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

Audit and Risk Assurance Committee

External Recommendations and Welsh Health Circulars Assurance Report

10 February 2026

Situation and Background

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 recommendations as raised by auditors, inspectorates and regulators, along with Welsh Health Circulars (WHCs) as issued by Welsh Government. This is in line with the requirements as noted in the Committee's Terms of Reference which state:

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.

The Health Board remains in 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 'Leadership and Governance' from Level 3 to Level 1, the Health Board is required to meet the following revised set criteria which relate to compliance with external recommendations from auditors, inspectorates and regulators:

- Financial controls at the health board that 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;
- 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;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

Progress since the previous report to ARAC

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A summary is provided below of the progress made against the next steps which were identified in the previous tracker report provided to ARAC in October 2025:

Next Steps	Progress Made
To address any feedback from Board Committees since the introduction of the Assurance and Risk Report to further strengthen the assurances provided on the progress being made to the implementation of recommendations raised.	Completed – This report will continue to develop. Since its introduction last year, this report now includes a summary of discussions held at Board Committees on presentation of the Assurance and Risk Report, highlighting the progress being made in the implementation of recommendations raised within audit and inspectorate reports, Welsh Health Circulars, and any barriers to their completion.
To continue to work with the Performance team and explore and confirm timescales, when capacity allows, to develop the audit tracking performance dashboard 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.	The Head of Assurance and Risk and Head of Performance are in the process of developing a specification document to inform the development of an audit performance dashboard, based on relevant metrics and criteria which will be accessible to staff across the Health Board, and support the provision of data for future Committee reporting along with required analysis as part of the Governance domain for the internal escalation framework. However, this work has not progressed since the previous report to ARAC due to capacity, but will be reviewed during Q4 of 2025/26. Once the specification document has been finalised this will inform implementation timescales, pending resource availability.

Audits and Inspections

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**. Since the last Committee report, three new status categories were introduced in October 2025 to provide a more accurate reflection of progress. Definitions for these new categories are included in the table below:

Status Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete (NEW)	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision (NEW)	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

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.

Overview of the Audit Tracker

This report provides an overview of the open Audit and Inspections reports based on the most recent analysis point at the time of preparation (31 December 2025).

There are some data variations in this report compared to the previous report in October 2025 due to organisational structural changes within the Health Board effective from 1 December 2025. These include the transfer of Long-Term Care and Chronic Conditions from the Primary Care Clinical Care Group to Community & Integrated Medicine, Medicines Management from Primary Care to the Medical Director, and Health Records from Chief Operating Officer Management to Digital (Director of Finance).

Key movements since the previous report presented to ARAC in October 2025 (based on data extracted 31 August 2025) include:

- increase in number of open reports from 123 to 134;
- reduction in number of overdue reports from 56 to 49;
- closure of 3 Audit Wales reports, 3 Internal Audit reports, 2 Peer Reviews, 1 Public Health Wales report, 1 Health Inspectorate Wales report and 1 Welsh Language Commissioner report.

The graphs on the following slides show the number of open reports per auditor/inspectorate/regulator as reported to ARAC during financial year 2025/26, and per Clinical Care Group / Executive Function.

Overview of the Audit Tracker

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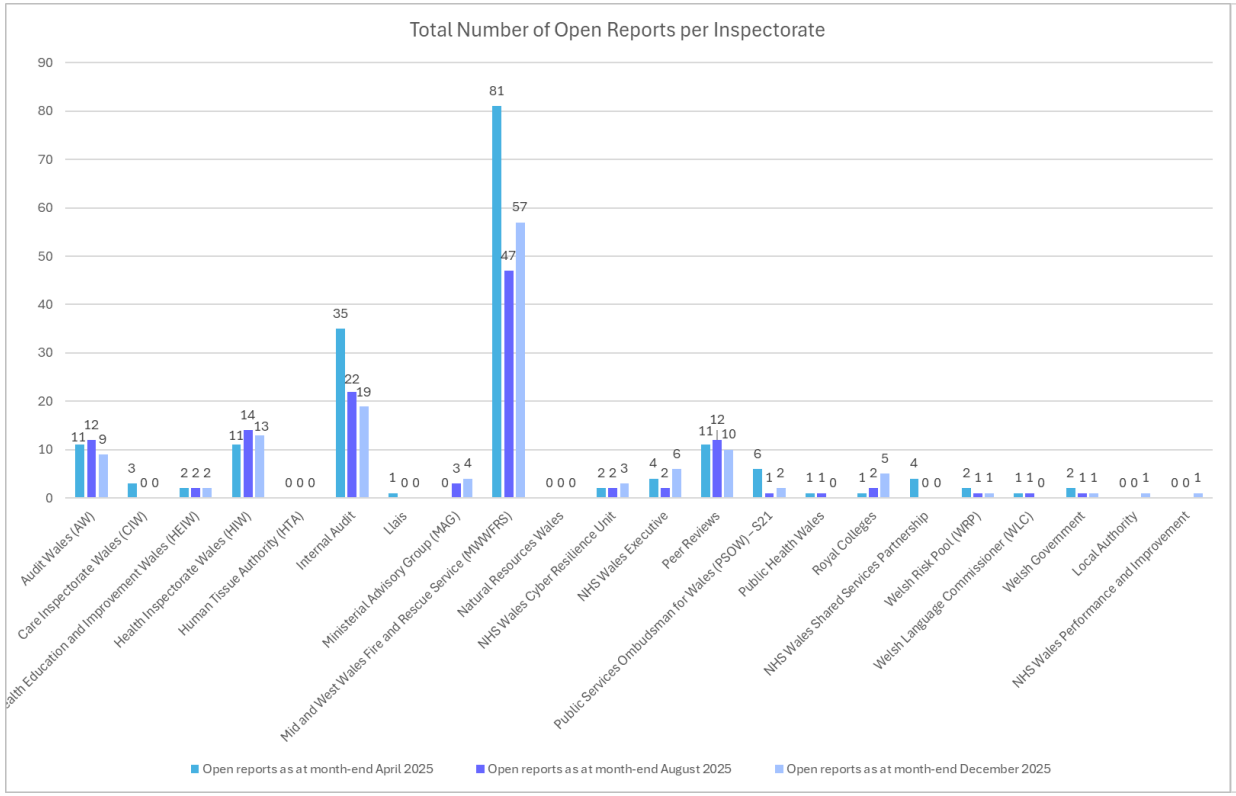

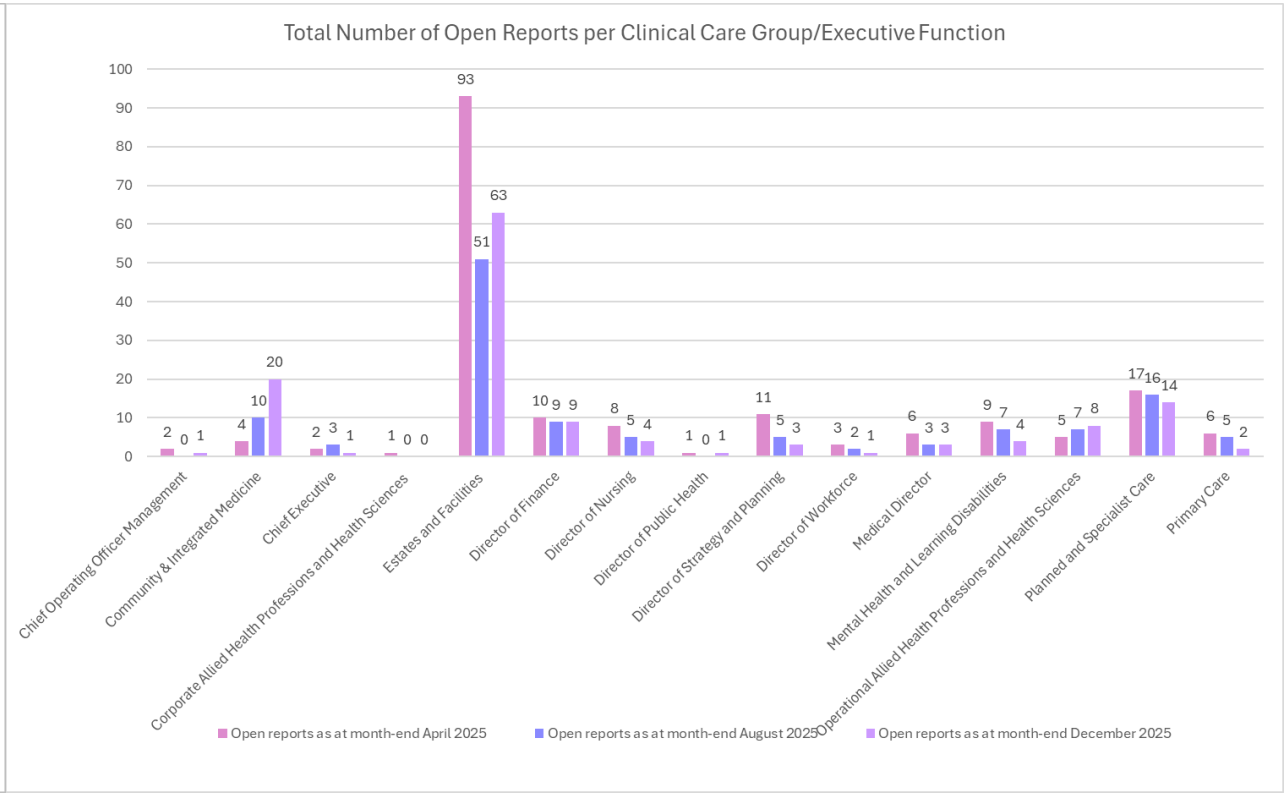

Audit Tracker Analysis – Overdue Reports

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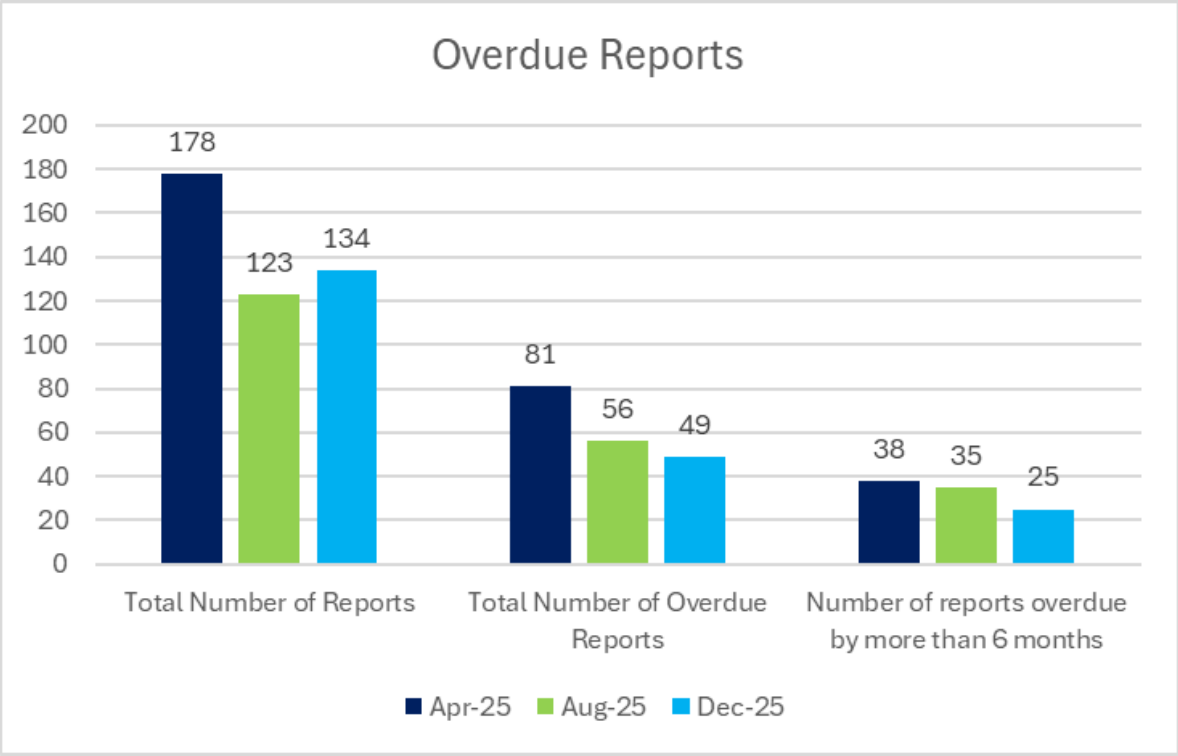
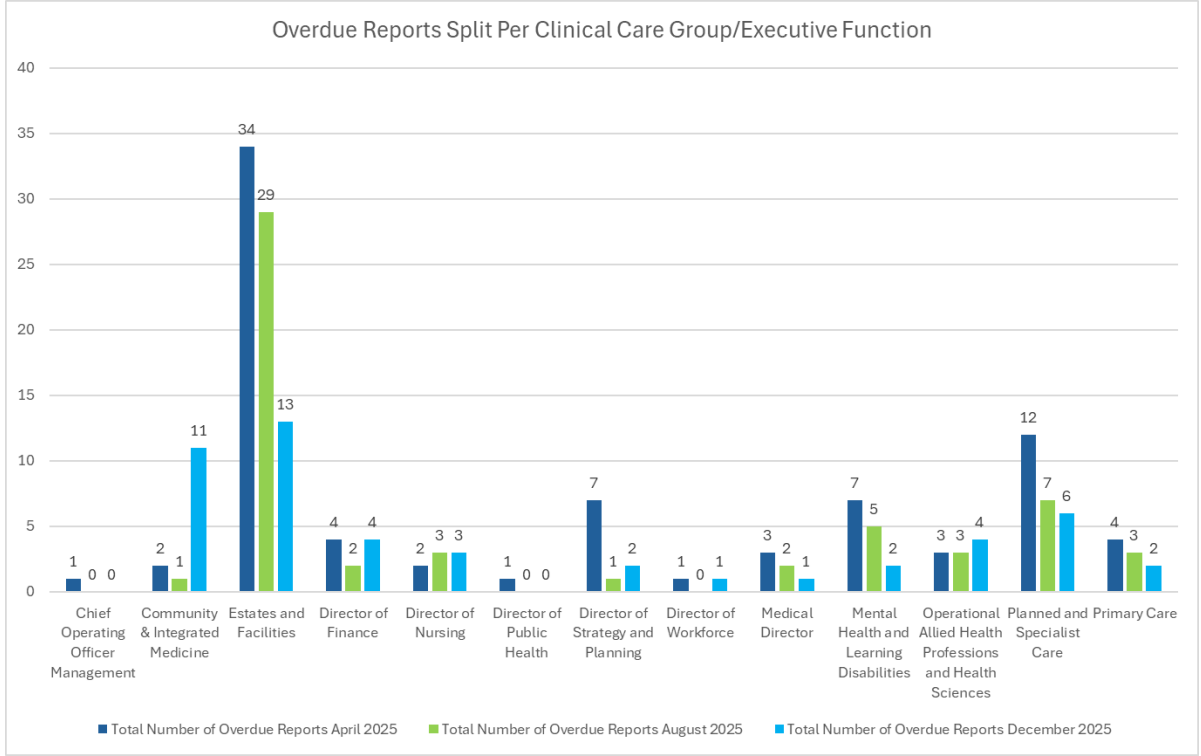
Of the current overdue reports, 25 are overdue by more than six months, an improvement compared to the 35 reports noted in October 2025. These reductions reflect continued progress made in clearing the backlog of historical reports, and the graphs illustrate a sustained downward trend in both the volume and ageing of the overdue reports.

The data reflects an improving trend, with several functions fully closing reports. Estates & Facilities, while still holding the highest volume of overdue reports, achieved a reduction from 29 to 13 since the previous report. Community and Integrated Medicine saw the largest increase in overdue reports from 1 to 11. Several functions maintained zero overdue reports throughout the period, indicating sustained compliance.





Audit Tracker Analysis – Overdue recommendations

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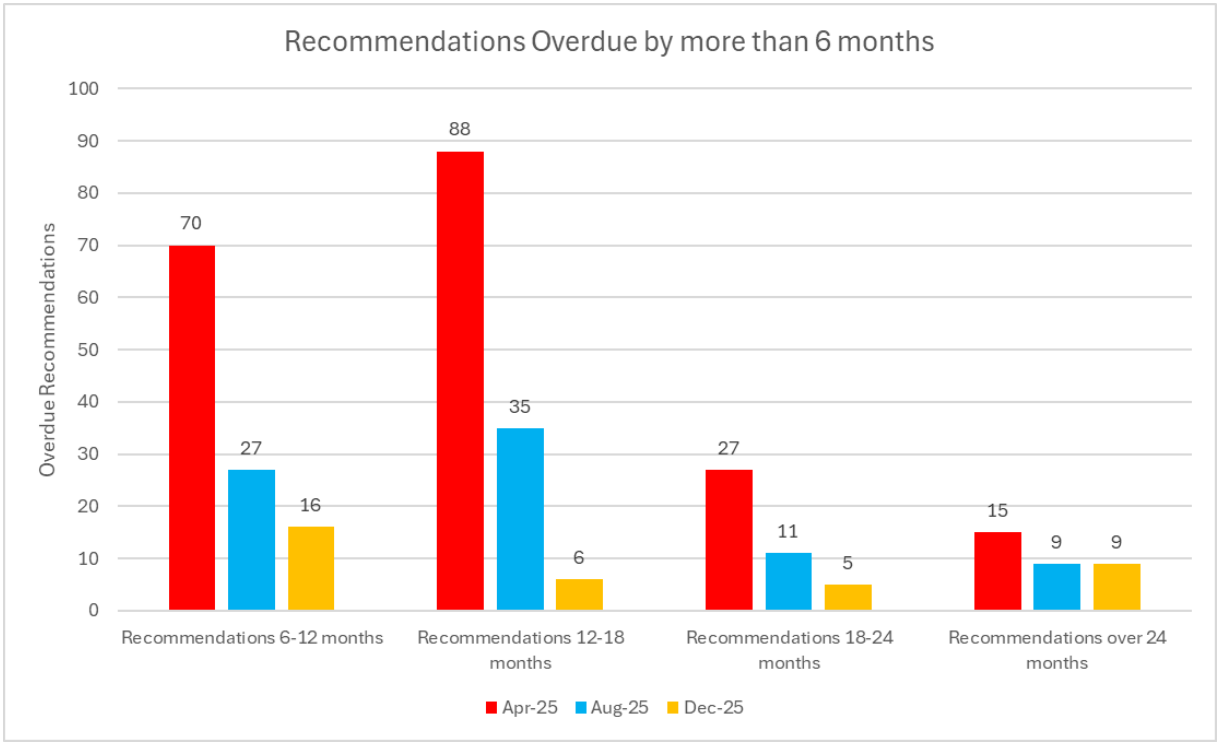
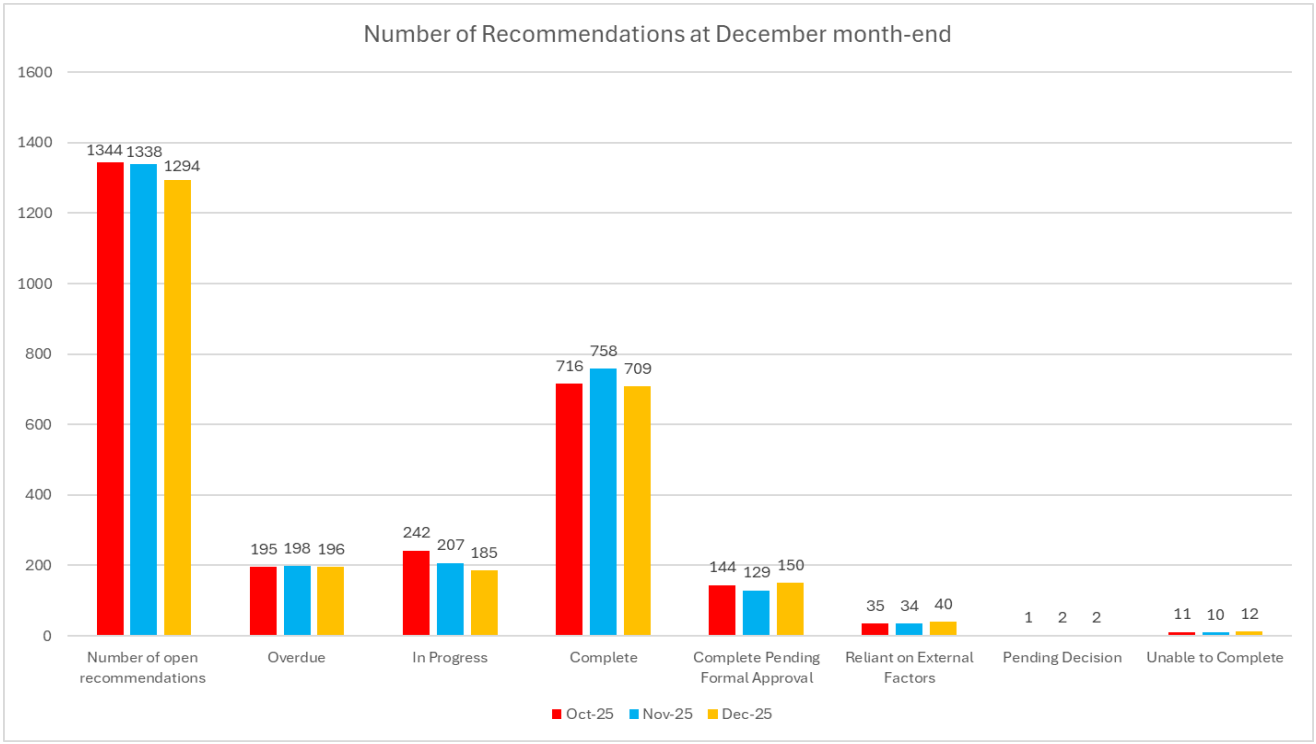
Whilst the total number of recommendations has slightly increased from 1,272 in August 2025 to 1,294, the number of **open** recommendations has decreased from 557 to 435.

The number of **overdue** recommendations (i.e those where the original completion date has not been met) has also decreased from 236 to 196, with **36 overdue by more than 6 months** (August 2025: 82), showing a significant improvement in this area. The number of recommendations without revised timescales has also improved from 162 to 133.





Audit Tracker Analysis – Overdue recommendations

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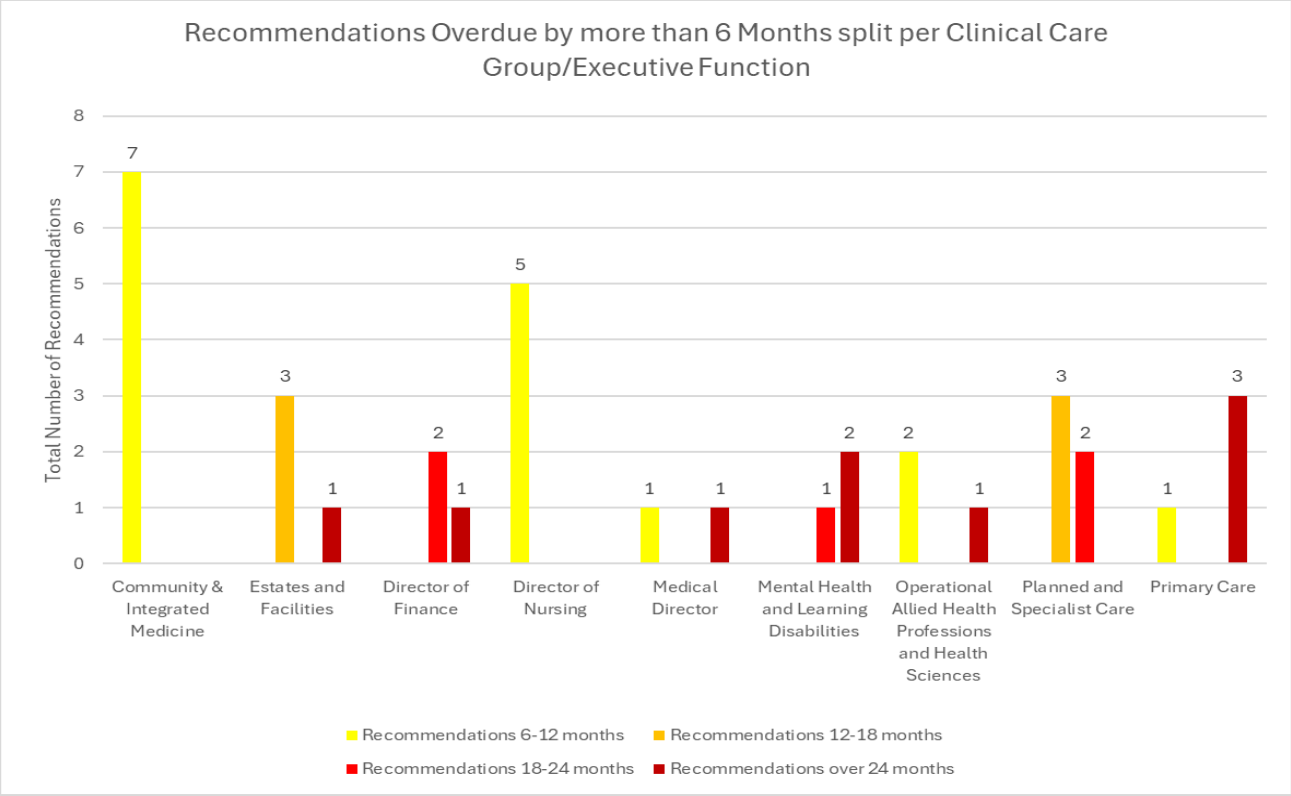
Meetings were scheduled during Q4 of 2025/26 with relevant Executive Leads and CCG / Function leads to review recommendations overdue by more than 6 months, to identify whether they have been fully implemented, or if additional support or escalation is required to further progress. Due to operational pressures and demands, these meetings have been stood down and will be rescheduled for Q1 2026/27.



Key improvement metrics for progress against audits, inspections and WHCs (as well as risk management and Ministerial Directions) are relayed via the 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. Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those CCGs or Functions who may be assessed as being in Level 4. At present, CCGs and Functions are assigned as being either level 1, 2 or 3 pending formalisation of these processes.

Measures to assess against the Governance domain for audits and inspections are explained in more detail later in this report.

Audit Tracker Analysis – Recommendations that are “Unable to Complete”

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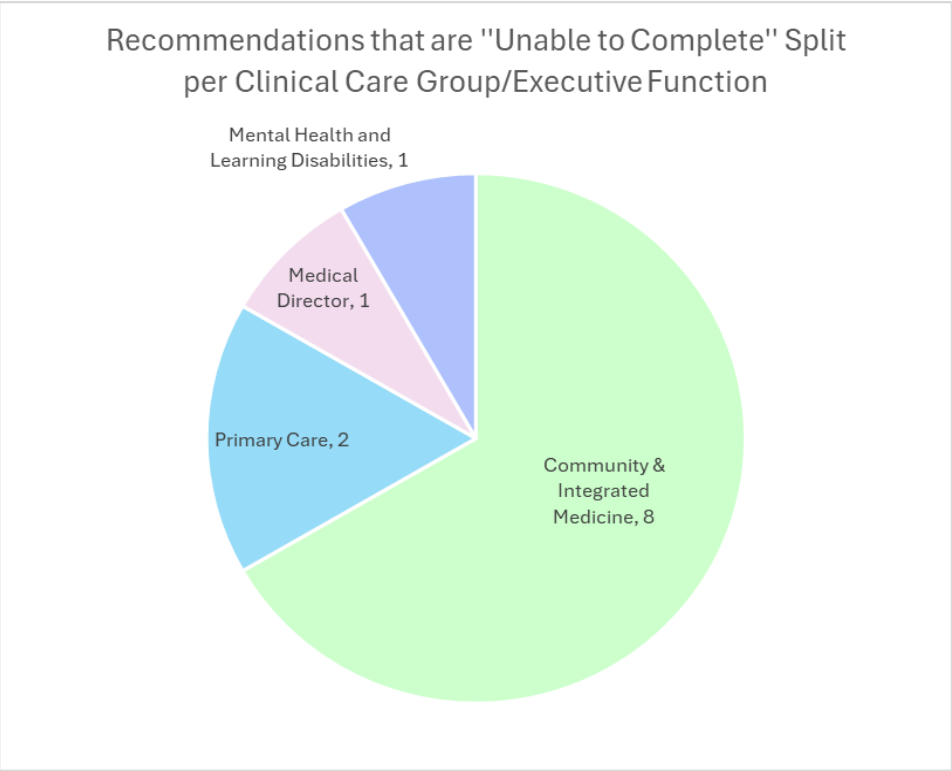
12 recommendations (<1%) on the Audit & Inspection tracker are marked as “Unable to Complete” as at December 2025.

Common barriers noted for recommendations that are ‘Unable to Complete’ include:

- The original actions were dependent on plans that were subsequently not developed or implemented;
- Financial constraints / lack of funding;
- Long term absence / workforce challenges / recruitment constraints; and
- Awaiting outcomes of wider plans (Operational Change Process, Clinical Service Plan, Fragile Services Plan).

Where CCGs and Functions note recommendations as being “Unable to Complete”, leads are required to formally note barriers to the full implementation of recommendations on AMAT.

These recommendations are then required to be escalated local operational governance arrangements. The relevant Lead Executive is required to provide approval of acceptance of these barriers prior to recommendations being closed. “Unable to Complete” recommendations will be discussed as part of the review meetings of long-standing overdue recommendations.



Audit Tracker Analysis - Recommendations without revised timescales

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Recommendations without revised timescales are mainly attributed to the following:

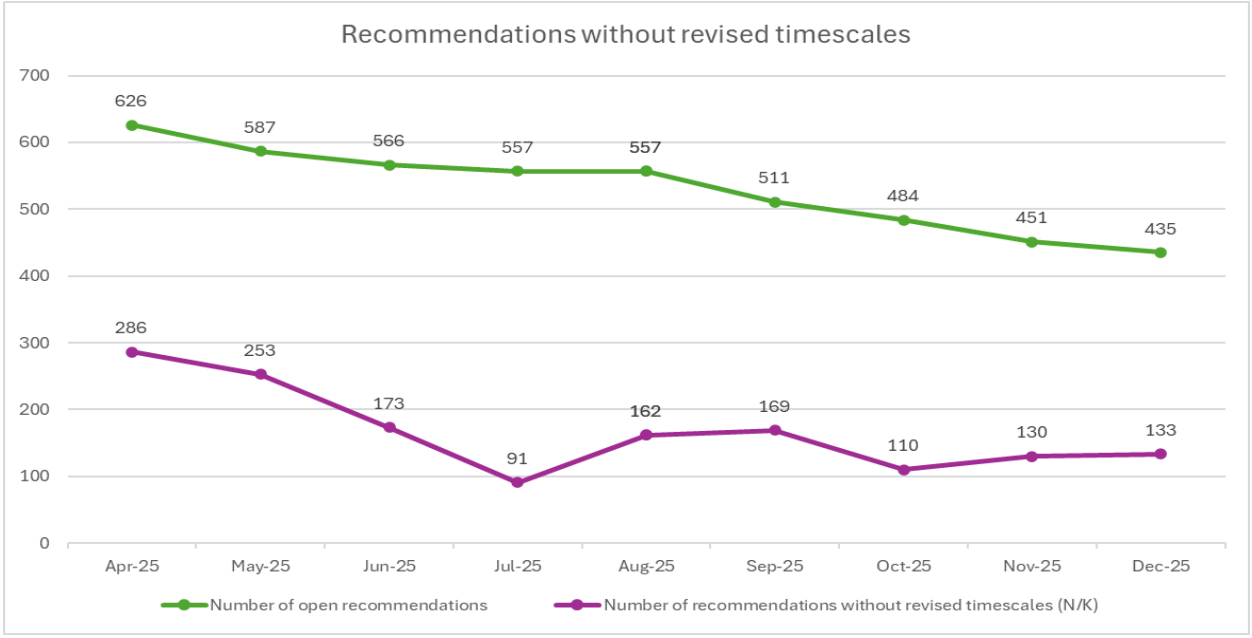
- Recommendations previously noted as 'complete' being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- A delay in the provision of revised completion dates due to operational pressures and capacity;
- CCGs / Executive Functions have provided progress updates on AMAT but not included a revised completion date.

The following slide details the number of recommendations without revised timescales per Clinical Care Group / Executive Function.

As at December 2025, 133 of the recommendations that have exceeded their original completion dates do not have revised timescales, an improvement from 162 in the previous report August 2025, with improvements noted in Community & Integrated Medicine (from 106 to 76) and Planned & Specialist Care (from 24 to 8).

In the absence of a specific 'revised date' field on AMaT, the Assurance and Risk team continue to remind services of the need to include revised completion dates within the governance reports presented to CCG / 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 continues to explore the development of performance dashboards to capture data from AMaT via 'Power BI' with colleagues in the Performance Team. Due to capacity, development has been on hold, however a meeting is being scheduled to finalise the requirements and identify timescales to enable the completion of this action. This would provide services with improved oversight of their performance, including the number of recommendations without a revised timescale, and further support the internal escalation framework.



**Recommendations that are reliant 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 are not counted as 'overdue'.*

Audit Tracker Analysis - Recommendations without revised timescales

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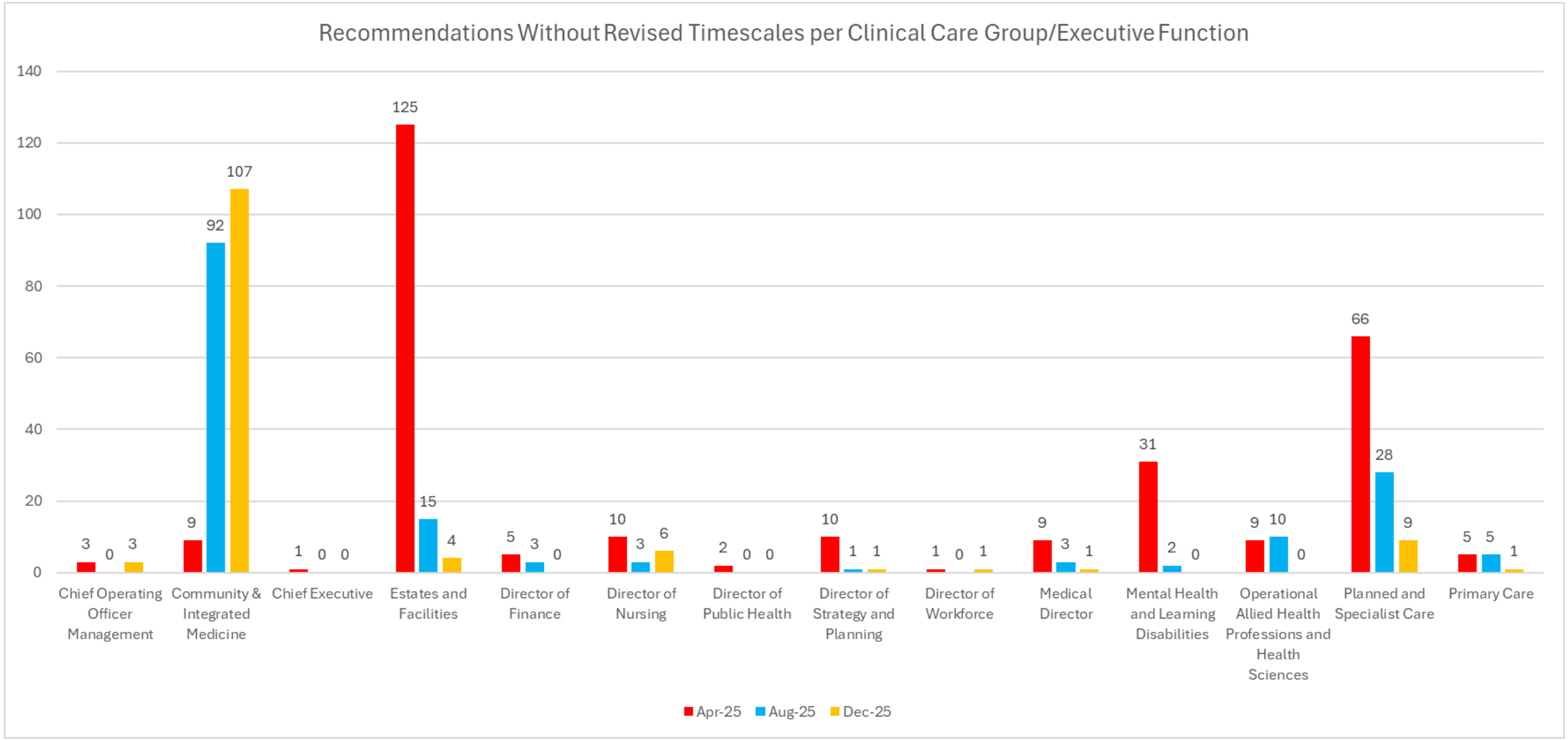

Three Lines of Defence

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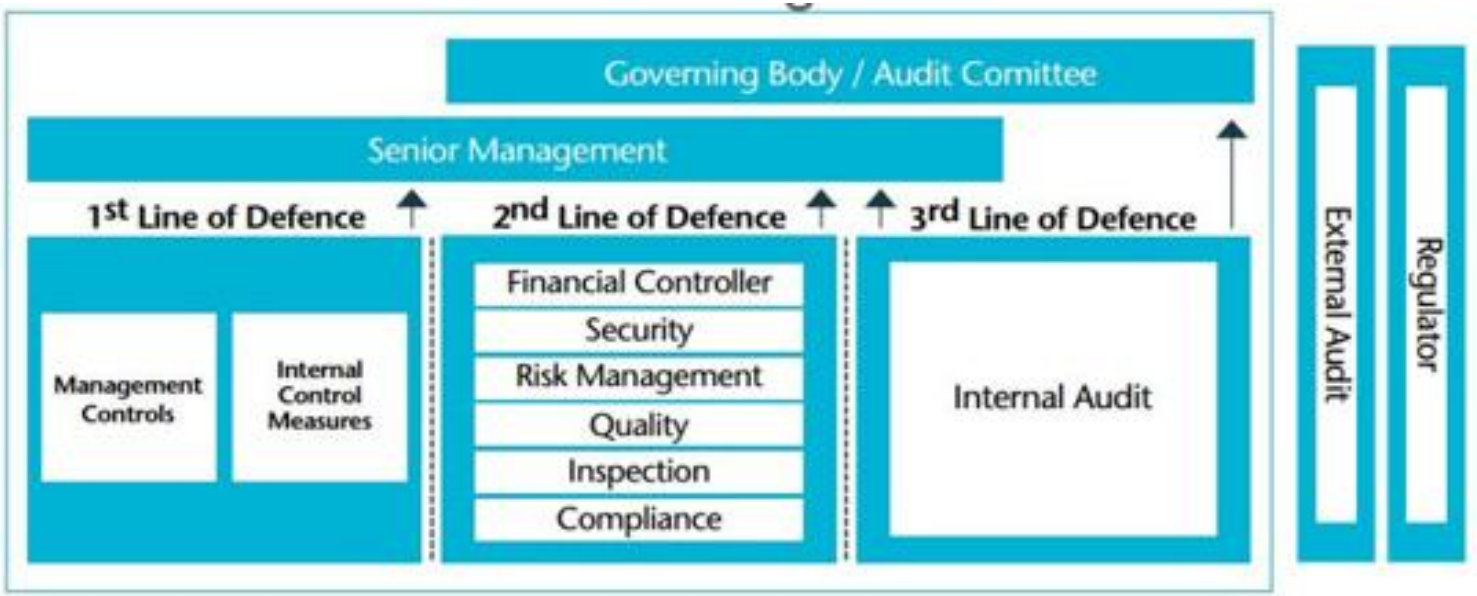
The Health Board operates within the "Three Lines of Defence" model, which provides a simple and effective way to delegate and coordinate roles and responsibilities within an organisation to ensure the appropriate allocation for the management, reporting and escalation of the implementation of recommendations.



Operational Management (1st line)
First line 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 the implementation of recommendations and WHCs are discussed at the Clinical Service Groups' (CSG) Integrated Governance Group meetings for operational areas in the first instance, and then escalated if required to their CCG Integrated Governance Group meetings. CSG meetings are scheduled to occur fortnightly to fall in-between alternating Business, Planning and Performance and Quality, Health and Safety CCG meetings. For Executive Functions (EF), recommendations are discussed within the Executive Function Services' local management meetings, and escalated as appropriate to Senior Leadership Team meetings/relevant Lead Executive as appropriate. CCG and EF 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 which identify proposed actions for the CCG / Function to take forward to address areas of improvement or concern in respect of outstanding recommendations and Welsh Health Circulars.

Three Lines of Defence: 1st Line – Audits and Inspections

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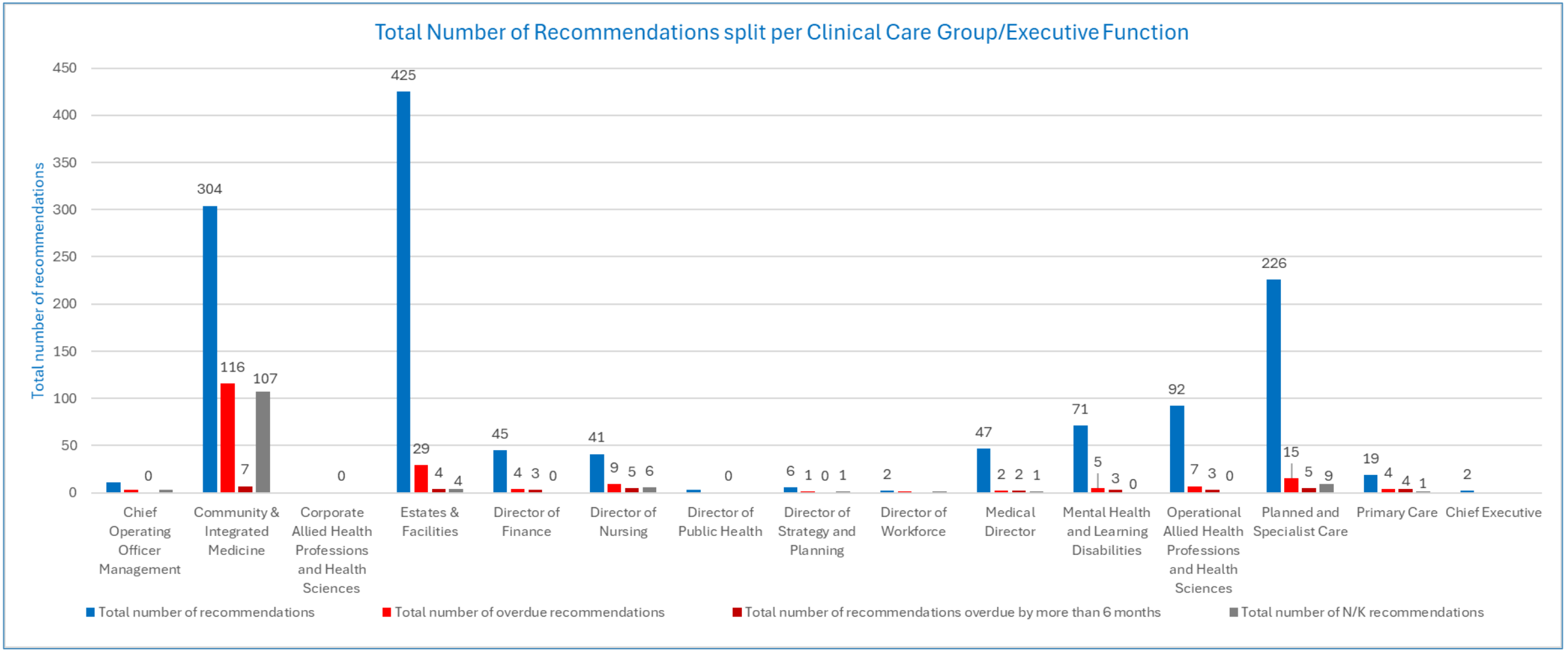
The graph below provides a summary of open reports as at December 2025, and the status of the recommendations split per CCG/ Executive Function.

The graph below details how many recommendations are overdue per CCG/Function, and of those overdue recommendations, how many are overdue by more than 6 months as well as the recommendations without revised completion dates. Detail on the underpinning processes have been included earlier in this report.



Three Lines of Defence

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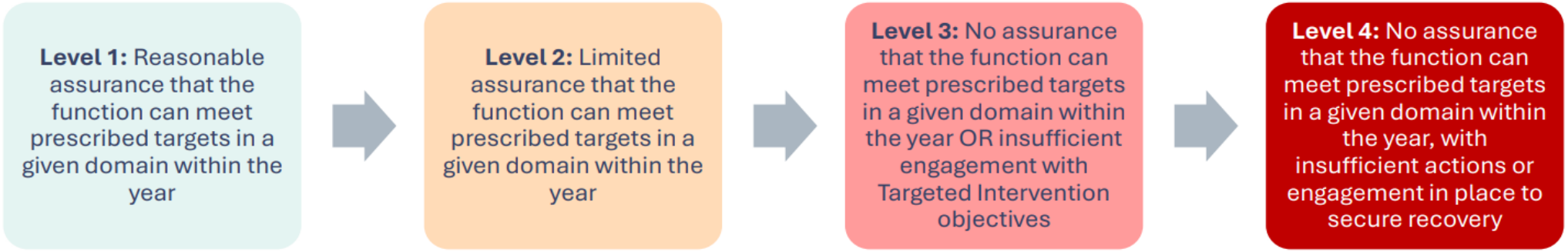
Internal Escalation (2nd Line)
The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG /Executive Functions are assessed monthly against seven domains, including 'Governance' (with specific focus on four key areas noted below), to drive improvement in performance, and awarded one of four levels based on their performance:

- Risk Management;
- Implementation of recommendations raised in audits / inspections and regulatory activity;
- Implementation of Welsh Health Circulars and Ministerial Directions; and
- Governance arrangements.



Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those CCGs or Functions who may be assessed as being in Level 4. At present, CCGs and Functions are assigned as being either level 1, 2 or 3 pending formalisation of these processes.

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.

Three Lines of Defence: 2nd Line - Audits and Inspections

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Internal Escalation - Measures to assess against the Governance Domain – Audit and Inspections
Levels are awarded based on the assessments undertaken by each function meeting the prescribed targets within the year.

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

Three Lines of Defence: 2nd Line- Internal Escalation - Governance Domain Levels

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Service	August 2025	September 2025	October 2025	November 2025	December 2025
Chief Operating Officer Management	1	1	2	2	2*
Community & Integrated Medicine	3	3	3	3	3
Estates & Facilities	2	1	1	1	1
Executive Director of Allied Health Professions and Health Sciences	1	1	1	1	1
Executive Director of Finance	1	1	1	1	2*
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2
Executive Director of Public Health	1	1	1	1	1
Executive Director of Strategy and Planning	1	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	1	1	1
Executive Medical Director	1	1	1	1	1
Medicines Management	n/a	n/a	n/a	n/a	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	2	2	2	1	1
Operational Allied Health Professions and Health Sciences	2	1	1	1	1
Planned and Specialist Care	3	3	2	2	2*
Primary Care	2	2	2	2	2

A summary of each CCG / Executive Function's performance for the Governance domain can be found in the table, and reflects the organisational structure effective from 1 December 2025 (changes detailed on slide 5).

Along with engagement, governance arrangements, risk management, and the monitoring of the implementation of WHCs and Ministerial Directions, the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews has been a dominant factor in assessing Function's escalation level.

The minimum requirement for a service to be de-escalated to Level 2 is that 80% of audit and inspection recommendations are implemented within agreed timescales, and 90% to achieve Level 1 status.

Detailed analysis of the Community and Integrated Medicine CCG who are the only CCG/Function assessed as Level 3 as at December 2025 is provided on the next slide, based on their performance in respect of the timely implementation of recommendations from audits and inspections.

* Indicates a CCG / function that has been escalated for factors other than audit and inspection recommendations.

Internal Escalation - Governance Domain : Level 3 - No Assurance (Audits and Inspections)

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Community & Integrated Medicine (C&IM) CCG

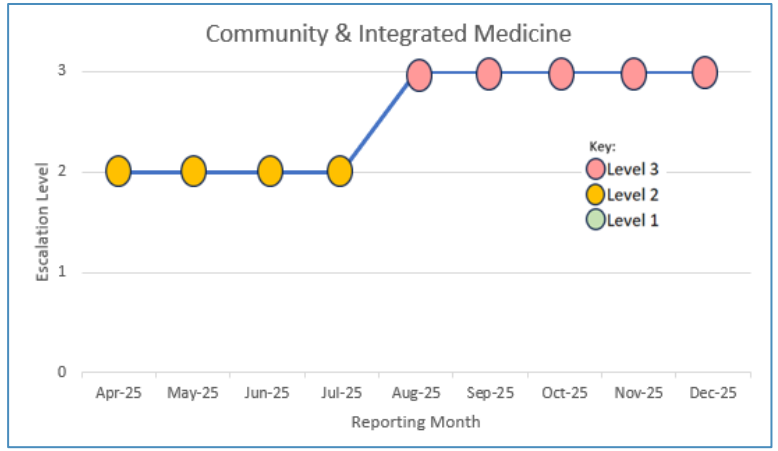
As of 31 December 2025, **116 of 304 (38%) recommendations assigned to the CCG are overdue**, with 7 of these overdue between 6-12 months. Of the 116, **107 do not have a revised implementation dates (N/K).** The lack of revised implementation dates is a combination of:

- No update provided on AMaT; or
- If updates are provided on AMaT, no clear revised completion date is included.

The CCG has been asked to consider the status of any overdue recommendations as to whether any could be changed to an alternative category (e.g. pending decision / unable to complete), as per the new status categories.

The breakdown by CSG of the 116 overdue recommendations are:

- **67 with Carmarthenshire Integrated System**, 4 of which are overdue 6-12 months. 66 of these 67 recommendations do not have revised implementation dates (N/K). Of the 67, 39 are from the NHS Wales Executive *Report on Urgent and Emergency Care Opportunities: GGH site report (October 2024)*.
- **28 with Ceredigion Integrated System**, 2 of which are overdue 6-12 months. 20 of these recommendations do not have revised implementation dates (N/K);
- **3 with Pembrokeshire Integrated System**, none of which are overdue by more than 6 months. All 3 recommendations do not have revised implementation dates (N/K); and
- **18 with the overarching Clinical Care Group**, 1 of which is overdue by 6-12 months. All 18 recommendations do not have implementation timescales (N/K).



Engagement varies across the CCG however the Assurance and Risk Officer has offered each CSG support for deep dive sessions to review overdue recommendations; these have not yet been scheduled due to current operational pressures. A meeting was scheduled for February 2026 with CCG leads and Executives to review recommendations overdue by 6 months or more, to determine the appropriate course of action to support their progression and implementation, however due to operational pressures and demands, this has been stood down and will be rescheduled for Q1 2026/27.

Management responses are also awaited to the NHS Executive Ambulance Patient Handover Process report, as well as the Getting it Right First Time (GIRFT) GGH revisit in September 2025. Management responses have been received following the revisit of the NHS Executive Opportunities Assessment of Urgent & Emergency Care at WGH.

Internal Escalation - Governance Domain : Level 2 – Limited Assurance

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The following services were awarded a Level 2 in terms of their audit and inspection reports as at December 2025, with both been awarded Level 2 status throughout the financial year to date:

Service	Reason for award of L2	De-escalation Criteria	Meetings scheduled to review recommendations overdue by more than 6 months
Executive Director of Nursing	9 (22%) of recommendations overdue	To achieve de-escalation to L1, Executive Function required to implement over 90% of recommendations and provide revised completion dates for those where completion dates have lapsed. Whilst the percentage of overdue recommendations is within the L3 threshold, the number is low in comparison to other CCGs and Functions (9/41 recommendations).	The meeting that was scheduled for 22 January 2026 will be rescheduled
Primary Care	4 (21%) recommendations overdue*	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales. Whilst the percentage of overdue recommendations is within the L3 threshold, the number is low in comparison to other CCGs and Functions (4/19 recommendations).	15 January 2026

Data for December 2025 does not include the performance of those CSGs previously aligned to Primary Care – Medicines Management, Long-Term Care

Three Lines of Defence: 2nd Line - Board and Committee Oversight – Audit and Inspections

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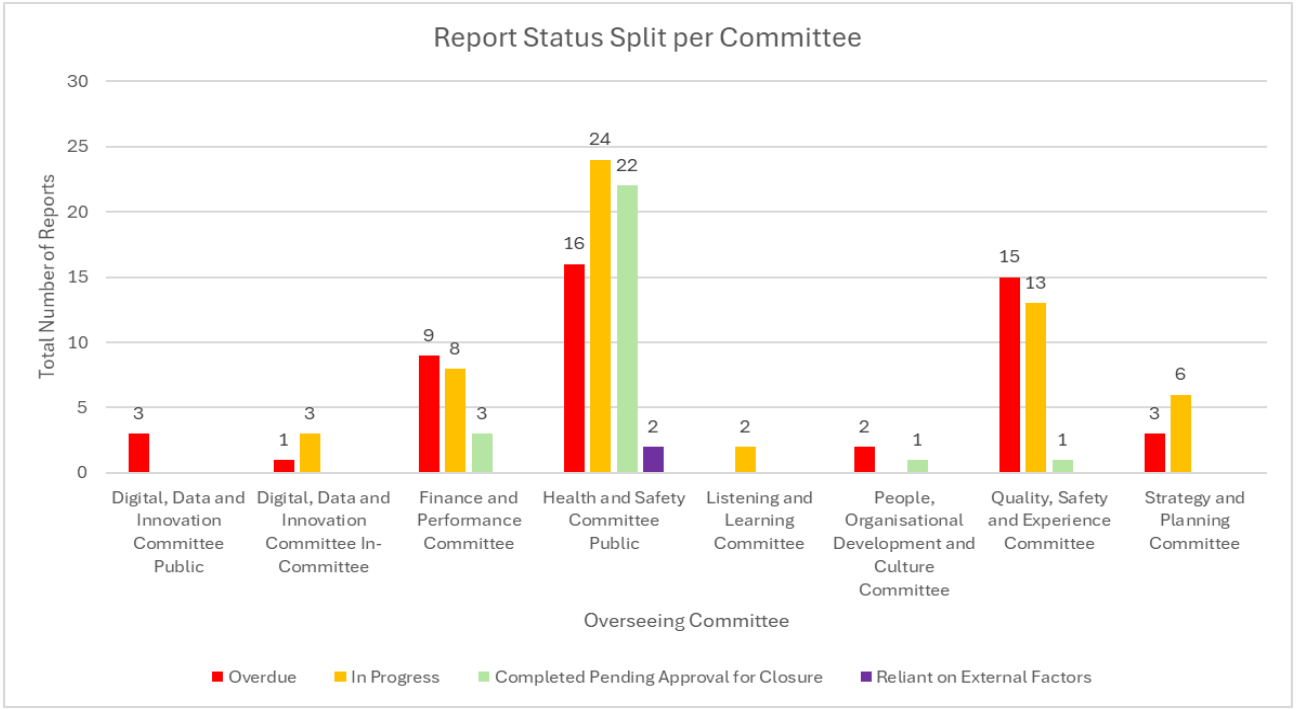
The graphs provide a breakdown of the number of reports and recommendations assigned to each Board level committee as at 31 December 2025.

Board level Committees receive assurance of the timely implementation of external recommendations via the *Assurance and Risk Report*. The reports detail progress on implementing recommendations aligned to each committee, highlighting any barriers to implementation and offering assurance on delivery.

The table below highlights actions from discussions at Board-level Committees in October and December 2025 relating to the progress being made in implementing recommendations raised at the relevant meeting. Progress against actions will be reported through the relevant Committee Table of Actions.

On initial 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 Care Inspectorate Wales (CIW). Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Committee	Minute Reference	Action
Audit and Risk Assurance Committee (ARAC)	AC(25)167	To examine process undertaken in closing Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow) report in 2017, share examples of good practice elsewhere, ensure that consideration of the report forms part of the People Organisational Development and Culture Committee (PODCC) item on the new operational structure and share the report with the Chair of QSEC.
	AC(25)172)	To examine Human Tissue Authority report with the Audit and Risk Business Partner for Pathology, the action plan and translate it into actions on the Audit tracker.
Quality, Safety and Experience Committee (QSEC)	QSEC 25 (42)	Cleaning Standards Audit Report – Discussion will take place outside of the meeting to determine whether to request a verbal update via the table of actions in October 2025 followed by a more substantial item a few months after this ahead of the follow up audit in March 2026.



Three Lines of Defence: 2nd Line - Thematic Analysis

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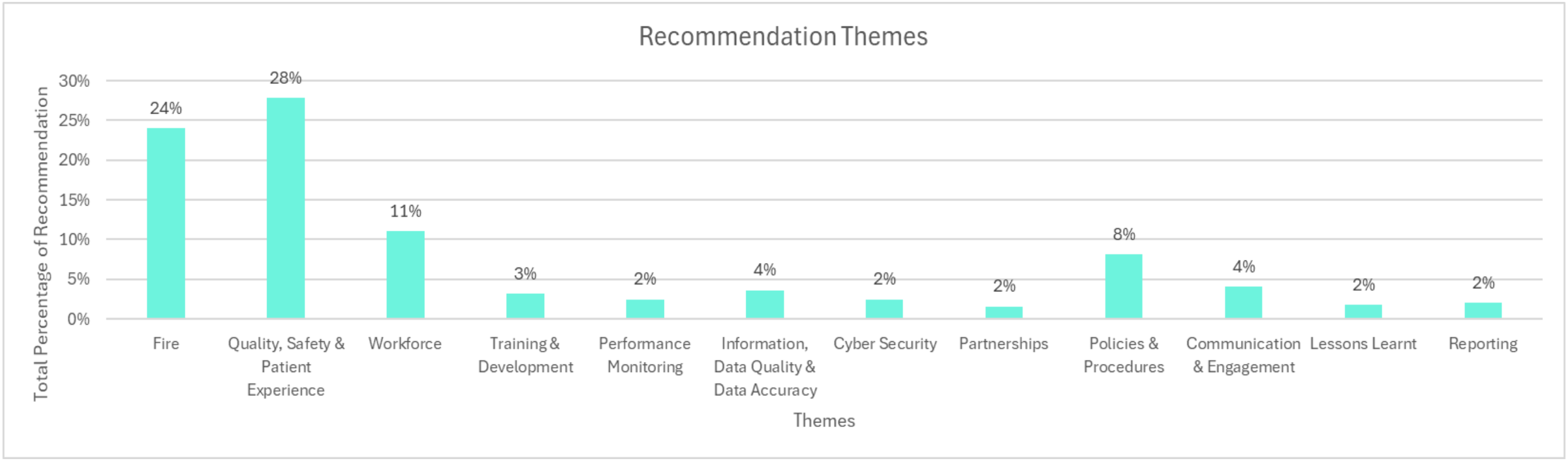
As part of the second line of defence, each recommendation is assigned a theme, enabling the Health Board to analyse groups of similar recommendations. The Assurance and Risk team share these themed recommendations with relevant subject matter experts on a bi-monthly basis to mirror the process used for thematic risk registers, with ongoing reviews to ensure alignment between Datix and AMaT.

The graph below provides a thematic analysis for all open recommendations per theme as at December 2025. 28% of the open recommendations were assigned the Quality, Safety & Patient Experience theme, and 24% assigned the Fire theme.

The following themes had less than 1% of recommendations assigned to them and are therefore not shown: Health and Safety, Governance, Medical Devices, Infection Control, Information Governance, Medication, Business Disruption, Approvals, Financial Management & Control, Planning Delivery & Deadline Management, Resourcing, Strategy, Capital Equipment, ICT (Information and Communication Technology), Risk Management, Fragile Services.



Welsh Health Circulars (WHCs)

GIG CYMRU NHS WALES
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All WHCs are managed via AMaT, which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Committees have responsibility to seek assurance that the Health Board is compliant with WHCs and that these are implemented in line with stated/agreed timescales, and where this has not been possible, to receive assurance the impacts resulting from late/non-delivery are understood and managed appropriately. Where WHCs are not clear in terms of implementation timescales, leads are requested to provide the planned date for implementation by the Health Board.

To align with the new statuses introduced for Audit & Inspection recommendations and maintain a consistent approach, three additional status categories have now been implemented for WHCs as outlined below:

Status Category	Definition
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.
Unable to Complete (NEW)	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision (NEW)	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval (NEW)	The Service / Function have completed the WHC and are currently awaiting formal approval to close.
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Oversight of the delivery of WHCs has been included in CCG Integrated Governance Group (IGG) Terms of Reference, with the requirement to escalate appropriately in instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

Overview of Welsh Health Circulars

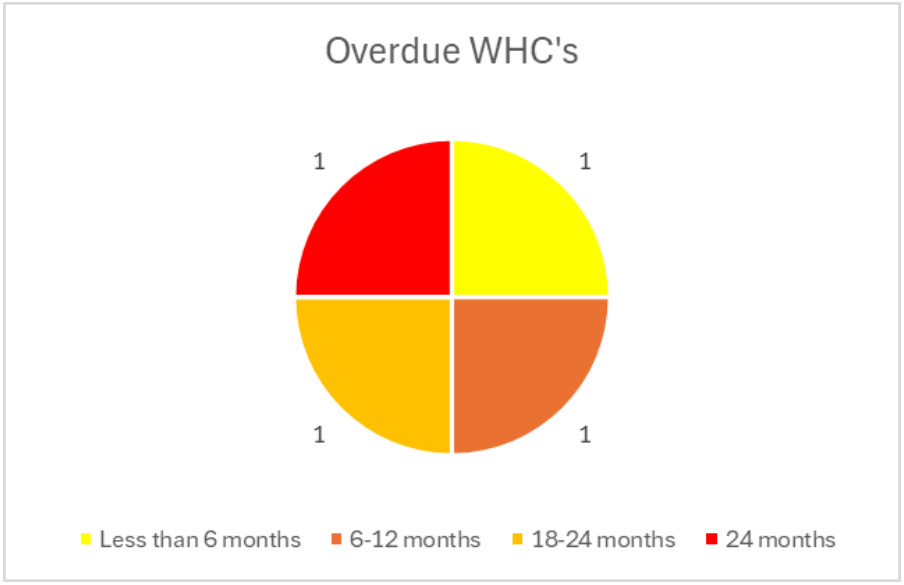
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

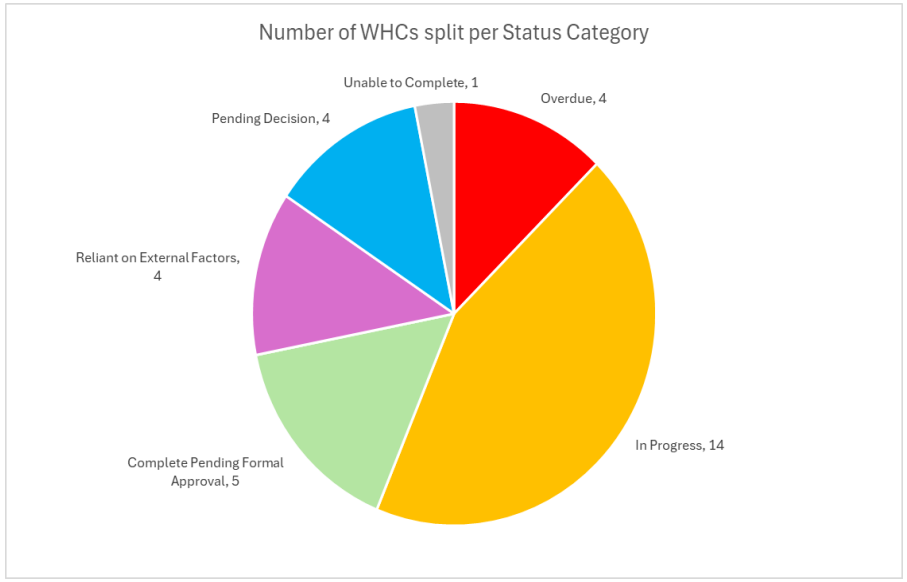
As at 31 December 2025, there were **32 open Welsh Health Circulars** assigned to the Health Board.

The graphs on this and the next slide show their status category and provide an analysis of WHCs which are noted as being “overdue”, split by Clinical Care Group / Executive Function.

In instances where WHCs cannot be implemented, the relevant lead is required to update AMaT to reflect the barriers to implementing the WHC and add a corresponding risk to the Clinical Service Sub-Group’s risk register on Datix. A Quality Impact Assessment (where appropriate) is also required to be undertaken, as well as escalating the WHC for the attention of relevant CCG Leads via their CCG IGG meetings. Barriers cited which prevent the implementation of these WHCs include lack of funding and ongoing challenges in recruiting staff.

Progress on the implementation of WHCs are also reported to the relevant Committee via the Assurance and Risk Report.



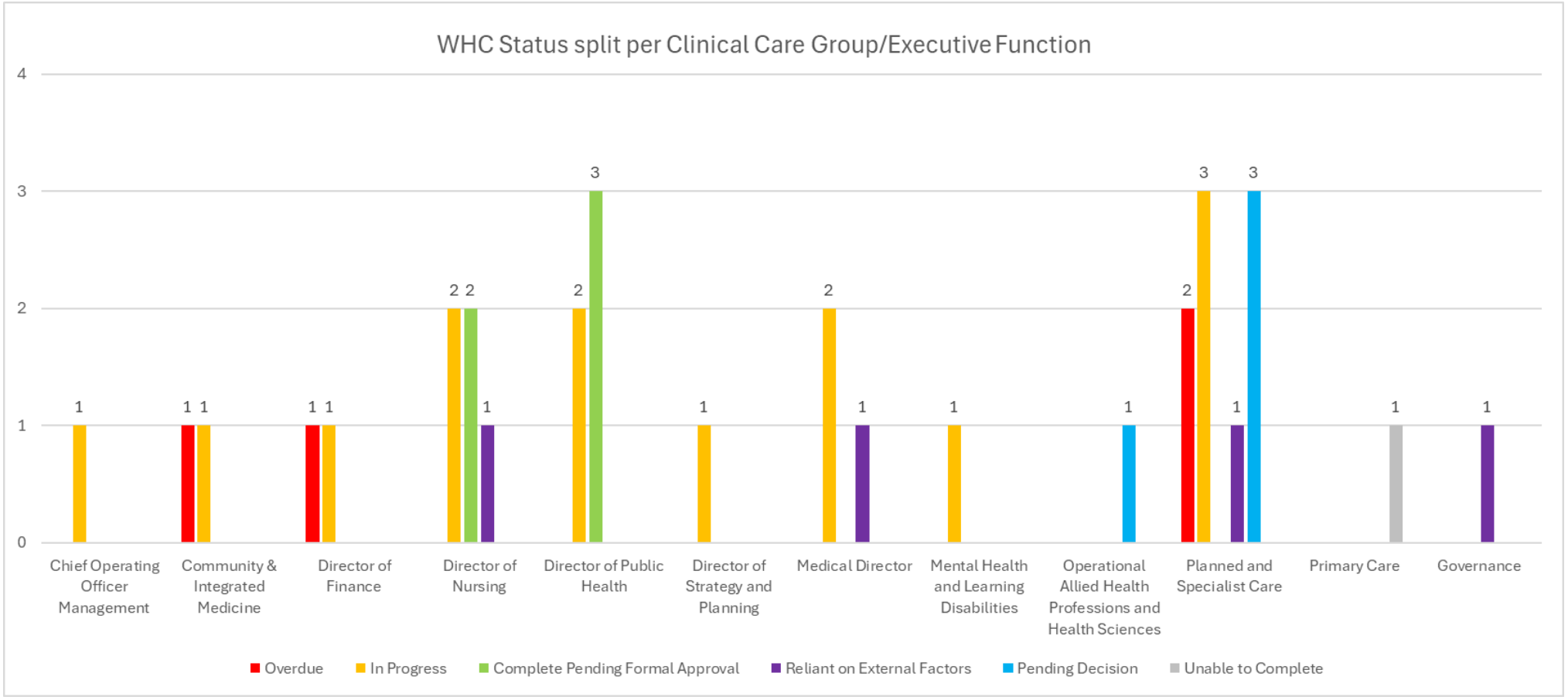


Overview of Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Along with risk management and the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews, the implementation of WHCs is a key factor in assessing a Function's escalation level.

A summary of each CCG / Executive Function's performance for the Governance domain for December 2025 can be found on slide 15.



The next slide outlines the minimum criteria required for a service to be assigned its escalation level based on the status of WHCs. This is followed by a detailed analysis of one Clinical Care Group (CCG) that was designated Level 3 as of December 2025.

Three Lines of Defence: 2nd Line - Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Internal Escalation - Measures to assess against the Governance Domain – Welsh Health Circulars

Levels are awarded based on the assessments undertaken by each function meeting the prescribed targets within the year.

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (e.g., no responses to WHC / MD requirements, **no revised dates** where original completion dates have lapsed). Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has not been raised, and a Quality Impact Assessment has not been completed (if applicable). No evidence that in instances of non-compliance, WHCs are escalated via CCG management structures where necessary.
Level 3 – no assurance	Responses to WHCs / MDs have been developed, but the function is **not delivering against revised completion dates** Limited evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable). Limited evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.
Level 2 – Limited assurance	Responses to WHCs / MDs 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. Some evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable). Some evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.
Level 1 – Reasonable assurance	Responses to WHCs / MDs have been developed, and the function is **delivering against original completion dates.** Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed. Evidence that in instances of non-compliance, WHCs and MDs are escalated via CCG management structures where necessary.

Internal Escalation - Governance Domain : Level 3 - No Assurance (WHC Continued)

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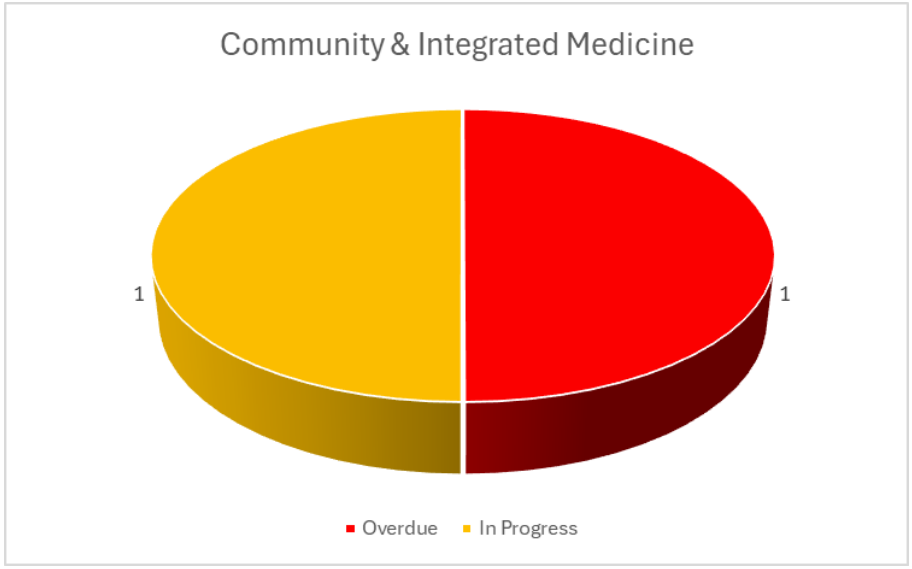
Community & Integrated Medicine CCG

As at 31 December 2025, two Welsh Health Circulars (WHCs) are assigned to the Community & Integrated Medicine CCG. The Ambulance Patient Handover Guidance WHC (WHC/2024/041) is in progress, with the Transformation Programme Office gathering evidence to support closure of the WHC.

The National Clinical Guideline for Stroke (WHC/2024/006), received in March 2024, is overdue by 18-24 months with no confirmed implementation timescale (N/K). An associated risk is recorded on the risk register (Risk 233 *Risk of poor patient outcome due to insufficient stroke therapy staff & lack of 7 day Consultant affecting the Health Board*. Current Risk Score 12 (High)) and a revised Quality Impact Assessment (QIA) is to be submitted to the QIA panel for review. Implementation cannot proceed until the Clinical Services Plan is developed, as Stroke Services form part of this wider plan. Current barriers to the implementation of this WHC include insufficient resources such as staffing, equipment, and appropriate facilities



Three Lines of Defence: 2nd Line: Board and Committee Oversight - WHCs

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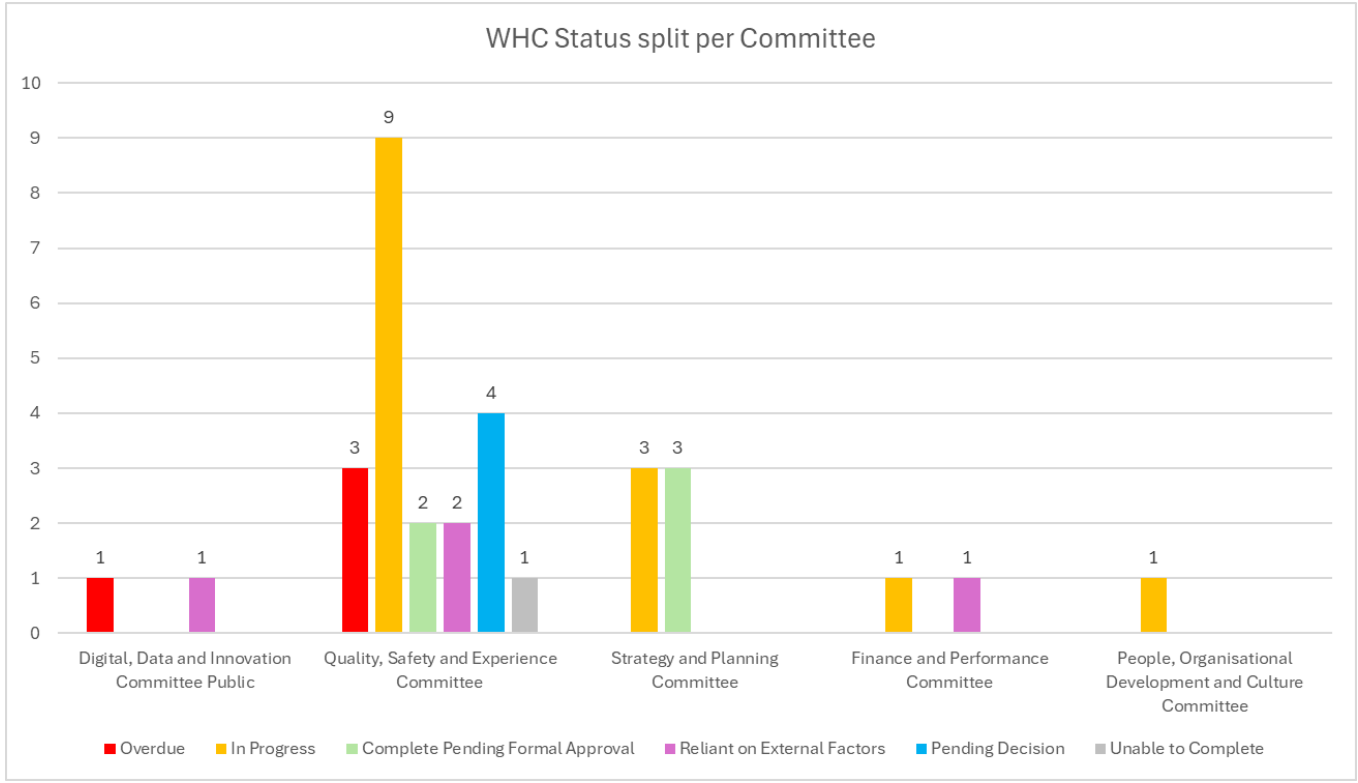
The graph provides a breakdown of the number of WHCs assigned to each Board level committee as at 31 December 2025

Board level Committees receive assurance of the timely implementation of the WHCs via the Assurance and Risk Report. The report details progress made in the implementation of WHCs, providing oversight and assurance while highlighting any barriers to implementation. The Committees are responsible for seeking assurance that the Health Board is compliant with the requirements of WHCs, and that these are implemented in line with stated and/or agreed timescales. In instances where this has not been possible, the Committees are asked to receive assurance that the impacts resulting from late/non-delivery are understood and managed appropriately.

The table below highlights actions from discussions at Board-level Committees in October and December 2025 relating to the progress being made in implementing recommendations raised at the relevant meeting. Progress against actions will be reported through the relevant Committee Table of Actions.

Committee	Minute Reference	Action
Digital, Data & Innovation Committee (DDIC)	DDIC(25)44	Assurance on governance arrangements – Implementation date requested for Welsh Health Circular 03-22: Further extending the use of Blueteq in secondary care

The process of obtaining formal approval for the closure of the WHCs requires the relevant Lead Executive to confirm that all requirements have been appropriately implemented.



Next Steps and Recommendations

Next Steps

This report has identified the following areas where further improvements can be made:

- To develop a revised plan and timescales with colleagues in the Performance team, taking into consideration capacity and existing development priorities to develop an audit tracking performance dashboard via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework. This will allow Health Board-wide access to information, and further support the escalation analysis undertaken by the Assurance and Risk Team.

Recommendations

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** that the Health Board is:

- continuing to address and implement findings from audits, inspections and regulators;
- addressing and implementing the requirements as raised within Welsh Health Circulars; and
- strengthening the internal escalation arrangements for the domain of governance.