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

Audit and Risk Assurance Committee

Internal & External Recommendations and Welsh Health Circulars Assurance Report

14 October 2025

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 internal and external recommendations as raised by auditors, inspectorates and regulators. 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 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 is required to meet the following revised set criteria:

- 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;
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s; and
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

This report now includes detail to provide ARAC with assurance on the effectiveness of processes in place across the Health Board in relation to the implementation of the requirements of Welsh Health Circulars (WHCs) as issued by Welsh Government.

Progress since the previous report to ARAC

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

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 June 2025:

Next Steps	Progress Made
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.	The Head of Assurance and Risk partakes in fortnightly meetings with AMAT super-users in Hywel Dda, where any identified system improvements are discussed and sent to AMAT development team. Requests are prioritised by the national system teams, with system development plans reviewed on a quarterly basis. This is an ongoing control process, supplemented by regular meetings between the Assurance and Risk Team and QAST to further identify system improvements, recognising that requests are not always actioned by the national AMAT team in a timely manner due their national prioritisation processes.
To work with the Performance team and explore and confirm timescales, when capacity allows, to develop audit 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.	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. Once the specification document has been finalised this will inform implementation timescales, pending resource availability.
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:	The Assurance and Risk SharePoint site has been further enhanced to strengthen accessibility and clarity of information. The site has been restructured to provide a more user-friendly and visually engaging layout, enabling staff to easily navigate and locate the relevant guidance. Updates include the incorporation of the internal escalation process and the addition of information reflecting recent structural changes made within the Health Board. Staff can now enrol for training on the AMaT system via the Assurance and Risk SharePoint site.
Reiterating the importance of developing SMART action plans to ensure Clinical Care Groups (CCG) 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.	Supporting information is available via the Assurance and Risk SharePoint site in the development of management responses, and the significance of providing SMART management responses has also been embedded within CCG and CSG Assurance and Risk presentation materials. This approach continues to promote consistency and strengthen accountability across governance processes. Corporate Governance training sessions have been delivered with the CCGs to reinforce the importance of developing SMART action plans, ensuring that management responses are both credible and deliverable.

Audits and Inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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** based on the following criteria:

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.

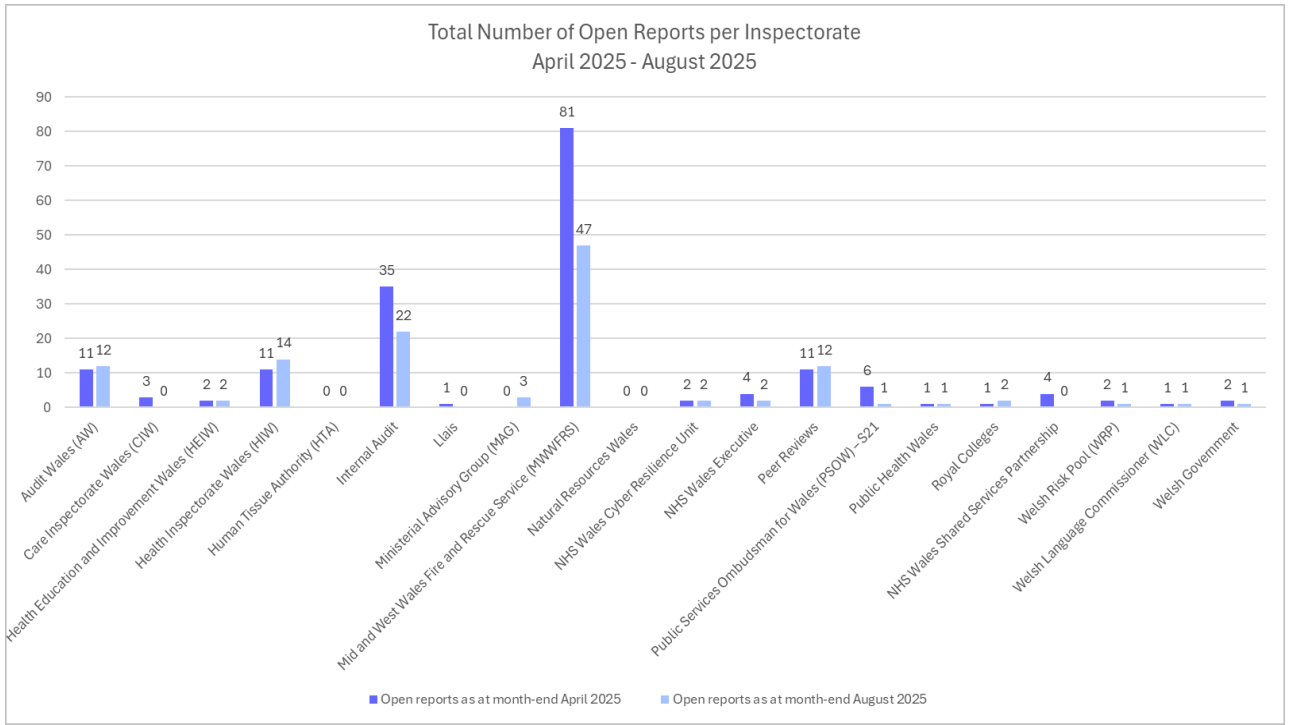
Overview of the Audit Tracker

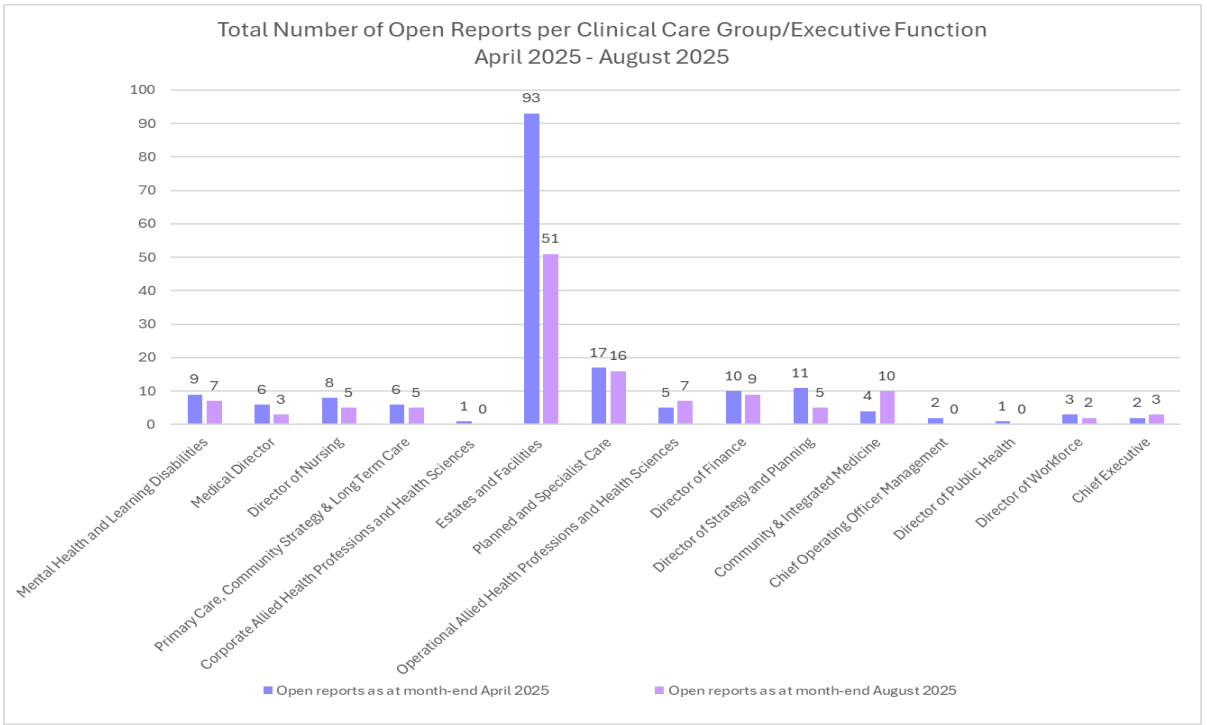
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 August 2025).

Since the previous report presented to the Committee in June 2025, (based on data as extracted on 30 April 2025), there has been a significant reduction in the total number of open reports, decreasing from 178 to 123 in August 2025. The number of overdue reports has also reduced from 81 to 56. The graph below illustrates the number of open reports per auditor/inspectorate/regulator as at April and August 2025, representing a 31% reduction in open reports.

Since the previous report presented to ARAC,13 Internal Audit reports have been formally approved for closure by the Internal Audit Team, with relevant evidence appropriately uploaded to the AMaT system. Additionally, a revised administrative process for managing the Letters of Fire Safety Management (LOFSMs) was presented and agreed at the Estates & Facilities Integrated Governance Group (Quality Health & Safety) in May 2025, reinforcing the requirement to provide 'evidence' for completed actions on AMaT. Following the implementation of this new process, evidence was uploaded to those reports which had been 'pending closure' which enabled 34 of LOFSMs (some historical) to be formally signed off via the Head of Fire Safety in July 2025.



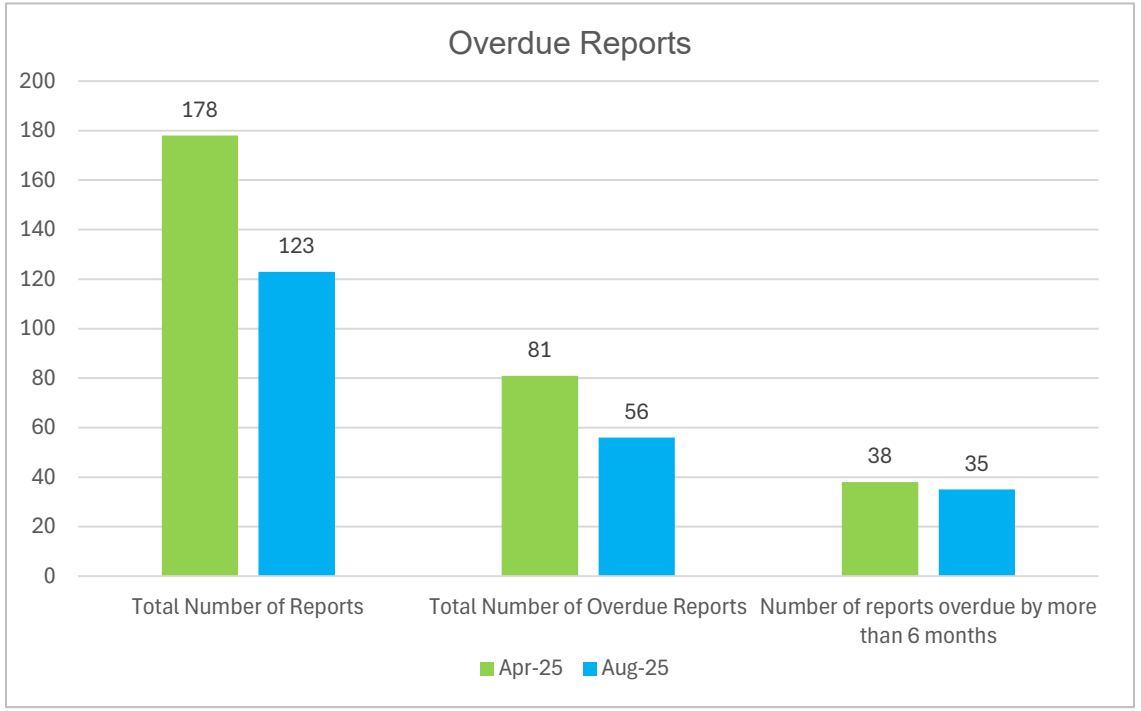


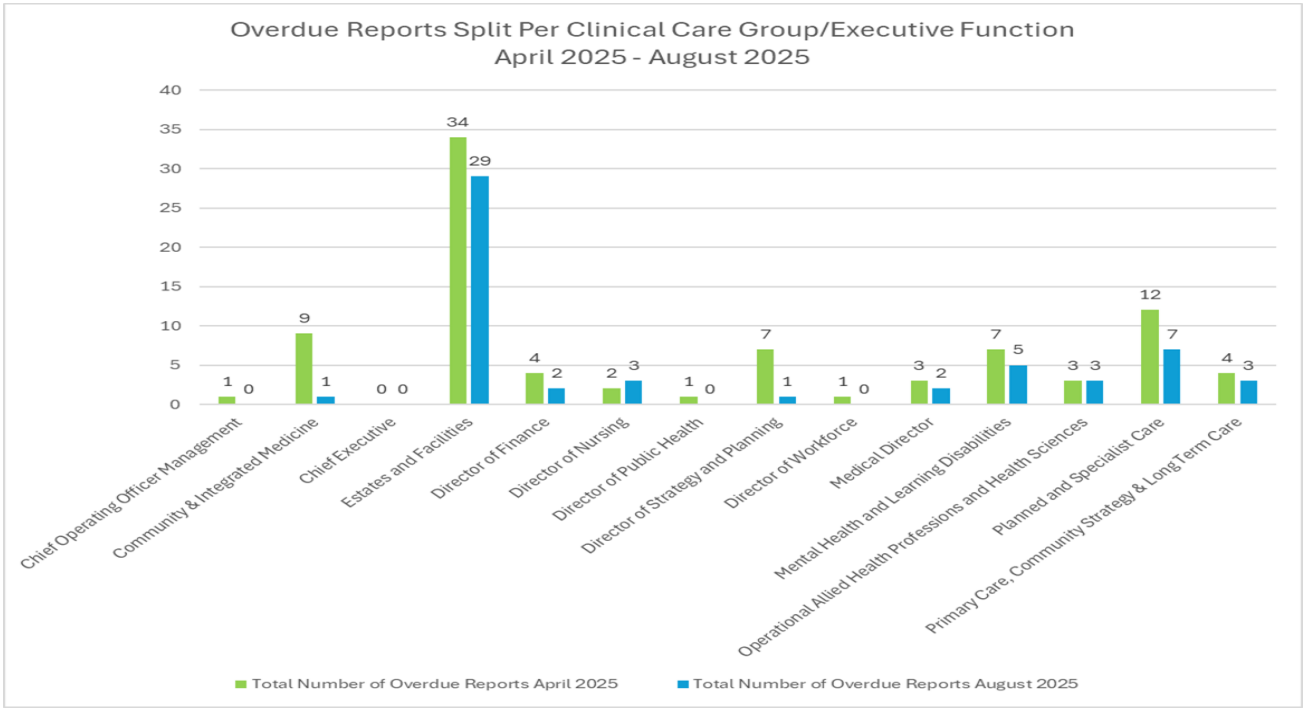
Audit Tracker Analysis – Overdue Reports

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the last report presented to ARAC in June 2025, the number of overdue reports has decreased by 31% (from 81 to 56). Of the current open reports, 35 are overdue by more than six months, compared to the 38 reports noted in April 2025, showing a marginal improvement These reductions reflect continued progress made in clearing the backlog of historical reports, and the graph below illustrates a sustained downward trend in both the volume and ageing of the overdue reports.

The graph below illustrates a comparative analysis of overdue reports across organisational functions between April and August 2025. The data reflects an improving trend with several functions fully completing reports. The Director of Allied Health Professions and Health Sciences, while still holding the highest volume of overdue reports, achieved a reduction from 34 to 29. Community and Integrated Medicine saw a decrease in overdue reports from 2 to 1, while the Director of Strategy and Planning reduced theirs from 7 to 1. A number of functions maintained zero overdue reports throughout the period, indicating sustained compliance. Currently, the Director of Public Health and Chief Operating Officer Management do not have any reports assigned to them, therefore are not noted on the graph below



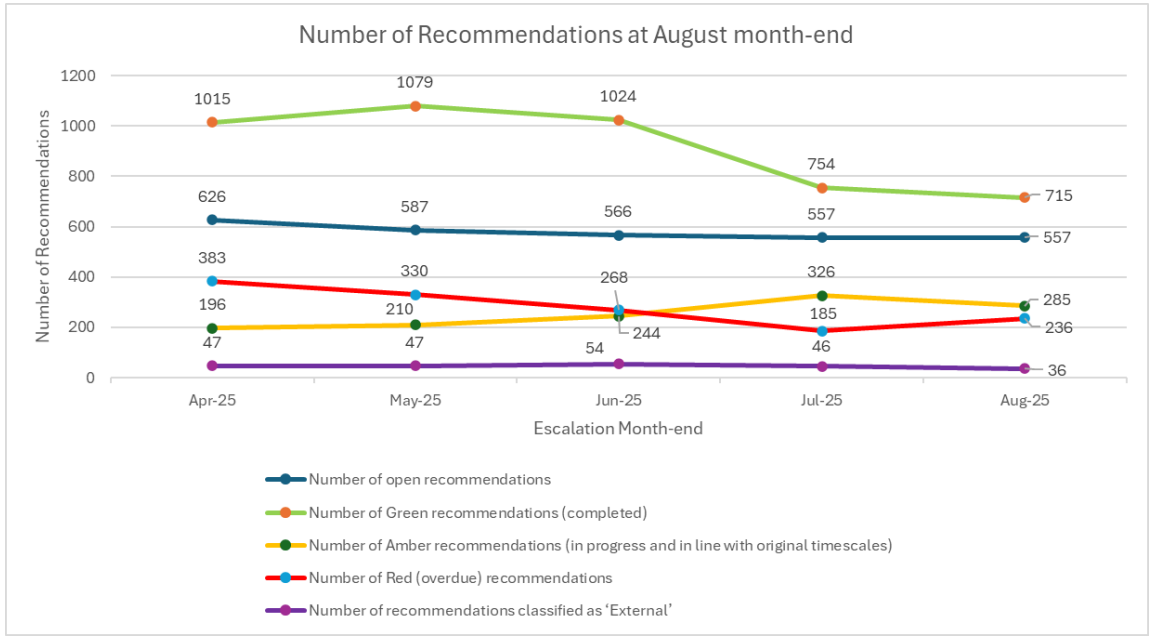


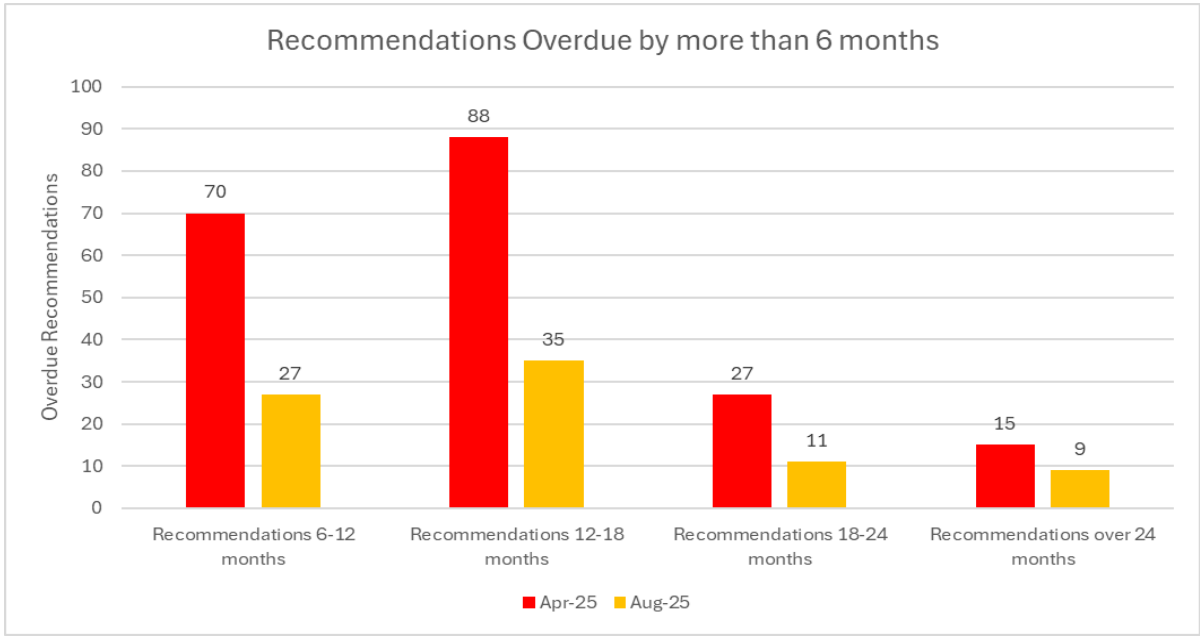
Audit Tracker Analysis – Overdue recommendations

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The August data demonstrates the progress made in the management of the Audit and Inspections recommendations. The total number of recommendations has reduced from 1,641 in April 2025 to 1,272, with the number of open recommendations decreasing from 626 to 557.

It is noted that there has been an increase in the number of “in progress” (Amber) recommendations primarily attributable to the number of new reports received since the previous report presented to ARAC. The number of “overdue” (Red) recommendations has fallen significantly from 383 to 236, with 82 overdue by more than 6 months. The number of recommendations without revised timescales has also reduced from 286 to 162. These reductions have been primarily seen within Estates and Facilities, Planned and Specialist Care and Mental Health and Learning Disabilities. The improvements noted in addressing long-standing overdue recommendations is primarily due to the completion of recommendations raised with reports issued by Mid and West Wales Fire and Rescue Service reports, NHS Wales Shared Services Partnership report and Peer Review reports.





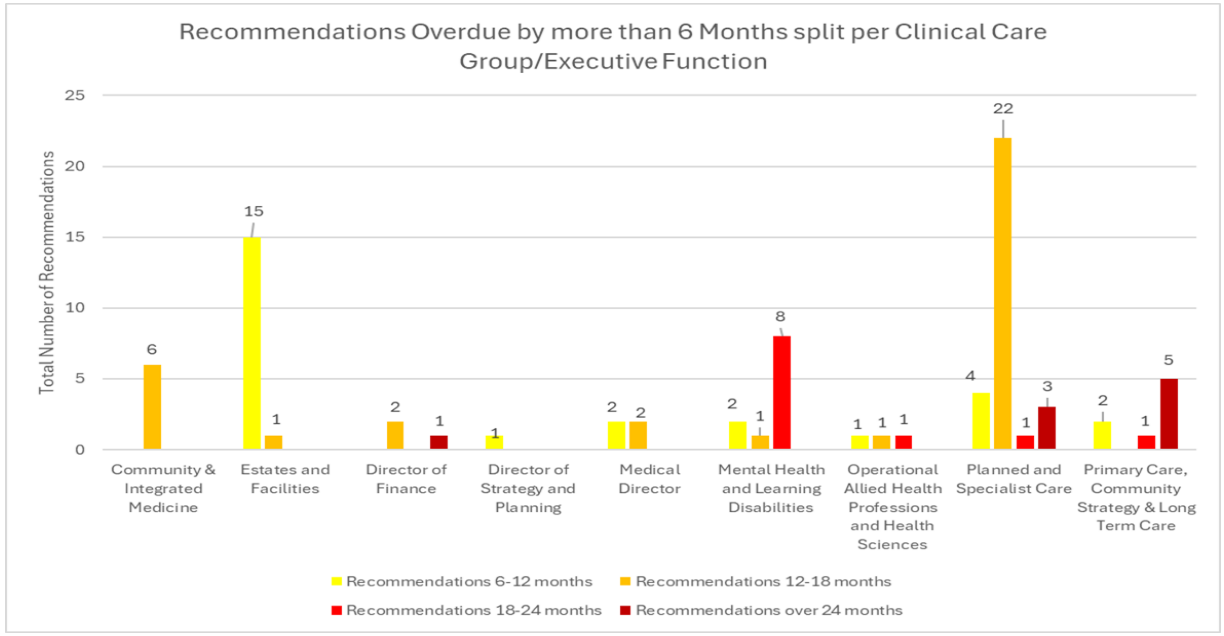
Audit Tracker Analysis – Overdue recommendations (continued)

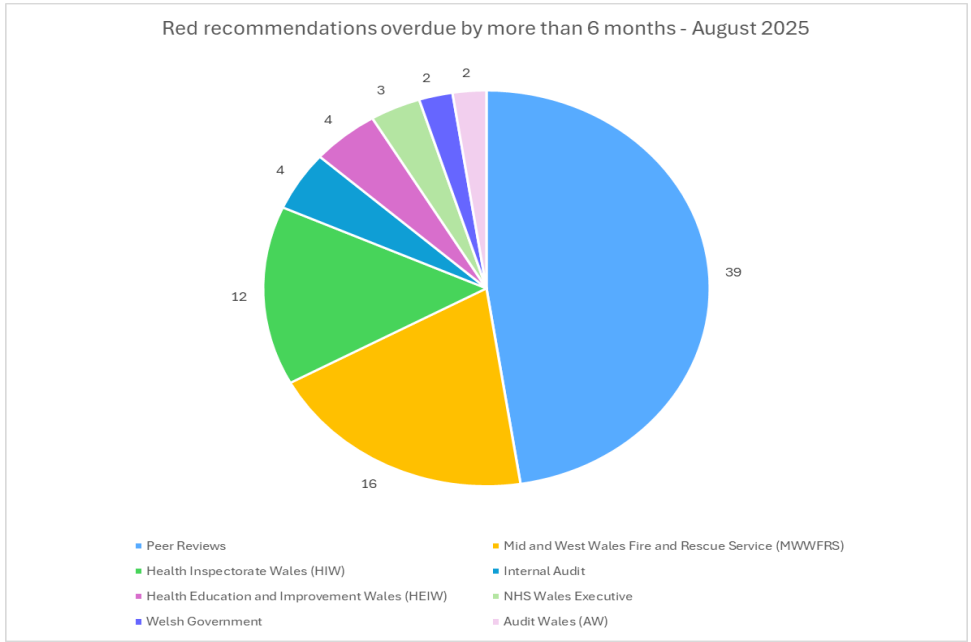
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Of the 82 recommendations overdue by greater than 6 month, 37% are attributable to Planned and Specialist Care, 19% to Estates and Facilities, and 13% to Mental Health and Learning Disabilities.

Analysis of the recommendations overdue by greater than 6 months per audit/inspectorate/regulator highlight that 39 (48%) are from Peer Review reports, 19 of which are from the Peer Review – 'Cervical Screening Wales Quality Assurance Visit Report' whereby the service has noted as them as "unable to complete" on AMaT due to barriers such as funding and the restrictions on recruitment of administrative staff. These 19 recommendations represent the majority of the 22 recommendations aged between 12–18 months assigned to Planned and Specialist Care. Since the data for this report was extracted, these recommendations have been escalated via the CCG IGG QSH meeting whereby it agreed that the Clinical Service Group review the recommendations further. In light of this, 4 of these recommendations previously marked as "unable to complete" have now been noted as complete on AMaT. 16 (20%) are attributable to the Mid and West Wales Fire and Rescue Service reports, 12 (15%) Health Inspectorate Wales, 4 (5%) Internal Audit, 4 (5%) Health Education and Improvement Wales, 3 (4%) NHS Wales Executive, 2 (2%) Welsh Government and 2 (2%) Audit Wales.

The Assurance and Risk Team have 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. 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.





Audit Tracker Analysis - Recommendations without revised timescales

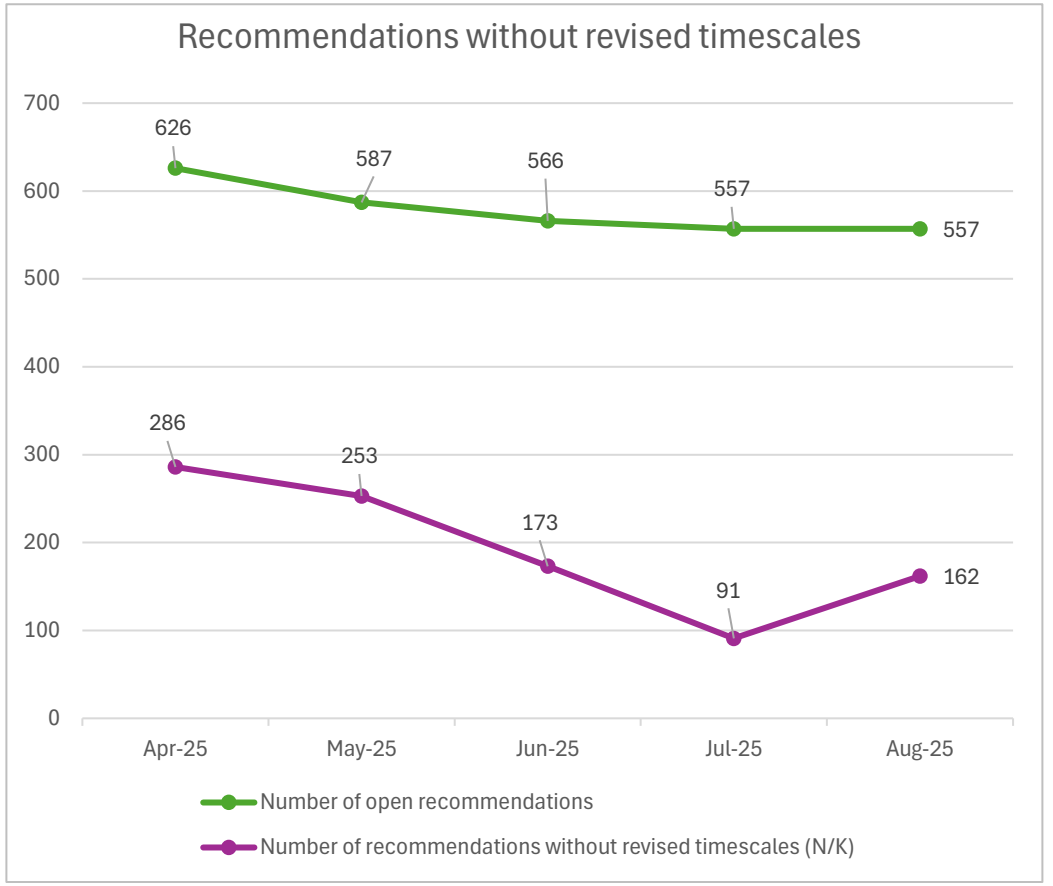
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 162 (29%) recommendations without revised timescales as at August 2025. 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;
- 79 recommendations lapsed since July 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 continue to remind services to provide revised dates on the AMaT system through their progress updates. A delay in the provision of revised completion dates may be attributable to operational pressures and capacity within the Health Board over the summer months;
- CCGs / Executive Functions have provided progress updates on AMAT but not included a revised completion date.

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 continue to remind services of the need to include revised completion dates within the Assurance and Risk overview 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.

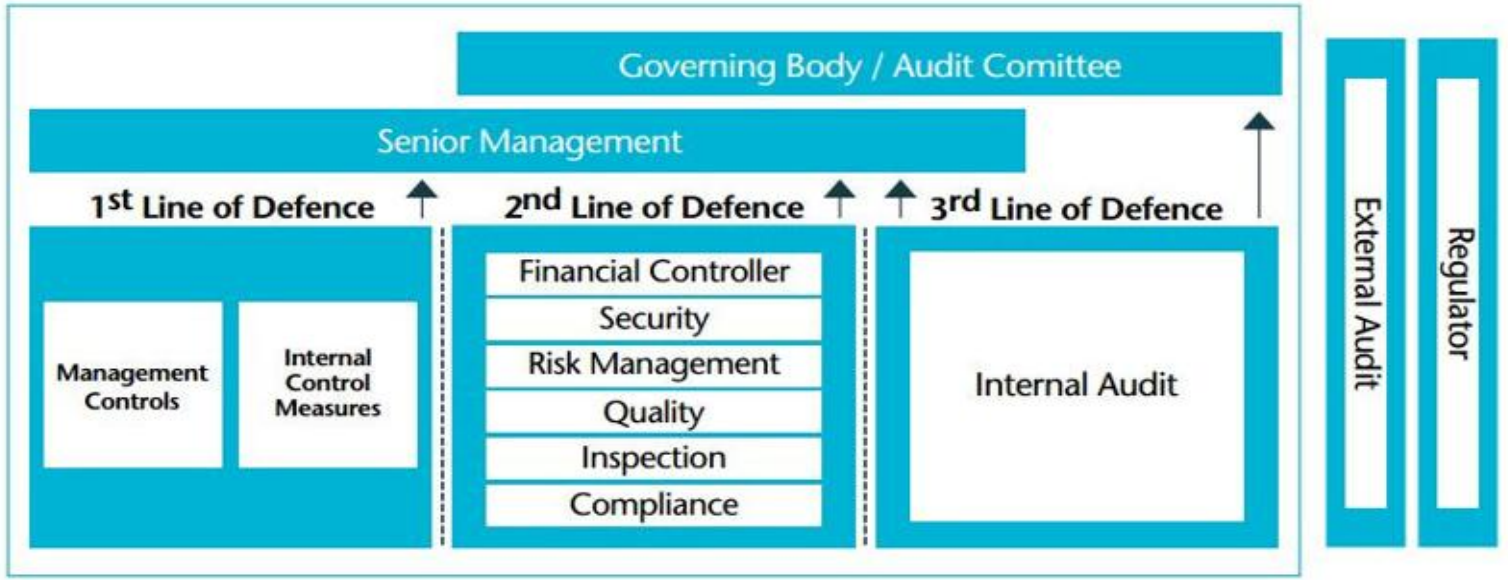
Scoping work has commenced to explore the opportunity to develop performance dashboards on the data captured on AMaT via 'Power BI' with colleagues in QAST and the Performance Team. This would provide services with improved oversight of their performance, including the number of recommendations without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



Three Lines of Defence

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 the implementation of recommendations and Welsh Health Circulars is 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 Clinical Care Group (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 managements meetings, and then escalated as appropriate to Senior Leadership Team meetings / escalated to the relevant Lead Executive as appropriate. CCG and EF governance arrangements are considered when assessing the escalation status for Governance.

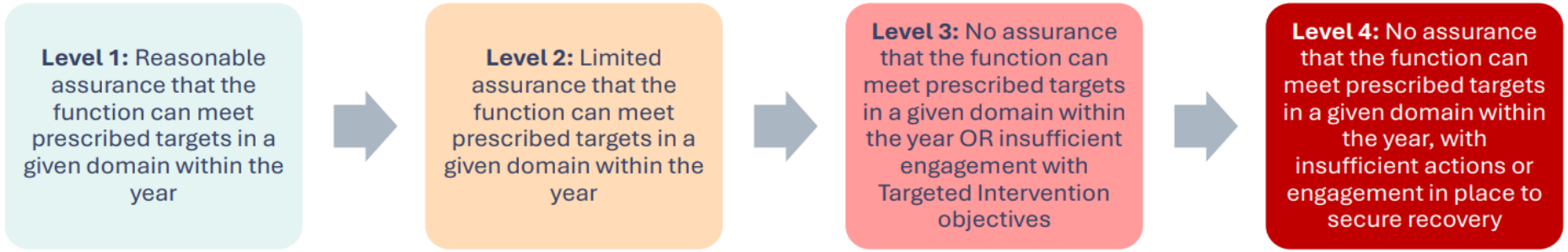
Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are provided to management and service leads via e-mail to enable them to address any areas of concern.

Three Lines of Defence

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 on a monthly basis 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.



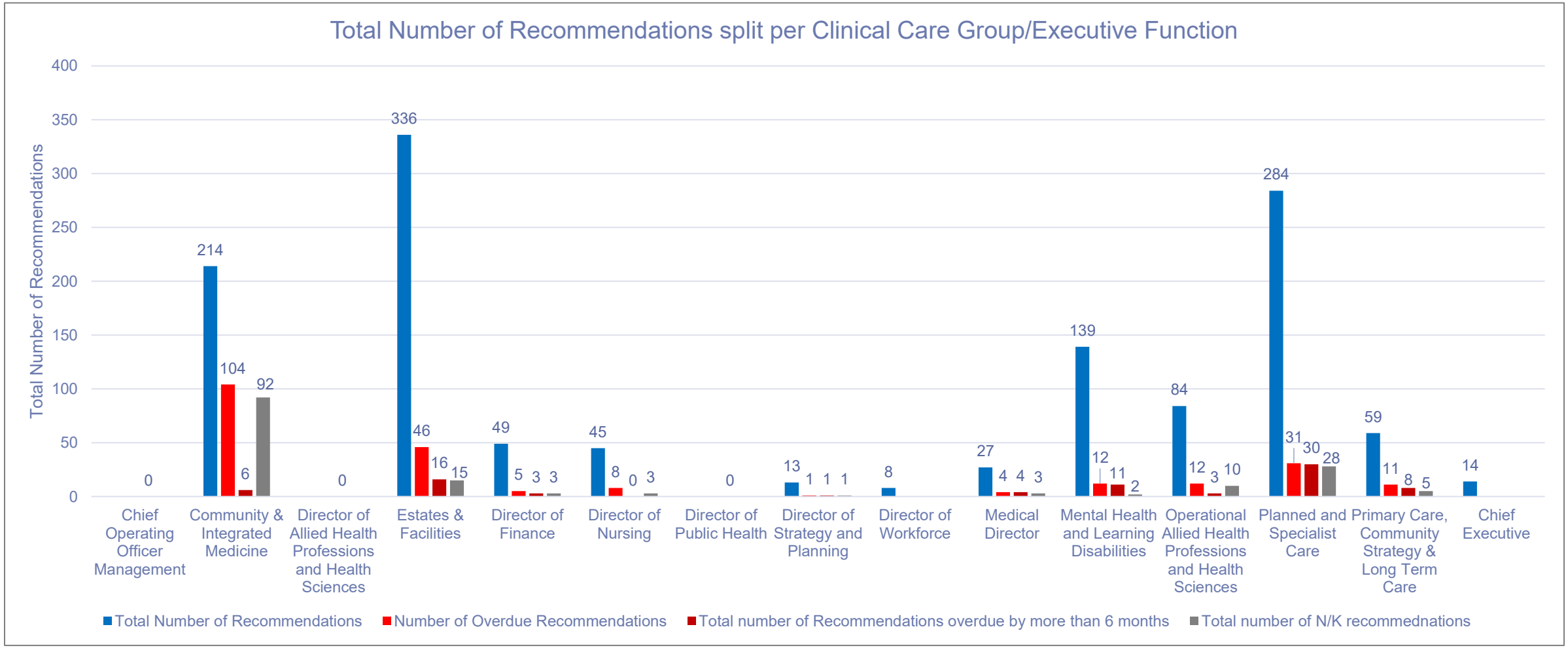
Independent Assurance (3rd line)

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: 1st Line – Audits and Inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The graph below provides a summary of open reports as at August 2025, and the status of the recommendations split per CCG/ Executive Function as per the revised internal escalation framework structure, further detail of which can be found on the next slide. The graph below details how many recommendations are overdue, and of those overdue recommendations how many are overdue by more than 6 months as well as the recommendations without revised completion dates.



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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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, (eg 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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Service	April 2025	May 2025	June 2025	July 2025	August 2025
Chief Operating Officer Management	2	2	1	1	1
Community & Integrated Medicine	2	2	2	2	3*
Estates & Facilities	3	3	2	2	2
Executive Director of Allied Health Professions and Health Sciences	1	2	1	1	1
Executive Director of Finance	2	2	2	1	1
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2
Executive Director of Public Health	2	1	1	1	1
Executive Director of Strategy and Planning	2	2	2	1	1
Executive Director of Workforce and Organisational Development	1	1	2	1	1
Executive Medical Director	2	2	1	1	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	3	3	2	2	2
Operational Allied Health Professions and Health Sciences	2	2	2	2	2
Planned and Specialist Care	3	3	3	3	3
Primary Care, Community Strategy & Long Term 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 to the left.

Along with 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 the 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 those CCGs / Executive Functions who have been awarded either a Level 3 status as at August 2025 is provided on the next slide, based on performance in the management of recommendations (to note, 0 functions were awarded Level 4 in August 2025).

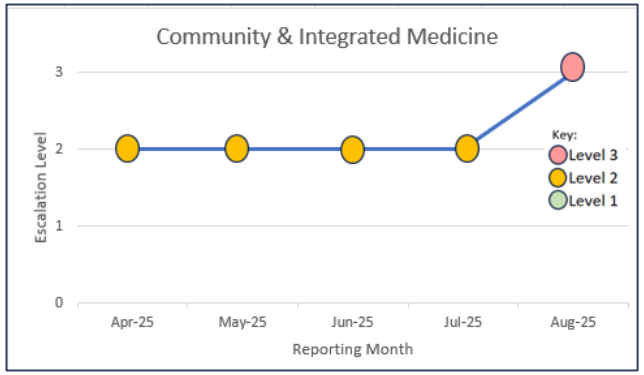
Internal Escalation - Governance Domain : Level 3 - No Assurance (Audits and Inspections)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Community & Integrated Medicine

As at 31 August 2025,104 of 214 recommendations are overdue (49%). 6 are overdue between 12-18 months, all others are less than 6 months overdue. Of the 104:

- 73 are aligned to Carmarthenshire Integrated System, none of which are overdue by more than 6 months. 62 of the 73 became overdue during August 2025. None of the overdue recommendations have revised completion dates);
- 12 are aligned to Ceredigion Integrated System, 5 of which are overdue by 12-18 months. 8 recommendations do not have revised dates (N/K);
- 7 are aligned to Pembrokeshire Integrated System, one of which is overdue by 12-18 months. 1 recommendation does not have a revised completion date; and
- 12 aligned to the overarching Clinical Care Group, none of which are overdue by more than 6 months. 10 recommendations do not have revised dates completion dates.



Of the 104 overdue recommendations, 57 are from the *NHS Wales Executive Report on Urgent and Emergency Care Opportunities: GGH site report*. Of these, 19 did not have original completion dates noted, therefore the status of these recommendations will be amended as appropriate once completion dates are including on AMaT. An additional 32 of the 57 recommendations were noted as complete in the initial management response, however evidence has yet to be uploaded to AMaT to support this response. These recommendations are noted as overdue until such time relevant evidence has been uploaded. NHS Wales Performance and Improvement have revisited the Health Board in August 2025, and the report is awaited.

18 overdue recommendations are from the *Getting It Right First Time (GIRFT) Emergency Department* report, of which 5 have revised completion dates. GIRFT are revisiting the Health Board during September 2025. 5 overdue recommendations sit with the *Ministerial Advisory Group (MAG) Urgent and Emergency care report*. A MAG progress update is scheduled to be reported to the Public Board in September 2025.

Internal Escalation - Governance Domain : Level 2 – Limited Assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following services were awarded a Level 2 in terms of their audit and inspection reports as at August 2025:

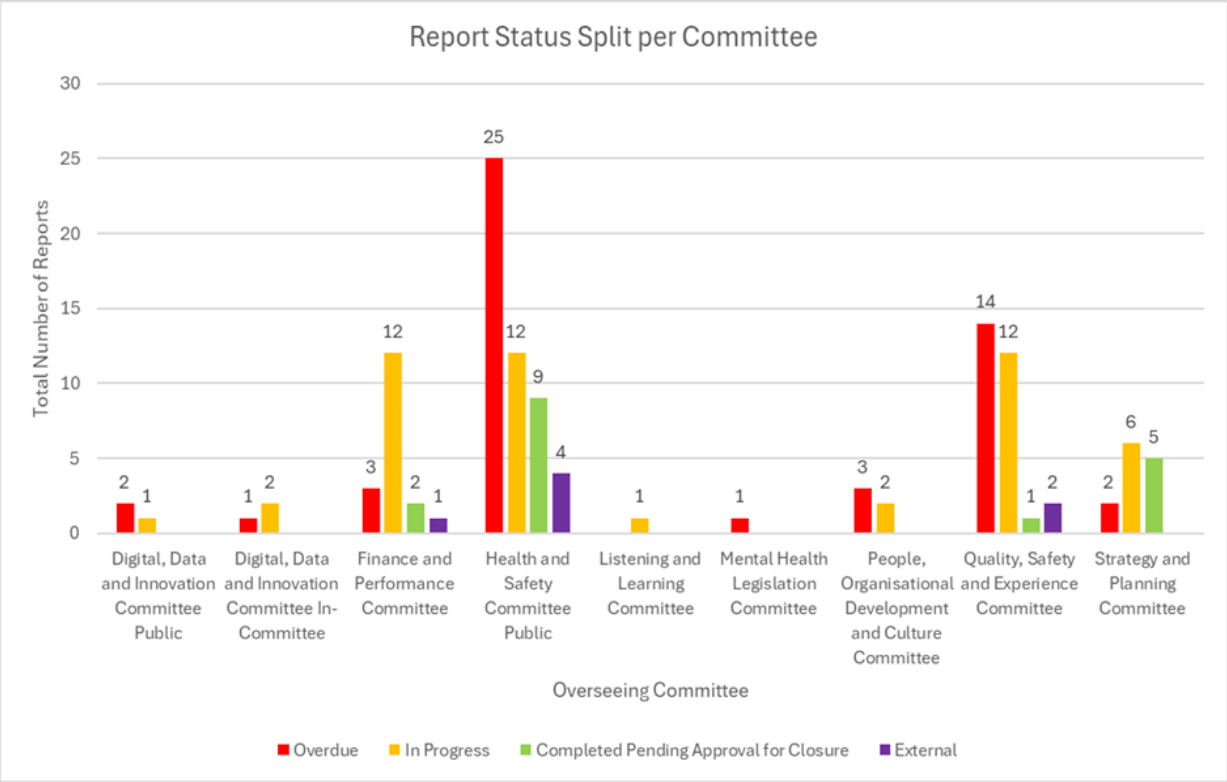
Service	Reason for award of L2	De-escalation Criteria
Medicines Management	17% of recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Estates & Facilities	46 (14%) of recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Executive Director of Nursing	8 (18%) of recommendations overdue	To achieve L1, Executive Function required to implement over 90% of recommendations and provide revised completion dates for those where completion dates have lapsed
Mental Health and Learning Disabilities	9 (8%) of recommendations overdue, however, 3 (60%) of reports overdue and trajectory target was breached with 1 action outstanding from July 2025.	To achieve Level 1, CCG required to implement over 90% of recommendations
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
Planned and Specialist Care	31 (11%) of 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	11 (19%) recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales

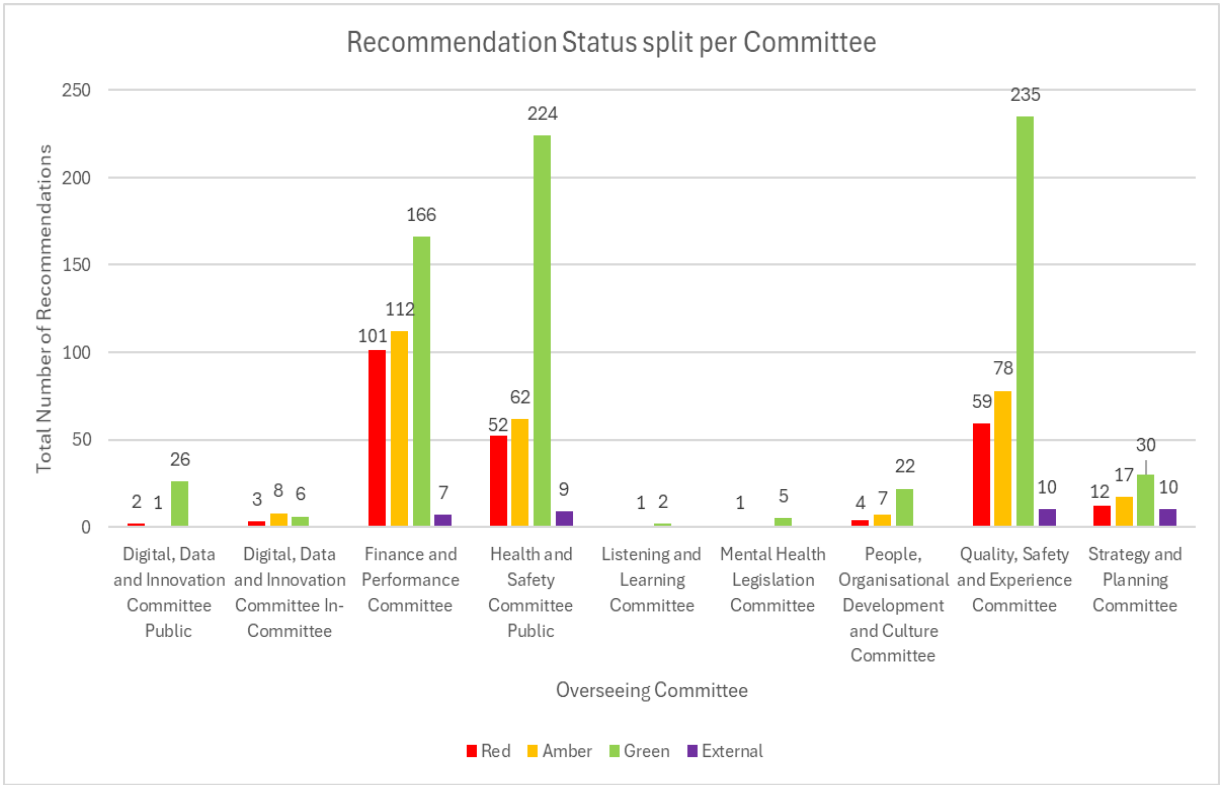
Three Lines of Defence: 2nd Line - Board and Committee Oversight – Audit and Inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Board level Committees are to receive assurance of the timely implementation of external recommendations. 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 CIW. Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Since the previous report to ARAC, the Assurance and Risk team have produced a new report for presentation to all Board Committees which includes on the progress made in implementing recommendations which are aligned to them in order to provide assurance and outlining any barriers to implementation. Below is a breakdown of the number of reports and recommendations assigned to each Board level committee.





Three Lines of Defence: 2nd Line - Thematic Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

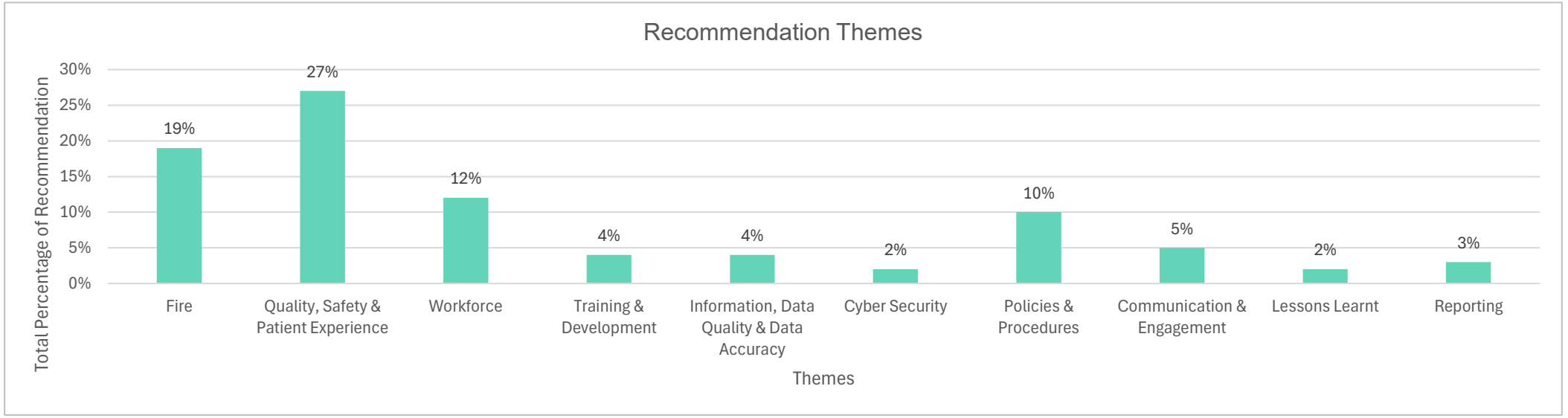
As part of the second line of defence, themes are assigned to each recommendation, which allows the Health Board to analyse groups of similar recommendations. The Assurance and Risk team commenced sharing recommendations with themed subject matter experts (replicating the process undertaken of sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMaT.

The graph below provides a thematic analysis for all open recommendations per theme as at August 2025. 27% of the open recommendations were assigned the Quality, safety & Patient Experience theme. (In June 2025, the Assurance and Risk Team amalgamated the 'Patient Safety' and 'Safe' themes with the Quality, Safety & Patient Experience theme).

The following themes had less than 1% of Recommendations assigned to them:

Health and Safety, Governance, Finance, Performance Monitoring, Medical Devices, Infection Control, Information Governance, Partnerships, Safeguarding, Estates, Medication, Business Disruption, Approvals, Financial Management & Control, Planning Delivery & Deadline Management, Resourcing, Strategy, Capital Equipment, ICT (Information and Communication Technology), Risk Management.

The Assurance and Risk Team share the themed 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.



Welsh Health Circulars

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

All WHCs are managed via the Audit Management and Tracking system (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.

Each WHC is assigned a RAG status, the table below provides the definition for each category:

RAG Status	Definition
Red	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.
Amber	A plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC)
Green	Completed
External	Considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement.

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

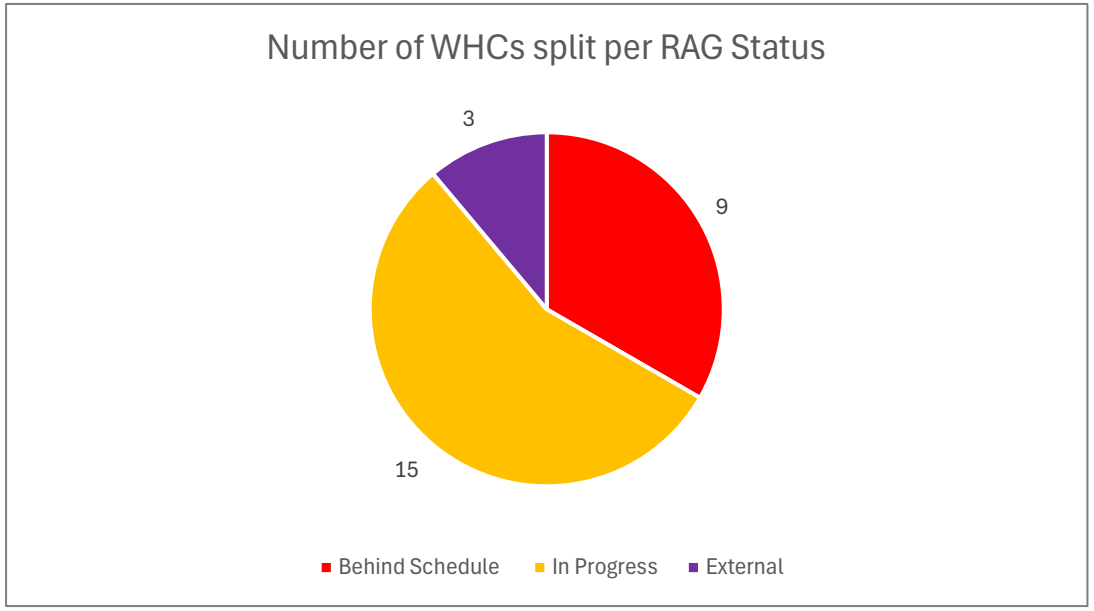
The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

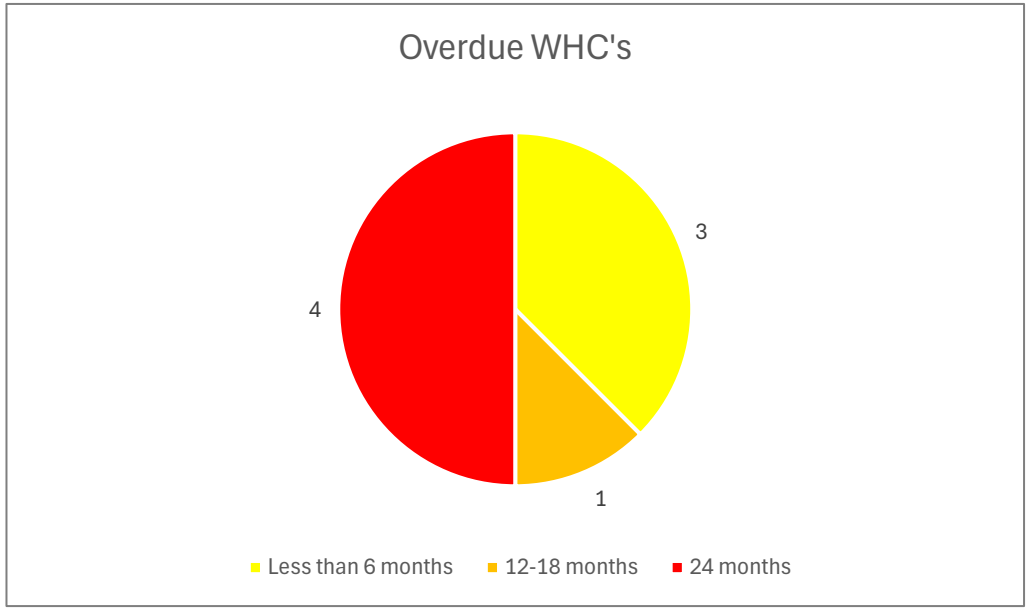
Overview of Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

This report provides an overview of the open Welsh Health Circulars, based on the most recent analysis point at the time of preparation (31 August 2025).

As at 31 August 2025, there are currently 27 open Welsh Health Circulars assigned to the Health Board. The graphs below denote their RAG status, and an analysis of the length of time these WHCs have been noted as overdue.





Of the 9 WHCs noted as behind schedule, 4 (50%) are behind schedule by more than 24 months (3 assigned to Planned and Specialist Care, and 1 to Nursing, Quality and Patient Experience). The main barriers preventing the implementation of these WHCs include lack of funding and ongoing challenges in recruiting staff.

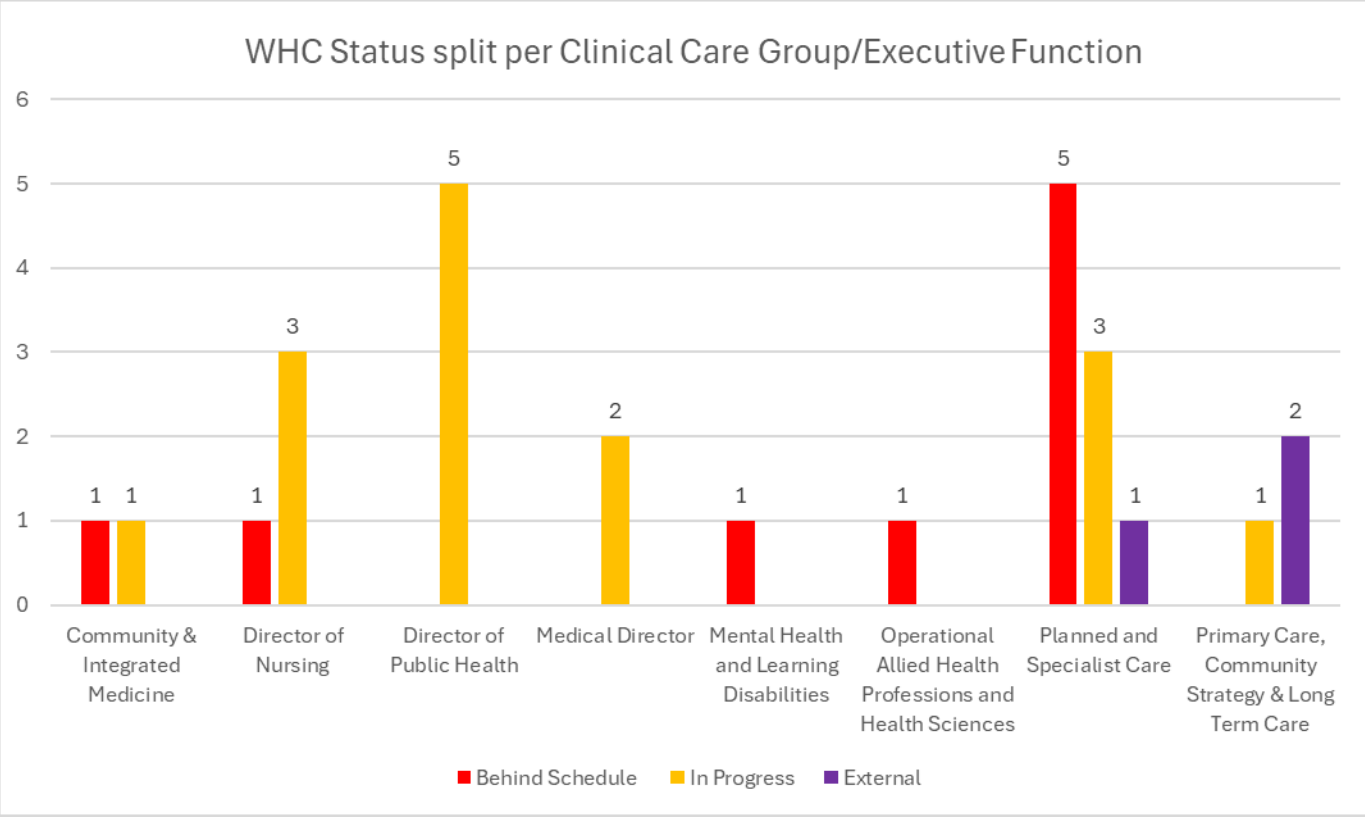
In instances where WHCs cannot be implemented, the relevant lead is required to update AMaT to reflect the barriers to implementing the WHC, and the addition of corresponding risk the Clinical Service Sub-Group's risk register on Datix. A QIA (where appropriate) is also required to be undertaken, as well as escalate the WHC to the attention of the relevant CCG Leads via their CCG IGG meetings.

Three Lines of Defence: 1st Line - WHCs

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The graph below provides a summary of the status of each WHCs assigned to the Clinical Care Groups and Executive Functions as at the end of August 2025.

As illustrated in the graph below, Planned and Specialist Care have 5 (56%) WHCs which are noted as behind schedule (red). The CCG has followed due process and has added corresponding risks to the Risk Register and completed QIA's for the overdue WHC.



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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Service	April 2025	May 2025	June 2025	July 2025	August 2025
Chief Operating Officer Management	2	2	1	1	1
Community & Integrated Medicine	2	2	2	2	3*
Estates & Facilities	3	3	2	2	2
Executive Director of Allied Health Professions and Health Sciences	1	2	1	1	1
Executive Director of Finance	2	2	2	1	1
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2
Executive Director of Public Health	2	1	1	1	1
Executive Director of Strategy and Planning	2	2	2	1	1
Executive Director of Workforce and Organisational Development	1	1	2	1	1
Executive Medical Director	2	2	1	1	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	3	3	2	2	2
Operational Allied Health Professions and Health Sciences	2	2	2	2	2
Planned and Specialist Care	3	3	3	3	3*
Primary Care, Community Strategy & Long Term 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 to the left.

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

The minimum requirement for a service to be awarded their escalation level is noted on the next slide, followed by a detailed analysis of those CCGs / Executive Functions who have been awarded either a Level 3 status as at August 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, (eg 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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Planned and Specialist Care

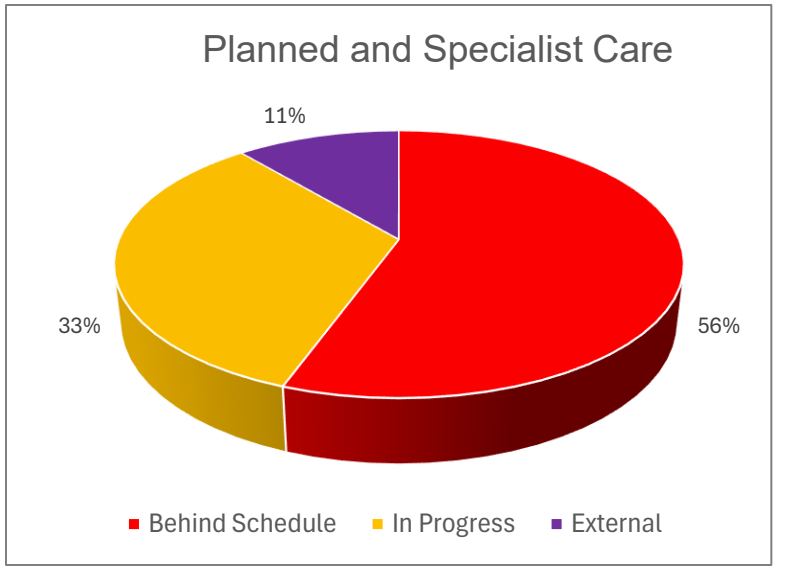
As at 31 August 2025, there are 9 Welsh Health Circulars assigned to the Planned and Specialist Care Clinical Care Group, of which 5 (56%) are noted as behind schedule. 4 of these have appropriate risks added the risk register and QIA's have been completed for 3 of them and sent to the Quality, Assurance and Safety team.

Children, Women And Family Health (CW&FH) Clinical Service Group are in the process of recruiting for a specialised nurse to address the requirements of the *Guidance for the provision of continence containment products for children and young people: a consensus document* WHC. CW&FH are currently compliant with all aspects of *The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)* WHC, apart from the data capture requirements, for which no national system is currently available. Compliance with this WHC is therefore currently outside the gift of the Health Board until an all-Wales data system becomes available (i.e external).

In September 2025, the CCG Director has met with Director of Corporate Governance. It was discussed that the following WHCs require investment in order to be implemented, and will need to be considered as part of HB's priorities and planning process for 2025/26:

- 006-18: Framework of Action for Wales, 2017-2020
- 009-21: School Entry Hearing Screening pathway
- 017-19: Living with persistent pain in Wales guidance.

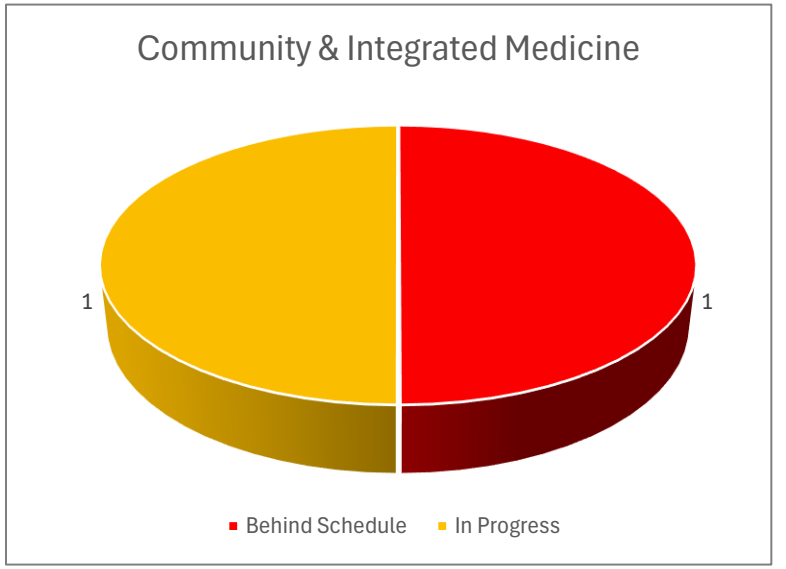
The Non-Specialised Paediatric Orthopaedic Services WHC requires information to be added to AMaT to outline what aspects of the WHC has already been addressed by the Trauma and Orthopaedic service and what requirements of the WHC can be addressed by Primary Care, Community Strategy & Long-Term Care Clinical Care Group.



Community & Integrated Medicine

As at 31 August 2025, there are 2 WHCs assigned to Community & Integrated Medicine Clinical Care Group. 1 WHC is in progress (Ambulance patient handover guidance (WHC/2024/041)) and due for implementation in December 2025.1 WHC is overdue relating to The national clinical guideline for stroke (WHC/2024/006).

The overdue WHC has an appropriate risk on the risk register, and a Quality Impact Assessment has been completed and sent to the Quality, Assurance and Safety team. The WHC cannot be implemented until the Clinical Services Plan has been developed. Stroke Services are part of this wider plan as there is a current lack of resource, including staffing, equipment and environment.



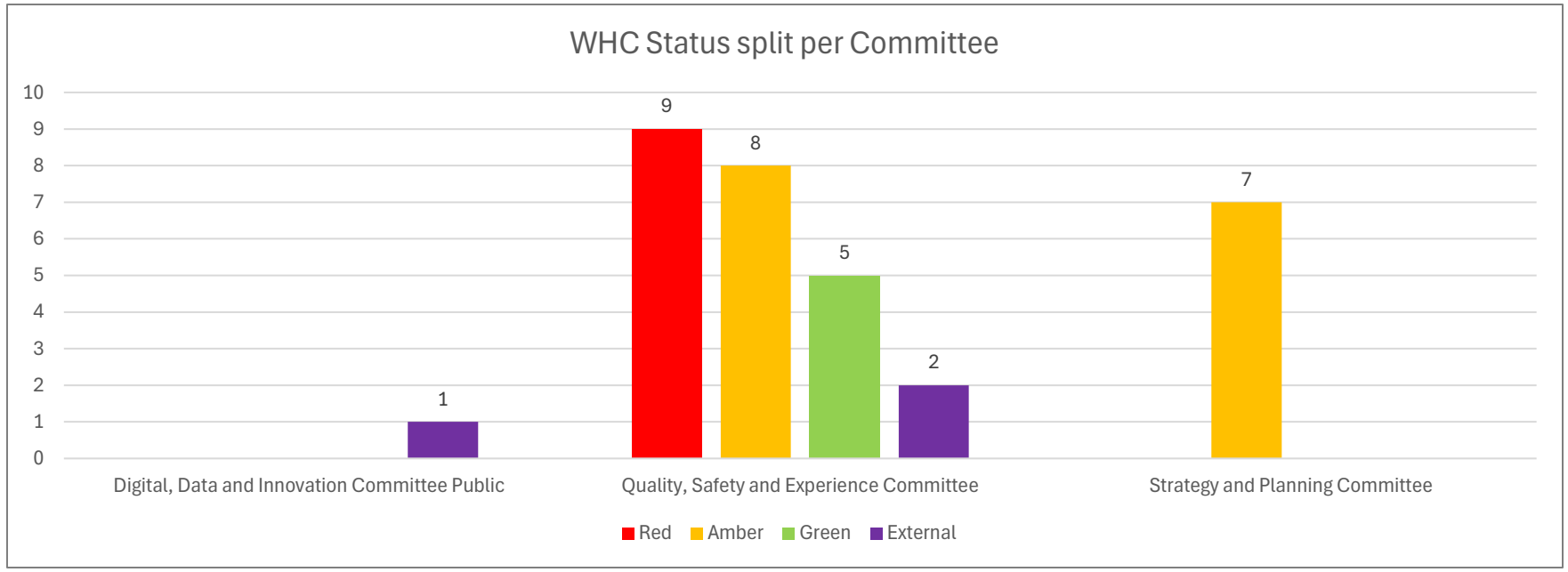
Three Lines of Defence: 2nd Line: Board and Committee Oversight - WHCs

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Board level Committees are to receive assurance of the timely implementation of the WHCs. 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 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.

The Assurance and Risk team have produced a new template for presentation to all Board Committees which includes on the progress made in implementing recommendations which are aligned to them in order to provide oversight and assurance, highlighting any barriers to implementation. Below is a breakdown of the number of Welsh Health Circulars assigned to each Board level committee.



Next Steps and Recommendations

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

Next Steps

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

- 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;
- 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.

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.