GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	External Recommendations Assurance Report
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.

The following criteria are included as part of the Welsh Government revised de-escalation criteria for the Health Board for 2025/26:

- 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 *(TI criteria 12)*; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s *(TI criteria 38)*

Asesiad / Assessment

The attached report aims to provide assurance on the progress in respect of the implementation of recommendations from audits, inspections and regulators, 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** that the Health Board is continuing to address findings from audits, inspections and regulators, and is strengthening the internal escalation arrangements for the domain of governance.

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 CCG – Clinical Care Group CIW – Care Inspectorate Wales CHC – Community Health Council CSG – Clinical Service Group 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 and Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IRMER – Ionising Radiation (Medical Exposure) Regulations LOFSM – Letter of Fire Safety Matters MHLD – Mental Health and Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid and West Wales Fire and Rescue Service NQPE – Nursing, Quality and Patient Experience PHW – Public Health Wales PPE – Post Project Evaluation PPH – Prince Philip Hospital PODCC – People, Organisational Development and Culture Committee PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SDM – Service Delivery Manager SMART – Specific, Measurable, Achievable, Realistic/Relevant, Time-bound/Timely UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women and 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 remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board has to meet the revised set criteria, which includes:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan *(TI criteria 12)*; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s *(TI criteria 38) – which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*

Overview

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

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

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

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (*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.

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

For the purpose of this report, data has been extracted at the most recent analysis point at the time of preparation (30 April 2025):

	December 2024	April 2025	Trend	Variation*
Total number of reports	**187**	**178**	↓	N/A
Number of overdue reports	71 (38%)	81 (46%)	↑	■
Number of reports overdue by more than 6 months	33 (18%)	38 (21%)	↑	■
Total number of recommendations	**1,638**	**1641**	↑	N/A
Number of Green recommendations (completed)	997	1015	↑	■
Number of recommendations classified as 'External'	35	47	↑	■
Number of open recommendations	**641**	**626**	↓	■
Number of Amber recommendations (in progress and in line with original timescales)	332	196	↓	■
Number of Red (overdue) recommendations	274	383	↑	■
Number of recommendations without revised timescales (N/K)	157	286	↑	■

This section of the report has now been strengthened by expanding on the length of time recommendations are overdue, i.e. by indicating the number of recommendations which have recently lapsed (within the last 6 months), lapsed over a year ago (12 months overdue), lapsed over 18 months ago, and over 2 years ago (24 months):

	December 2024	April 2025	Trend	Variation *
Number of recommendations overdue by less than 6 months	156	183	↑	
Total number of recommendations overdue by more than 6 months	118**	200 *(see further split in rows below)*	↑	■
Number of recommendations overdue by 6-12 months	*[Not previously reported]*	*70*	*N/A*	

Number of recommendations overdue by 12-18 months	*[Not previously reported]*	*88*	*N/A*	
Number of recommendations overdue by 18-24 months	*[Not previously reported]*	*27*	*N/A*	
Number of recommendations overdue by more than 24 months	*[Not previously reported]*	*15*	*N/A*	

*** December 2024 figure of 118 included all overdue recommendations by 6 months and over. From April 2025 onwards these are further split as shown in the table above.*

*A summary of the variation icons as below:

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

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

Inspectorate / Regulator	Open reports as at month-end December 24	Open reports as at month-end April 2025	Open reports which are overdue	Red recommendations	Red recommendations overdue by more than 6 months
Audit Wales (AW)	10	11	6	15	5
Care Inspectorate Wales (CIW)	3	3	2	3	3
Health Education and Improvement Wales (HEIW)	3	2	2	9	9
Health Inspectorate Wales (HIW)	11	11	7	39	31
Human Tissue Authority (HTA)	1	0	0		
Internal Audit	33	35	15	27	10
Llais	1	1	1	2	2
Mid and West Wales Fire and Rescue Service (MWWFRS)	95	81	31	96	13
Natural Resources Wales	1	0	0	0	0
NHS Wales Cyber Resilience Unit	1	2	0	0	0
NHS Wales Executive	4	4	4	8	7
Peer Reviews	10	11	8	102	100
Public Services Ombudsman for Wales (PSOW) – S21	5	6	0	1	0

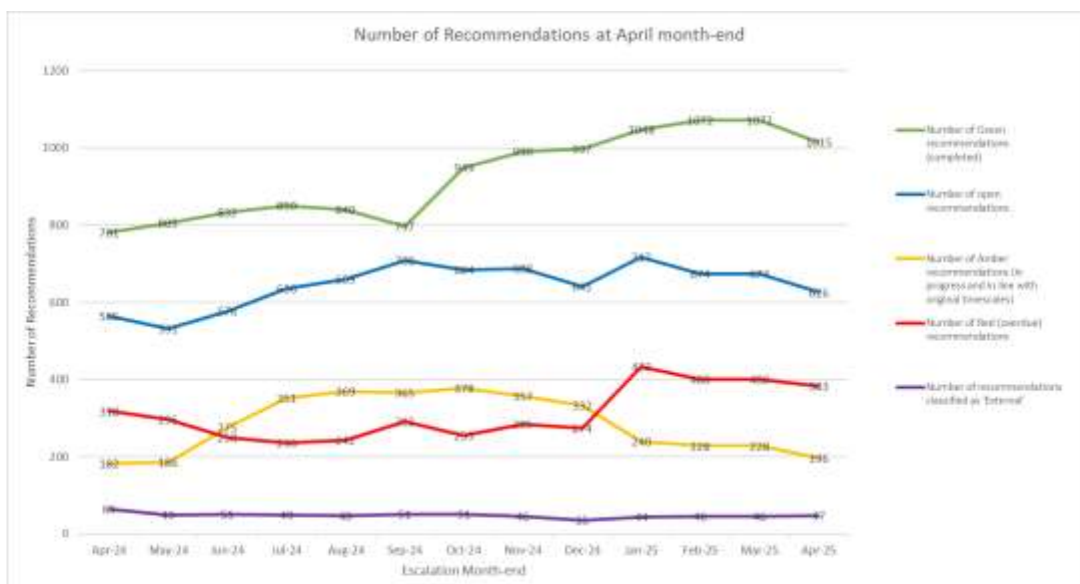
Public Health Wales	1	1	1	0	0
Royal Colleges	1	1	0	0	0
NHS Wales Shared Services Partnership	3	4	0	62	9
Welsh Risk Pool (WRP)	1	2	2	10	2
Welsh Language Commissioner (WLC)	1	1	1	0	0
Welsh Government	2	2	1	9	9
TOTAL	**187**	**178**	**81**	**383**	**200**

Overdue reports

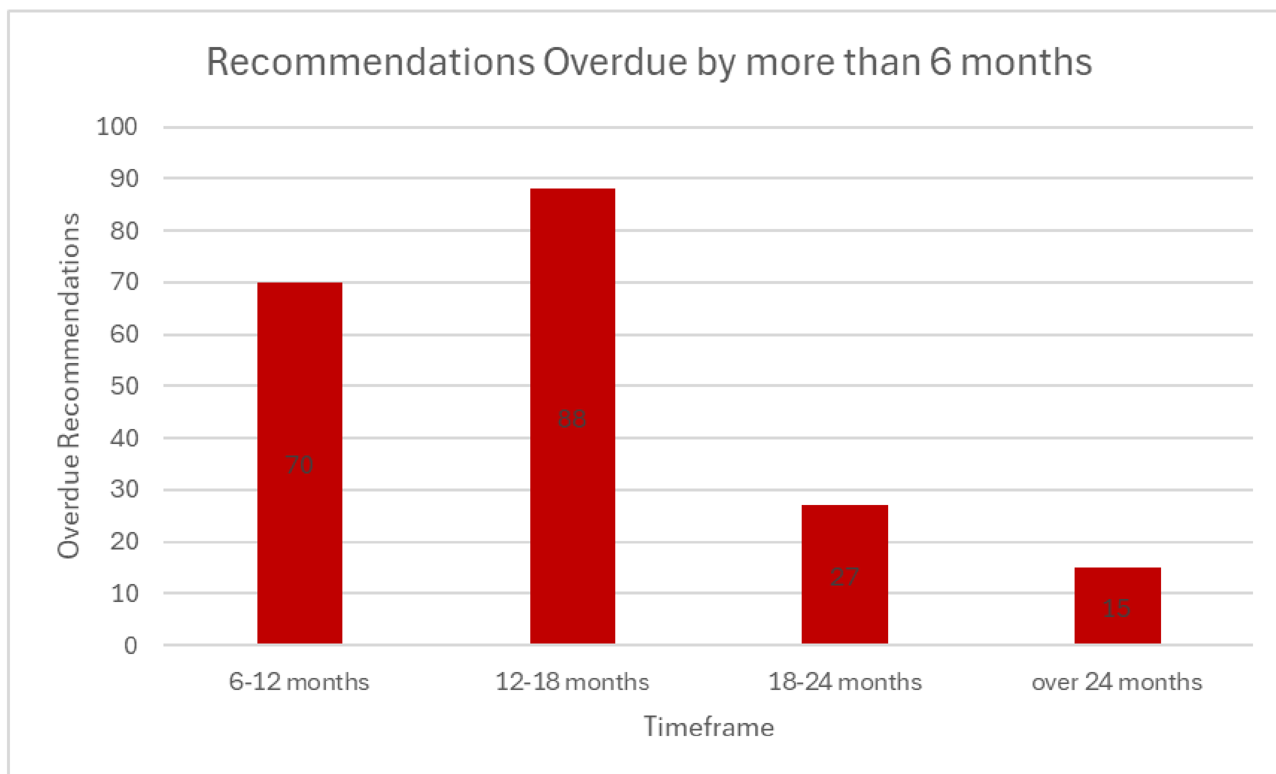
Whilst there has been a reduction in the total number of open reports since the previous report presented in February 2025 (187 to 178), there is an increase in the number of overdue reports from 71 to 81, primarily driven by Internal Audit reports, and MWWFRS Letters of Fire Safety that have passed their original completion date of 3 months.

Overdue recommendations

The graph below illustrates the trend in the number of overdue recommendations.



The fluctuating performance of the number of overdue recommendations, along with a consistent trend in the number of recommendations overdue by more than 6 months (see graph below) suggests that the Health Board is not consistently achieving a sustainable reduction in the closure of overdue recommendations, and therefore minimal improvement in addressing long-standing recommendations. This is a result of historical reports where unrealistic timescales were originally provided in management responses to recommendations, and recommendations which cite financial challenges as a barrier to their implementation. It is further exacerbated by current resource and capacity challenges within services, and ageing estate and infrastructure.



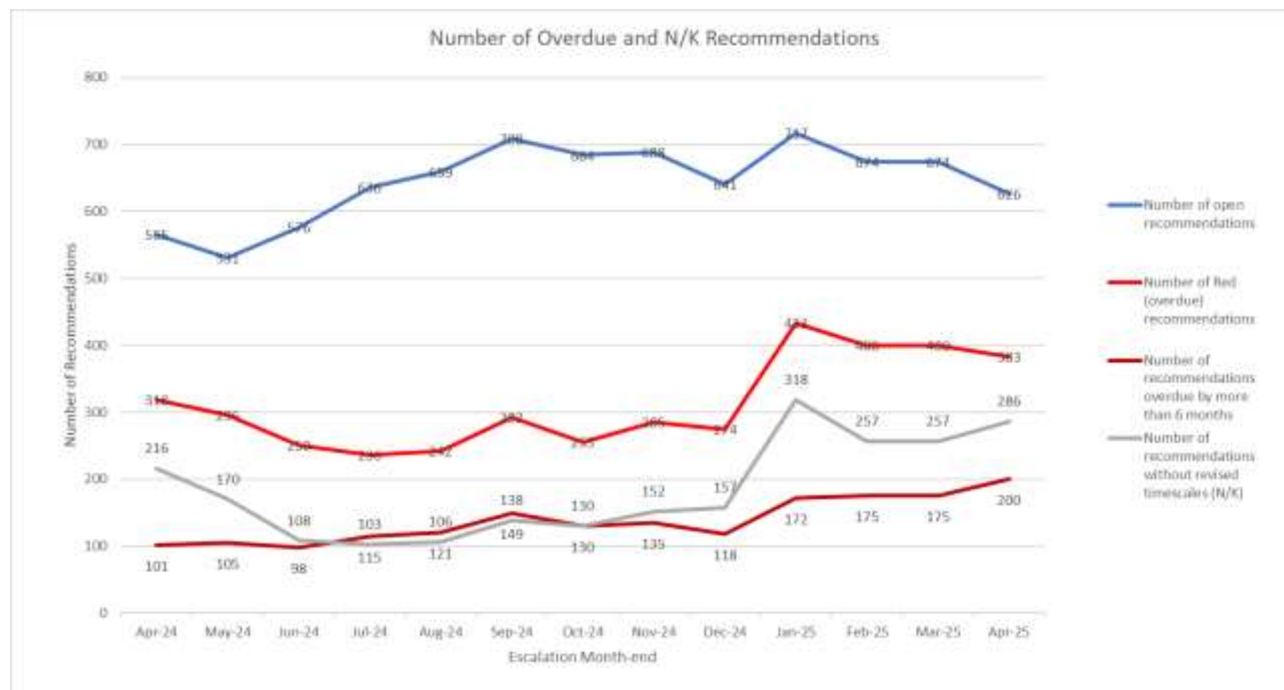
Of all 200 recommendations overdue by greater than 6 months, 47% are attributable to Planned and Specialist Care, and 18% to Mental Health and Learning Disabilities. Of the 15 recommendations overdue by greater than 24 months, 13 are attributable to Planned and Specialist Care. Both Planned Care and Mental Health and Learning Disabilities have been in Level 3 for the Governance domain within the Health Board's internal escalation framework since April 2024.

Analysis of the recommendations overdue by greater than 6 months per audit/ inspectorate/regulator highlight that 100 (50%) are from Peer Review reports, 58 of which are from the *Peer Review – 'Cervical Screening Wales Quality Assurance Visit Report'.* Since the data was extracted for this report, management responses and timescales have now been received for this peer review and will be reflected in the next Audit Tracker Assurance Report.

The Assurance and Risk team has strengthened the escalation criteria within the Governance domain, per the internal escalation framework, to include more detail on those services with long-standing overdue recommendations, with these criteria to be implemented from Q1 of 2025/26, coinciding with the roll-out of new operational

structures. Key improvement metrics for progress against audits and inspection (as well as risk management) are now relayed via the Clinical Care Group (CCG) / Executive Function structures, with a level between 1 and 4 assigned for each metric based on the level of assurance around the targets in each area. The key measures to assess against the Governance domain for audits and inspections are explained in more detail later in this report.

Recommendations without revised timescales



There were 286 (46%) recommendations without revised timescales as at April 2025 (December 2025: 157 (24%).

Recommendations without revised timescales are mainly attributed to the following:

- Reliance on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems to inform revised completion dates;
- Recommendations previously noted as ‘complete’ being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- 53 recommendations lapsed since March 2025 which have yet to be updated with a revised completion date. In the absence of a specific ‘revised date’ field on AMaT, the Assurance and Risk team continues to remind services to provide revised dates on the AMaT system through their progress updates;
- 58 recommendations from the ‘Peer Review – ‘Cervical Screening Wales Quality Assurance Visit Report’ where the CCG had exceeded the timescale for submitting the management responses. Since the numbers were run off for this report, management responses and timescales have now been received and will be reflected in the next Audit Tracker Assurance Report.

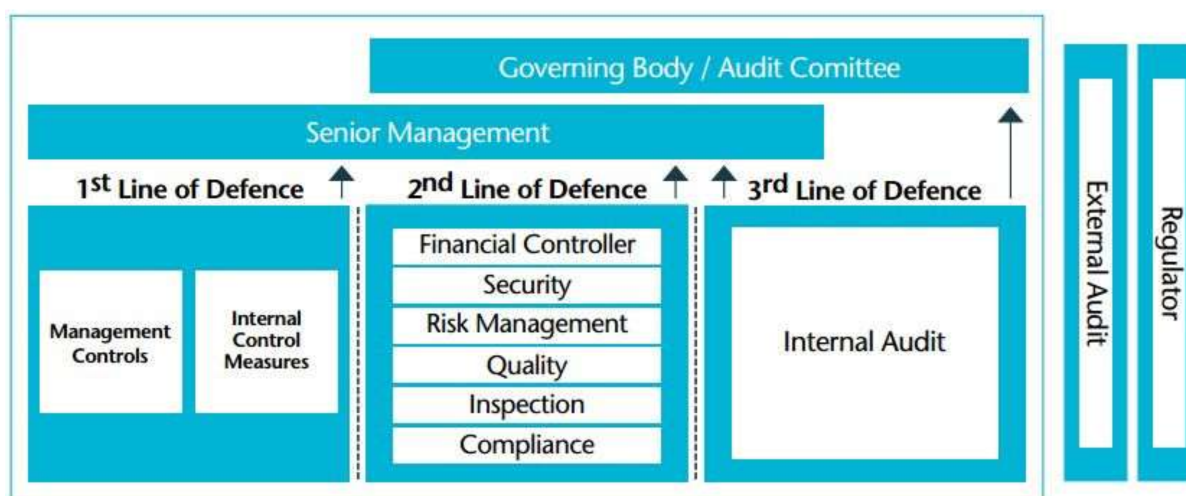
- CCGs / Executive Functions have reviewed recommendations but have not provided a revised completion date when providing progress updates. This may be due to a combination of factors, including financial challenges / resource and capacity challenges which require resolution or clarification in order to provide revised dates. The lack of a specific 'revised date' field on the AMaT system, which could also serve as a prompt, may also be a contributing factor.

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

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

Three Lines of Defence

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



Operational Management (1st line)

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

Progress on implementation of recommendations is discussed at CSG Integrated Governance Group meetings for operational areas, and reported up to their CCG Integrated Governance Group meetings, or senior management meetings for corporate functions. The frequency of these meetings are currently being scheduled to fall in-between alternating Business, Planning and Performance and Quality, Health and Safety CCG meetings. CCG governance arrangements are considered when assessing the escalation status for Governance.

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

The table overleaf provides a summary of open reports, and the status of recommendations per CCG, as per the revised internal escalation framework structure for 2025, further detail of which can be found later in the report.

Area	Total number of reports as at April month end 2025	Total number of recommendations as at April month end 2025	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6	Total number of N/K recommendations
Chief Operating Officer Management					
Chief Operating Officer Management	2	10	5	2	3
Community & Integrated Medicine					
Community & Integrated Medicine	4	94	10	7	9
Director of Allied Health Professions and Health Sciences					
Corporate Allied Health Professions and Health Sciences	1	5	0	0	0
Estates, Facilities and Health & Safety	93	765	163	27	125
Director of Finance					
Finance	3	16	4	0	4
Digital	7	31	5	5	1
Director of Nursing					
Nursing, Quality and Patient Experience	8	49	11	2	10
Director of Public Health					
Public Health	1	4	2	0	2
Director of Strategy and Planning					
Strategy and Planning	11	63	10	3	10
Director of Workforce					
Workforce and Organisational Development	3	16	2	1	1
Medical Director					

Area	Total number of reports as at April month end 2025	Total number of recommendations as at April month end 2025	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6	Total number of N/K recommendations
Medical Directorate	6	36	9	9	9
Mental Health and Learning Disabilities					
Mental Health and Learning Disabilities	9	157	43	35	31
Operational Allied Health Professions and Health Sciences					
Allied Health Professions and Health Sciences	0	0	0	0	0
AHP&HS: Pathology	2	26	8	7	7
AHP&HS: Radiology	3	30	3	2	2
Planned and Specialist Care					
Cancer and Scheduled Care	12	175	34	29	5
Children, Women and Family Health	5	96	64	64	61
Primary Care, Community Strategy & Long Term Care					
Long Term Care & Chronic Conditions	0	0	0	0	0
Medicines Management	2	35	2	2	2
Primary Care	4	25	7	5	3
Corporate Services					
Governance	2	8	1	0	1
Chief Executive					
Communications	0	0	0	0	0
Total:	**178**	**1641**	**383**	**200**	**286**

Oversight of Recommendations (2nd Line)

Internal Escalation Framework

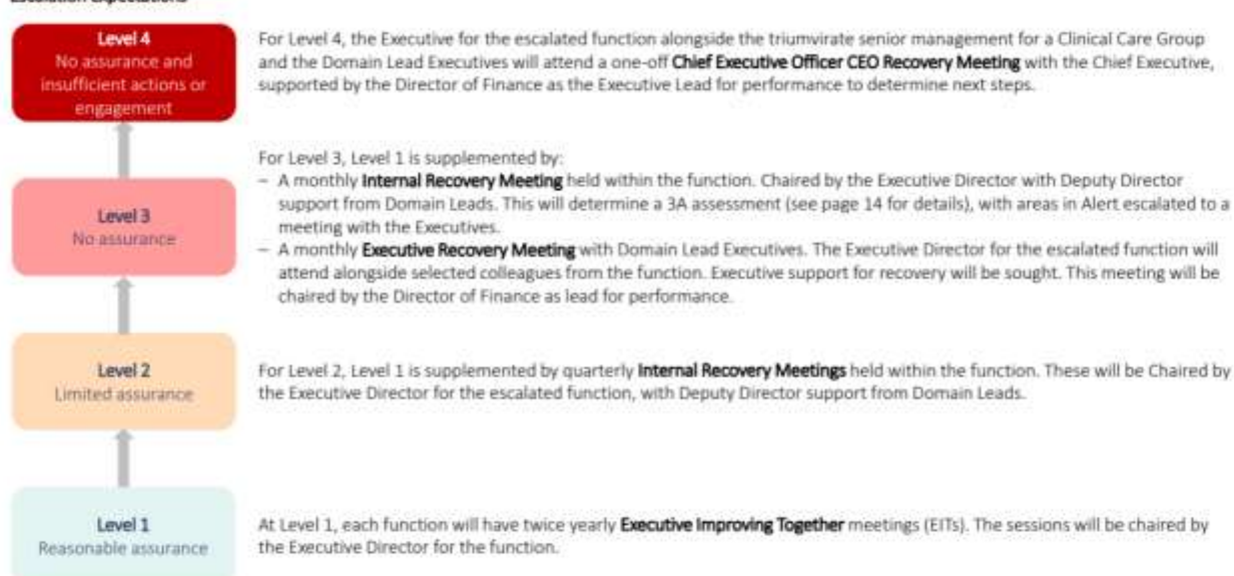
The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG /Executive Functions are assessed on a monthly basis against the following seven domains to drive improvement in performance:

- Quality and safety;
- Governance;
- Workforce;
- Finance;
- Strategy, planning and fragile services;
- Population health; and
- Performance.

Escalation levels

The lead Executive (or nominated deputy) will assign one of the escalation levels below for their domain for each function. Function leads can replicate internally the escalation process for each of their services/teams if they so wish.

Following a review of the internal escalation process, a new Level 4 has been introduced from April 2025 for functions that are unable to provide any assurance that prescribed targets are being met within the year, are taking insufficient actions, or have unsatisfactory levels of engagement.



Each month, the lead Executive Director for each domain (or their nominated deputy) will review the progress of each function (Executive Directorate or Clinical Care Group) against the key improvement metrics for that domain.

Escalation levels for Governance are assigned by the Director of Corporate Governance at month-end for each CCG / Executive Function based on metrics for risk management, audit and inspections, Welsh Health Circulars and Ministerial Directions, and policies, as well as general governance arrangements. The criteria for audits and inspections is outlined below.

Measures to assess against the Governance Domain – Audits and Inspections

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (e.g., no responses to recommendations raised, no revised dates where original completion dates have lapsed). No evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Responses to recommendations have been developed, but the function is not delivering against revised completion dates, with no realistic revised completion dates provided. Management responses have not been developed within a month of receipt of report. **Less than 80% compliance** with achieving original and revised completion dates stipulated against recommendations Limited evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Responses to recommendations have been developed, but lack of evidence that original timescales are being achieved. Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates. **Between 80-90% compliance** with achieving original completion dates stipulated against recommendations Some evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Responses to recommendations have been developed and the function is delivering against original completion dates **Over 90% compliance** with achieving original completion dates stipulated against recommendations Evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

A summary of each CCG / Executive Function’s performance for the Governance domain can be found in the following table:

Service	December 2024	January 2025	February 2025	March 2025	April 2025
Chief Operating Officer Management	N/A	N/A	N/A	N/A	2
Community & Integrated Medicine	N/A	N/A	N/A	N/A	2
Estates & Facilities	2	3	3	3	3
Executive Director of Allied Health Professions and Health Sciences	N/A	N/A	N/A	N/A	1
Executive Director of Finance	2	2	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	1	1	1	2
Executive Director of Public Health	1	1	1	2	2
Executive Director of Strategy and Planning	2	2	2	2	2
Executive Director of Workforce and Organisational Development	1	1	1	1	1
Executive Medical Director	2	2	3	3	2
Governance and Communication	N/A	N/A	N/A	N/A	1
Mental Health and Learning Disabilities	3	3	3	3	3
Operational Allied Health Professions and Health Sciences	N/A	N/A	N/A	N/A	2
Planned and Specialist Care	N/A	N/A	N/A	N/A	3
Primary Care, Community Strategy & Long Term Care	N/A	N/A	N/A	N/A	2

Along with risk management, the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews has been the dominant factor in assessing directorates’ escalation levels. The minimum requirement for a service to be

de-escalated to Level 2 is that 80% of audit and inspection recommendations are implemented within agreed timescales, and 90% to achieve Level 1 status.

Detailed analysis of those CCGs / Executive Functions who have been awarded either Level 2 or 3 status as at April 2025 is provided below, based on performance in the management of recommendations (to note, no functions were awarded Level 4 in April 2025).

Level 3 - No Assurance

Estates and Facilities

As at 30 April 2025, Estates and Facilities has 91 open reports with 32 reports noted as overdue (36%). 78 open reports relate to Letter of Fire Safety Matters (LOFSMs) and 3 relate to Enforcement Notices. 163 recommendations are overdue (21%), 27 are overdue by greater than 6 months, with 1 recommendation 9 months overdue. 125 recommendations are without revised timescale.

At their escalation meeting in April, Estates provided a trajectory of improving their compliance within 90% by September 2025. 30 LOFSMs were closed in April 2025 following formal approval for closure sought from the Executive Director, as per new process.

Monthly Operational Risk and AMaT Report meetings have now been established, taking place from June 2025, to review risks and overdue reports/recommendations. The Assurance and Risk business partner will be in attendance to support the provision of progress updates and revised completion dates where applicable. This is in addition to the monthly meetings between the Head of Compliance for Estates & Facilities, Site Managers and the Assurance and Risk business partner.

Estates and Facilities Integrated Governance Group meetings are now in place, with Assurance and Risk Officer present to support.

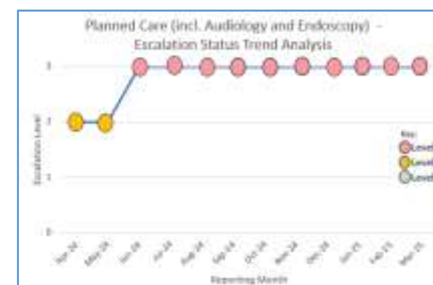
Mental Health & Learning Disabilities (MHLD)

As at 30 April 2025, MHLD had 9 open reports with 7 reports (78%) overdue. 43 recommendations are overdue (27), 35 being overdue by greater than 6 months (4 overdue between 6-12 months, 15 overdue between 12-18 months, 16 overdue over 24 months).

4 reports are reliant on other CCGs to complete overdue recommendations - 2 HIW reports have all 3 overdue recommendations to be implemented by Estates and Facilities and 2 NHS Executive reports have 3 overdue recommendations to be implemented by Children, Women and Family Health (CW&FH).

CCG meetings in place, with first meeting held on 15 April 2025, and CSG meetings to be in place shortly, with Assurance and Risk Officer present to support. Regular monthly meetings are held with the Assistant Director of Nursing MHLD to review risks and recommendations and there is regular communication with the individual service leads, with advice and support provided by the Assurance and Risk Officer. The Assurance and Risk Overview reports are also submitted on a monthly basis, for information and review.

<u>Planned & Specialist Care</u> *(graphs show previous trend analysis to March 2025 before CCG restructure)*



Since the previous report in February 2025, Cancer Services, Planned Care and Children, Women and Family Health are now situated under the Planned and Specialist Care CCG.

As at 30 April 2025, the CCG had 17 open reports of which 12 are overdue (71%). There are 271 open recommendations of which 98 are overdue (36%). 93 recommendations are overdue by greater than 6 months, of which 18 are overdue by 6-12 months, 61 are overdue by 12-18 months, 1 is overdue by 18-24 months and 13 are overdue by over 24 months. Of the 98 overdue recommendations, 64 recommendations are assigned to CW&FH, 32 are assigned to Planned Care and 2 are assigned to Cancer Services. 58 of the overdue recommendations relate to the Peer Review – Cervical Screening Wales Quality Assurance Visit Report which sits with CW&FH (since the figures of this report have been run off 17 recommendations have been completed which will be reflected in the next Audit Tracker Assurance Report), 6 recommendations relate to GIRFT - Gynaecology Review and 27 recommendations relate to the historic Ophthalmology reports.

A meeting took place on 8 May 2025 between the Director of Corporate Governance, the Interim Medical Director, the Chief Operating Officer and the Ophthalmology Service lead to discuss the outstanding recommendations on the historical Ophthalmology reports. As a result, the following 4 reports are to be closed following formal Executive sign off, resulting in 8 overdue recommendations to be closed:

- CHC Eye Care Services in Wales, March 2020
- NHS Delivery Unit Focus on Ophthalmology: Assurance Reviews, issued January 2016
- HIW Thematic Review of Ophthalmology 2015/16
- NHS Delivery Unit All Wales Review of progress towards delivery of Eye Care Measures 2019

At the meeting, the GIRFT Ophthalmology review report was also discussed, resulting in 12 of the 21 overdue recommendations being completed. These figures will be reflected in the next Audit Tracker Assurance Report.

Fortnightly CCG and CSG governance meetings are now in place, with a report provided by the Assurance and Risk Officer summarising open reports assigned to the CCG and CSG, and recommendations that require updating.

Level 2 - Limited Assurance

The following services were awarded a Level 2 as at April 2025:

Service	Reason for award of L2	De-escalation Criteria
Chief Operating Officer Management	5 (50%) recommendations overdue. Level 2 awarded due to low numbers.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Community and Integrated Medicine	10 (11%) recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Medicines Management	17% of recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Executive Director of Finance	19% of recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales and governance meetings to be scheduled in order to provide reasonable assurance
Executive Director of Nursing	11 (22%) recommendations overdue	To achieve de-escalation to Level 1, 90% compliance of risks and risk actions being updated within required timescales and 90% of recommendations to be implemented within agreed timescales
Executive Director of Public Health	2 recommendations (50%) overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Executive Director of Strategy and Planning	10 (16%) recommendations overdue	To achieve de-escalation to Level 1, 90% compliance of risks and risk actions being updated within required timescales and 90% of

		recommendations to be implemented within agreed timescales
Executive Medical Director	9 (25%) recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Operational Allied Health Professions & Health Sciences	11 (20%) recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Primary Care, Community Strategy & Long Term Care	15% recommendations overdue (12% by over 6 months)	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales

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

Board and Committee Oversight

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

Thematic Analysis

As part of the second line of defence, themes are assigned to each recommendation, which allows the Health Board to analyse groups of similar recommendations. Additional themes from Internal Audit reports have been added.

The table below provides a thematic analysis for all open recommendations per theme as at month-end April 2025, compared to the last report in February 2025:

Theme	December 2024	April 2025	Trend
Fire	37%	28%	↑
Health and Safety	12%	15%	↑
Quality, Safety & Patient Experience	11%	16%	↑
Safe	6%	0%	↓
Workforce	7%	7%	→

Governance	3%	3%	→
Patient Safety	2%	0%	↓
Finance	2%	2%	→
Training & Development	1%	2%	↑
Performance Monitoring	1%	1%	→
Reputation	1%	1%	→
Infection Control	1%	1%	→
Information, Data Quality & Data Accuracy	1%	6%	↑
Information Governance	0%	0.5%	↓
Physical Security	1%	<0.5%	↓
NICE/National Guidance	1%	<0.5%	↓
Partnerships	0.5%	<0.5%	→
Safeguarding	0.5%	<0.5%	→
Capital	<0.5%	<0.5%	→
Estates	<0.5%	1%	↑
Medication	<0.5%	<0.5%	→
Environmental	<0.5%	0%	↓
Additional themes below added from Internal Audit reports			
Policies & Procedures	N/A	2%	N/A
Communication & Engagement	N/A	1%	N/A
Capital Estates	N/A	1%	N/A
Financial Management & Control	N/A	1%	N/A
Planning, Delivery & Deadline Management	N/A	0.5%	N/A
Reputation	N/A	0.5%	N/A
Resourcing	N/A	0.5%	N/A
Strategy	N/A	0.5%	N/A
Capital Equipment	N/A	<0.5%	N/A
ICT (Information and Communications Technology)	N/A	<0.5%	N/A
Person Centred	N/A	<0.5%	N/A
Reporting	N/A	<0.5%	N/A
Risk Management	N/A	<0.5%	N/A

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

During quarter 3 of 2024/25, the Assurance and Risk team commenced sharing recommendations with themed subject matter experts (replicating the process undertaken of sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMaT.

Independent Assurance (3rd line)

The third line of defence relates to those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies.

On 11 March 2025, the Cabinet Secretary for Health and Social Care announced that three areas have now been de-escalated from targeted intervention to enhanced monitoring (level 3), reflecting the progress our teams have made in these areas. One of the three de-escalated areas was Governance, which reflects increased WG confidence in our systems of assurance (also reflected in AW Structured Assessment 2024).

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 of implementation of recommendations on AMaT, to follow up requests with the national systems team to address these gaps;
- To work with the Performance team and explore and confirm timescales, when capacity allows, to develop performance dashboards via ‘Power BI’, replicating the detail as utilised for the monitoring of risks via the internal escalation framework, so that this information is readily available to users across the Health Board;
- Further development of the Assurance and Risk Sharepoint site to provide guidance and support, including the development of material detailing the purpose and benefits of tracking recommendations and supporting processes within the Health Board to ensure transparency and accountability;
- Reiterating the importance of developing SMART action plans to ensure CCGs develop management responses which are credible and deliverable. Information on developing SMART responses is available from the Assurance and Risk Sharepoint site and shared at CCG and CSG meetings. This will also be included in the Corporate Governance training which will be provided to CCGs in July 2025.