopaedics, the number of recommendations overdue by more than 6 months has increased, with 21 noted as such at August month end. 8 recommendations did not have revised completion dates,

Barriers to the full implementation of recommendations include:

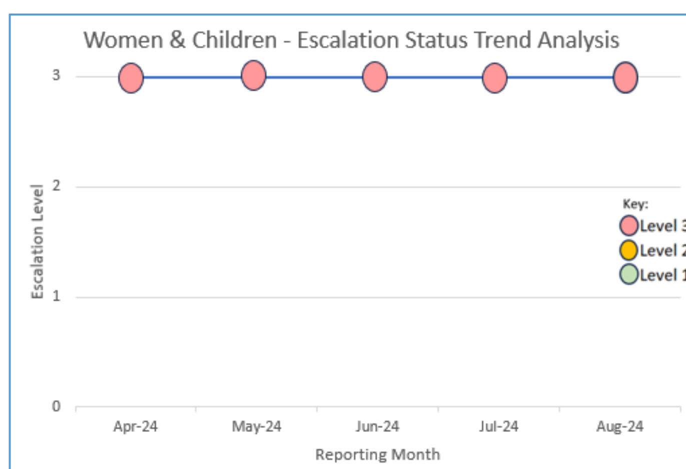
- Staffing challenges including difficulties recruiting substantive consultants and optometrists;
- delays in the rollout of national systems; and
- difficulties in balancing Ministerial Priorities against Eye Care Measures (tackling long waiting lists vs prioritising emergency patients).

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 due to availability, or where due to time constraints, the report has not been formally presented at a meeting, the paper is disseminated to attendees for information and action. The Head of Assurance and Risk also 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.

A meeting was held with Service Delivery Managers for Urology, Orthopaedics and General Surgery reports in August 2024 to review and provide support and constructive challenge in relation to outstanding recommendations on their GIRFT reports. Clarification was also provided on the required governance processes regarding the management of new reports. A further meeting is planned with the Ophthalmology service in October 2024 to review the outstanding recommendations from their GIRFT report.

The Directorate have also appointed their Clinical Risk Practitioner as a dedicated individual with responsibility for overseeing governance within the Directorate.

Women & Children



As at 31 August 2024, the Women & Children's Directorate had 4 open reports containing 45 recommendations, with 21 (47%) noted as being overdue, 19 of which by more than 6 months. 12 of the overdue recommendations relate to GIRFT report on Gynaecology, with revised completion dates provided ranging between December 2024 and September 2026. A plan to address the progression of these actions with support from the Assurance and Risk Team is currently in development with relevant service leads.

A further 6 overdue recommendations relate to the Congenital Heart Defect Provider peer review, 5 of which had no revised timescales as at 31 August 2024. A meeting has been held where further progress updates were obtained, which will be reflected in the data as at September month-end. 3 recommendations have been noted as complete, and 1 recommendation has been given an 'external' status, as all actions within the gift of the Health Board have been enacted, with 1 recommendation still requiring a revised completion date.

Barriers to implementing recommendations include:

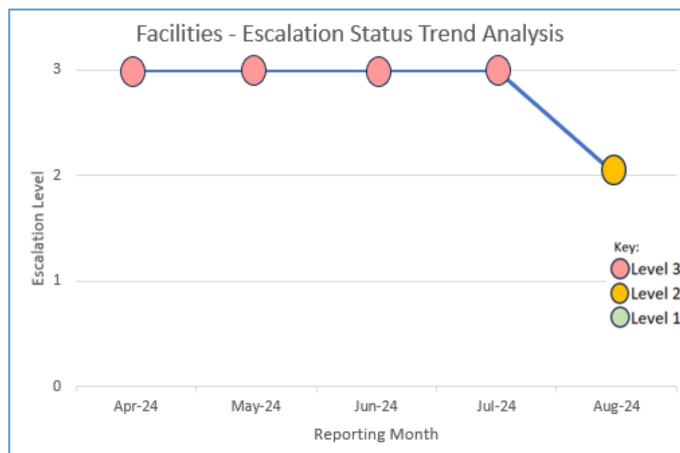
- reliance on external factors such as the review being undertaken on national training programmes; and
- financial challenges.

Monthly Quality Safety and Experience meetings are held, with a report provided by the Assurance and Risk Officer outlining progress and timescales of audits and inspections. There is positive engagement from the Directorate, with ad-hoc meetings scheduled to support relevant service leads to update recommendations when required.

Level 2: Advise Status - Services with Limited Assurance

Facilities

As at 31 August 2024, the Directorate had 88 open reports, primarily arising from Letters of Fire Safety Matters (LOFSMs) issued by MWWFRS. 40 (6%) of these recommendations were overdue, 8 (1%) (8) of which by more than 6 months. 29 (4%) of recommendations were without revised completion dates.



There has been an improvement in the Directorate's performance since the inception of the escalation framework in April 2024, with the requirement to meet the de-escalation criteria achieved of 90% of audit and inspection recommendations implemented within agreed timescales. This, coupled with the review of health and safety governance has resulted in their de-escalation from Level 3 status.

Barriers to implementing recommendations on include:

- provision of supporting evidence to enable formal approval of closure;
- interdependencies with supporting staff;
- absenteeism of nominated recommendation owners (due to sickness/annual leave);
- installation delays due to workload pressures; and
- legacy of older report with unrealistic completion dates set; and
- limited funding, resulting in submission of Capital Bids and associated delays to carry out works.

Established governance arrangements are in place whereby the Assurance and Risk Overview Reports are presented by the Assurance and Risk Officer to the monthly Audit Tracker meeting (last meeting held on 27th August 2024).

There is frequent engagement and communication with the Assurance and Risk Team. Monthly meetings are in place to review outstanding recommendations, and AMaT training has been undertaken with the Directorate to ensure timely progress updates.

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, however the processes to present Peer Reviews to the relevant Committees requires strengthening. Work is underway to ensure these reports are received centrally to ensure their timely presentation at the relevant

Committee. 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 August 2024.

Theme	June 2024	August 2024	Trend
Fire	27%	34%	↑
Service Delivery	12%	11%	↓
Governance	11%	10%	↓
Quality	10%	8%	↓
Workforce	9%	8%	↓
Patient Safety	6%	5%	↓
Health and Safety	0.5%	4%	↑
Training	3%	3%	→
Consent and Mental Capacity	3%	3%	→
Finance	1.5%	2%	↑
IM&T	2%	2%	→
Performance	2%	2%	→
Estates	2%	1%	↓
Reputation	2%	1%	↓
Infection Control	1%	1%	→
Information & Data Capture	1%	1%	→
Safe and effective care	1%	1%	→
Security	1%	1%	→
Information Governance	1%	0.5%	↓
NICE/National Guidance	0.5%	0.5%	→
Partnerships	0.5%	0.5%	→
Safeguarding	0.5%	0.5%	→
Capital	<0.5%	<0.5%	→
Environmental	<0.5%	<0.5%	→
Medication	<0.5%	<0.5%	→

It is noted that 78 of the 174 reports currently open, which represents 45% of reports currently being tracked, 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”.

Whilst recommendation owners and relevant service leads are responsible for reviewing and updating progress made, recommendations per theme are not currently distributed to the relevant subject matter experts. From Quarter 3, the Assurance and Risk Team will share recommendations with subject matter experts (replicating the process undertaken of sharing of thematic risk registers) on a quarterly basis.

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. During the previous 12 months, the following reports have 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:* The report was presented to ARAC at its meeting in December 2023. 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 has maintained and enhanced corporate systems of assurance related to recommendation tracking, with appropriate Board oversight.

- *Audit Wales – Review of Operational Governance:* The report was presented to ARAC at its meeting in June 2024. The key focus of the report was on whether directorate level arrangements support the economic, efficient, and effective use of resources, and specifically whether directorates have clear leadership and governance arrangements, and are conducting business effectively. It was found that while there were adequate systems of assurance at directorate level, there was inconsistent practice within directorates, with scope to strengthen and standardise to support good flows of information. Work is currently underway to address the recommendations raised in the report relating to the development of standard terms of reference, agenda and reporting templates which aligns with the Improving Together Framework. These will be implemented alongside the new Operations Directorate structure.

Next steps

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

- Where system improvements have been identified in relation to the recording, reporting and monitoring implementation of recommendations on AmAT, to raise requests with the national systems team to address these gaps;
- To further liaise with the Performance Team to explore the opportunity to develop performance dashboards via PowerBI, replicating the detail as utilised for the monitoring of recommendations via the internal escalation framework, so that this information is readily available to users across the Health Board;
- Further development of the Assurance and Risk Sharepoint site to provide guidance and support based to services and directorates, including:
  - Development of guidance on how to provide SMART responses to recommendations raised, and the ability to constructivley challenge recommendations on initial receipt (if necessary); and
  - Development of material detailing the purpose and benefits of tracking recommendations, and supporting processes within the Health Board to ensure transparency and accountability.

- To strengthen second line assurance and oversight of recommendations, send thematic trackers to all relevant subject matter experts, in line with the quarterly process of sending thematic risk registers; and
- Ensure that peer reviews are formally received via a central route in order to ensure their timely presentation at the relevant Committee.