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EXTERNAL RECOMMENDATIONS AND WELSH HEALTH CIRCULARS ASSURANCE REPORT

Audit and Risk Assurance Committee

15 October 2026

Situation and Background



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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 to track the progress made to implement recommendations identified by auditors, inspectorates and regulators, and implement Welsh Health Circulars (WHCs) issued by Welsh Government. This is in line with the requirements contained within 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 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 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 University Health Board (HDdUHB) 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 *Getting It Right First Time* (GIRFT) and the national programme reviews opportunities;
- Support the implementation and realisation of the 'Three Ps' policy, GIRFT, theatre optimisation, Clinical Implementation Networks (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 June 2026:

Next Steps	Progress Made
To agree audit and inspection 'PowerBI' dashboard specification with the Performance Team, to enable this to be built by August 2026.	The Audit and Inspection Power BI dashboard specification has been finalised, and received stakeholder sign-off from the Quality, Assurance and Safety (QAST) and Health and Safety Teams. An agreed project plan is in place, with publication expected in November 2026.
Following the Chief Operating Officer being informed of the possible escalation by ARAC, Assurance and Risk business partner to meet Community and Integrated Medicine CCG Director on 10 June 2026 to agree a plan to ensure all management responses are added to the Audit Management and Tracking (AMaT) system by the end of June 2026, and to support improvement in the number of recommendations overdue by more 6 months, and the number of recommendations without revised implementation dates.	The Assurance and Risk business partner meets with the Clinical Care Group (CCG) Triumvirate team, together with each integrated system monthly to support improvement of quality of updates on AMaT, including revised dates where appropriate. The Community and Integrated Medicine CCG provided an update to ARAC on progress in addressing audit and inspection recommendations at its meeting in August 2026. It was agreed that management responses and completion dates would be agreed for those reports outstanding within a month, as well as an improvement in the review of recommendations to identify those which may already have been completed, are duplicated, or are not achievable as currently written. A progress is provided on Slide 13 relating to the current performance of the CCG.

Audits and Inspections Summary

139

Total open reports

April 142 | ▼ 3

1,478

Total recommendations

April 1,404 | ▲ 74

68

Overdue reports

April 50 | ▲ 18

231

Overdue recommendations

April 174 | ▲ 57

30

New reports received

since previous meeting

18

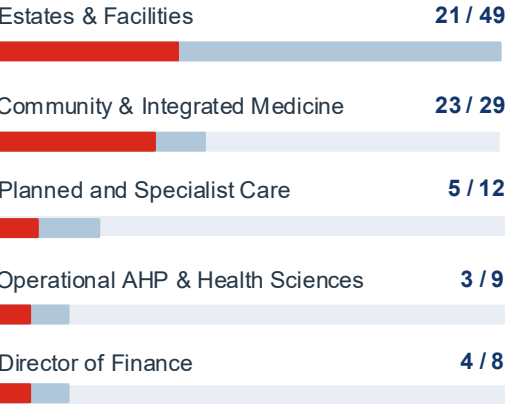
Reports closed

since previous meeting

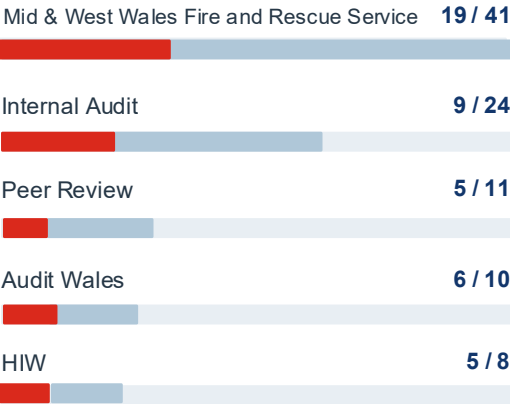
Largest Open Report Profiles (Top 5 CCGs / Functions)

Total open reports Overdue

Care groups / functions



Reviewing bodies



Reports considered overdue as they have one or more overdue recommendations / total open reports.

Recurring recommendation themes include **operational performance, service transformation, fire safety, workforce capacity, digital resilience** and **quality assurance**.

Over half of all open recommendations relate to **long-term improvements** such as **service re-design, infrastructure programmes, digital developments, workforce challenges** and **fire safety schemes** and require additional **funding, capacity** and **wider organisational change programmes**. Implementation can therefore take several years rather than months, highlighting the need to provide realistic timescales for implementation and challenging unachievable recommendations on receipt of new reports, and to provide realistic revised completion dates where original dates have lapsed.

The growing number of aged recommendations indicates the **organisational capacity to deliver change remains a key challenge**. Overdue recommendations are concentrated within specific functions, suggesting that some areas face difficulties in translating planned actions into sustainable implementation within noted timescales.

Recommendations may be reported as overdue where management responses, progress updates, or supporting evidence have not been provided. This can result in actions appearing outstanding despite potential progress having been made. Discussions with service leads indicate that some recommendations may have progressed further than is reflected within AMaT; however, progress cannot be verified until management responses and supporting evidence are provided. Work is currently underway to review the definitions of overdue, external and unable to complete and underpinning processes to ensure their appropriate oversight, detail of which will be provided to ARAC in February 2027.

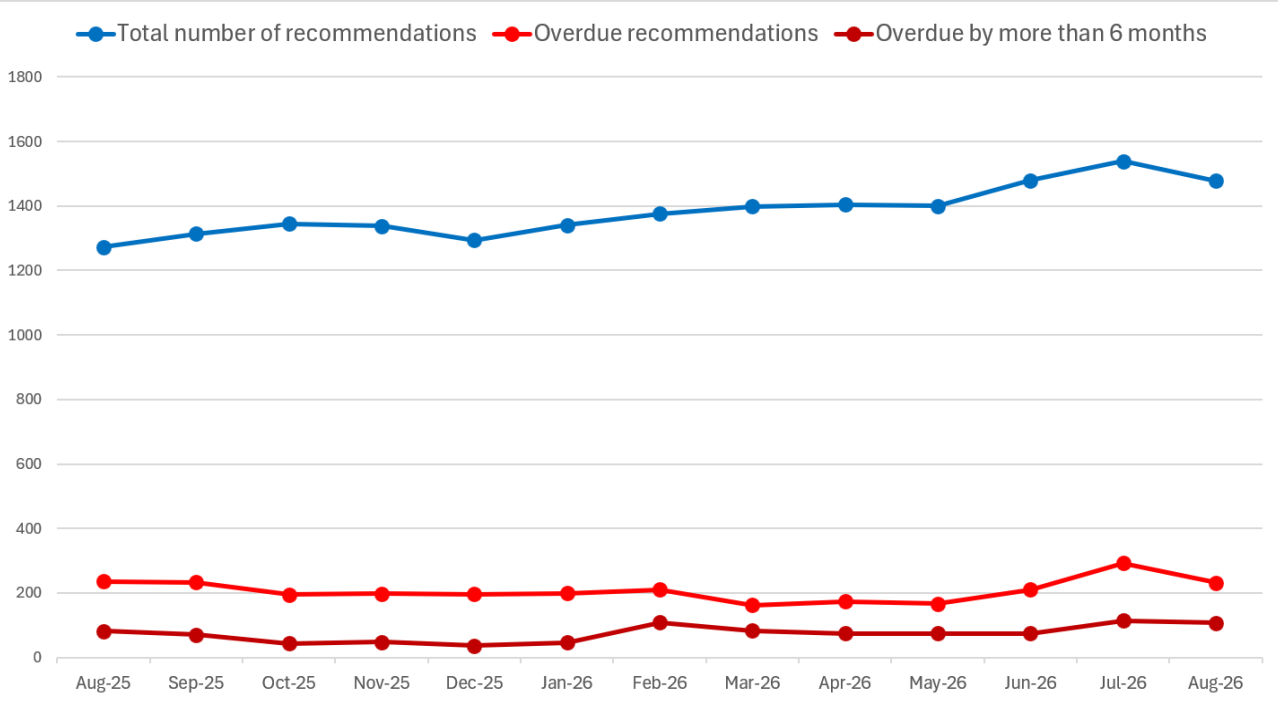
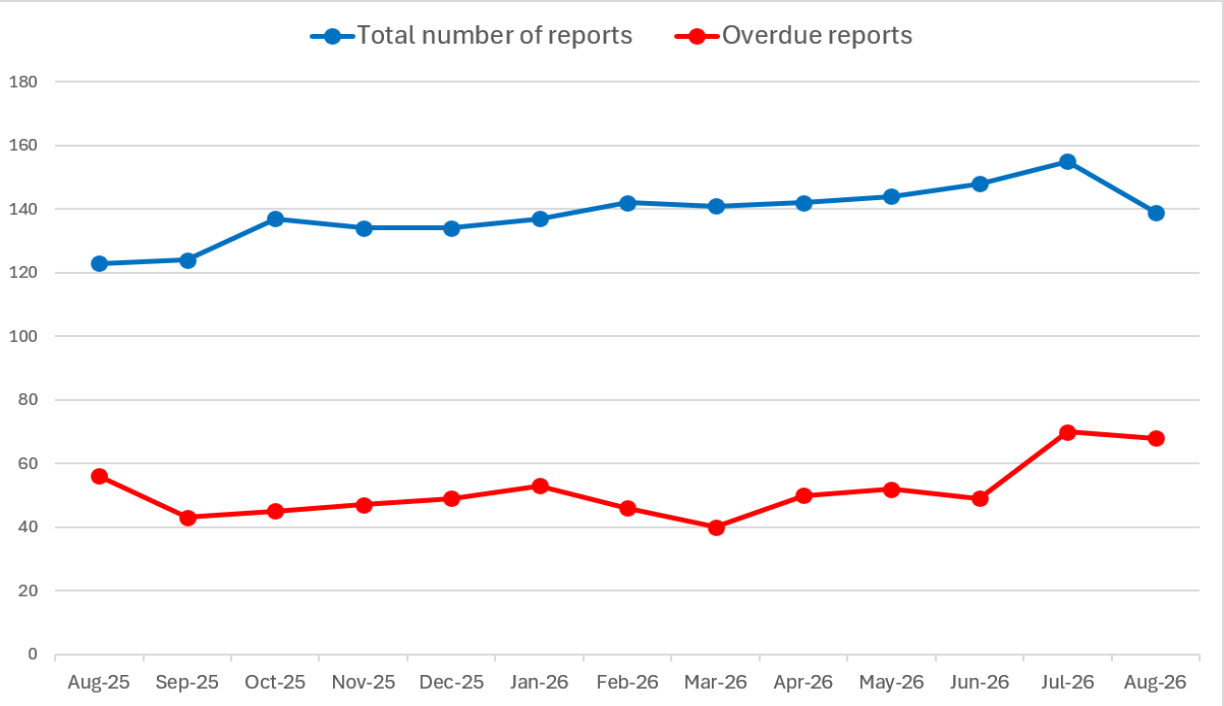
The Assurance and Risk Team continue to provide support via CCG/Clinical Service Groups (CSG)/Executive Functions reporting arrangements and AMaT system training, and the system sends weekly updates to recommendation owners.

Performance of reports and recommendations: Previous 12 months



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Analysis

The number of open reports has increased over the previous 12 months, accompanied by a rise in both overdue reports and overdue recommendations. The proportion of open reports classified as overdue has increased from 35% to 49%, reflecting growing challenges in maintaining recommendations within agreed timescales. This trend aligns with concerns previously raised by ARAC and may reflect a combination of implementation pressures, delays in evidencing and recording progress, ambitious implementation dates, and the continued receipt of follow-up reviews and recurring recommendations across multiple services.

Continued management focus will be required to support timely implementation and strengthen the level of assurance to Committees and the Board.

Recommendations Analysis

231

Overdue recommendations

April 174 | ▲ 57

107

Overdue >6 months

April 75 | ▲ 32

127

No revised date

April 128 | ▼ 1

23

External factors

April 30 | ▼ 7

2

Pending decision

April 4 | ▼ 2

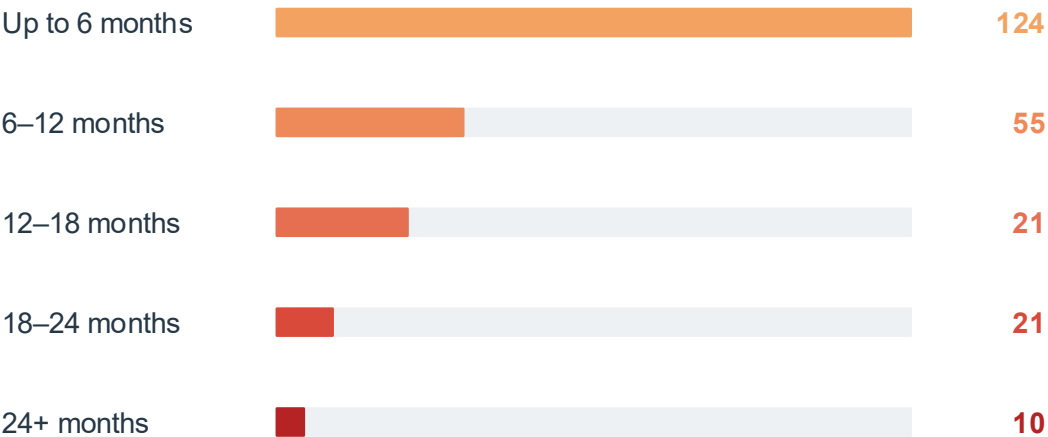
14

Unable to complete

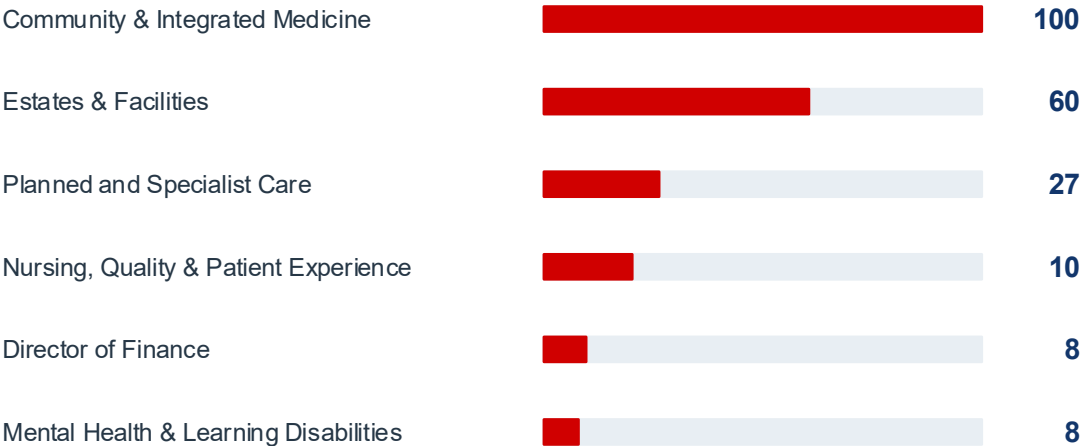
April 12 | ▲ 2

Definitions of these categories can be found in [Appendix 1](#)

Age of overdue recommendations



Ownership of overdue recommendations (number of recommendations)



Common barriers to the implementation of recommendations

Progress against recommendations continue to be affected by **workforce capacity**, **funding/capital dependencies**, and **external factors** outside the Health Board's direct control, such as the implementation of national digital systems, or guidance from external bodies. Of the 231 overdue recommendations, 127 (55%) do not have a revised timescale for implementation. Governance and administrative factors, including **outstanding management responses and evidence of completion**, account for over 17% of overdue recommendations and are likely to have the biggest impact on improving the current overdue position. Work is currently underway to strengthen the processes around those recommendations noted as “Unable To Complete” to further support the Health Board's ability to obtain assurance on their delivery and identify barriers to completion, including a review of the category definition and the processes to escalate appropriately via operational governance arrangements.

Recommendations Analysis



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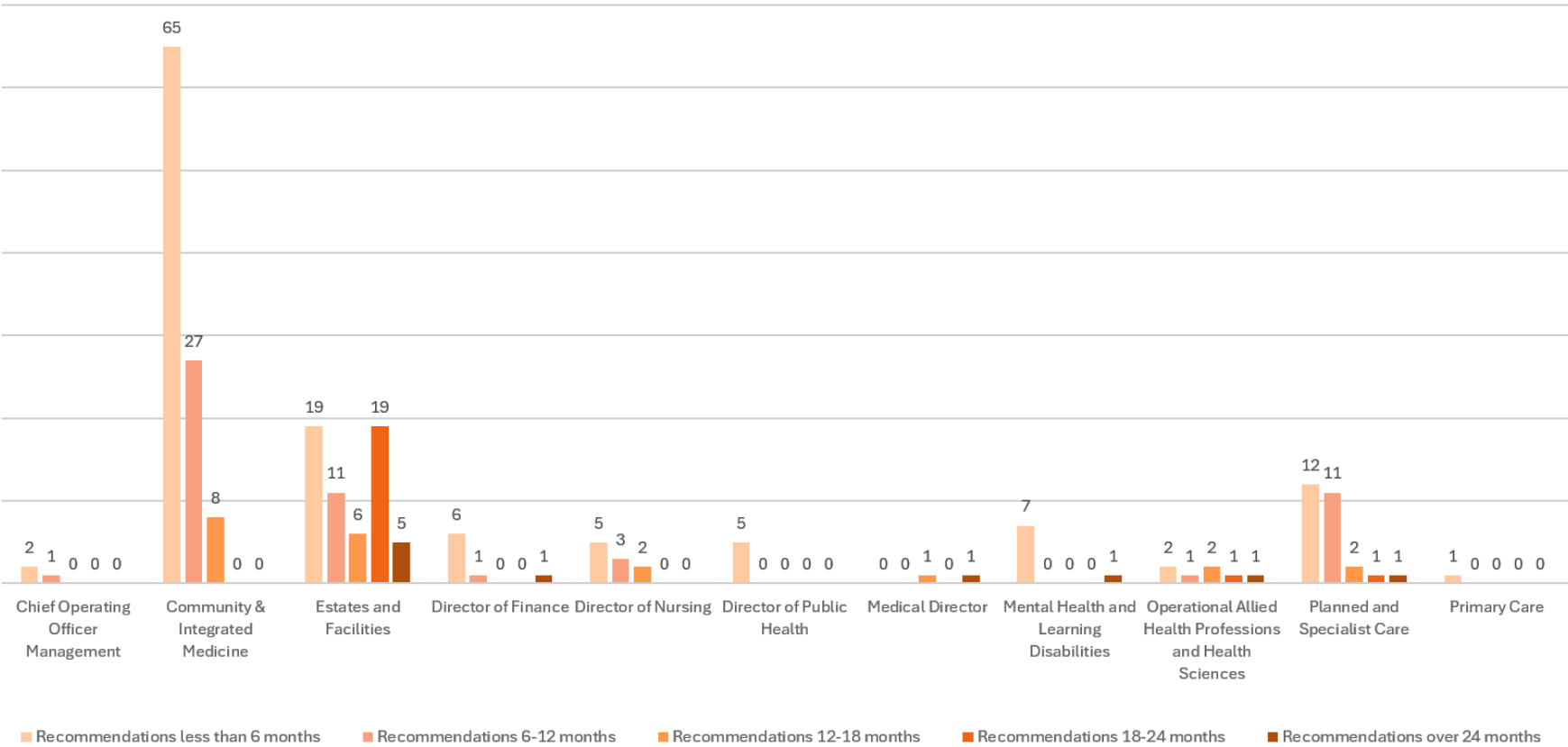
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The profile of overdue recommendations suggests that several long-standing actions relate to **estate infrastructure, fire safety compliance, building configuration and capital investment requirements**. This indicates that some of the most complex and difficult recommendations facing the Health Board are associated with the **condition, suitability and adaptability** of the estates infrastructure, which require external capital funding.

Enhanced oversight arrangements have been introduced within Estates and Facilities, including an agreed one-month deadline for the submission of outstanding documentary evidence. This provides assurance that overdue Letters of Fire Safety Matters (LOFSM) recommendations are being actively managed and that clear actions are in place to address barriers to closure. Subject to evidence being validated, this is expected to support a reduction in overdue recommendations over the coming months.

Community and Integrated Medicine (CIM) continue to hold the largest volume of overdue recommendations (100), of which 41 are overdue due to management responses and implementation plans not yet being fully developed, particularly in relation to urgent and emergency care reviews. **Workforce capacity, recruitment challenges, system-wide dependencies with partner organisations, and the complexity of urgent and emergency care transformation programmes** represent the most common barriers to completion. Further detail on overdue recommendations aligned to CIM is provided on Slide 13.

Overdue recommendations split per Clinical Care Group/Executive Function



Audits and Inspections: Exceptions Analysis – Recommendations



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External Recommendations

23

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.

23 recommendations depend on actions outside the Health Board's direct control, with the largest concentrations as follows:

- Estates and Facilities: 7
- Planned and Specialist Care: 5
- Medical Director: 4
- Mental Health and Learning Disabilities: 3

Common external factors include national policy development, reliance on Welsh Government or HEIW-led programmes, regional service transformation initiatives, digital interoperability solutions, and capital funding approvals. Estates and Facilities accounts for the largest concentration of actions reliant on external factors, reflecting the extent to which progress is dependent on capital investment, infrastructure programmes, external approvals and contractor-led activity.

Next steps:

- Remind services to document external factors, and to continually review and update should external factors change, and progress via appropriate escalation routes
- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Pending Decision

2

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.

2 recommendations are awaiting a decision before implementation can progress.

Current ownership:

- Community and Integrated Medicine: 1
- Strategy and Planning: 1

Since data was extracted for this report, the recommendation aligned to Strategy and Planning has been noted as "Unable to Complete" and progressed for formal closure by the Executive lead.

Additionally, the status of the recommendation aligned to Community and Integrated Medicine has been amended to "overdue" since data extraction, with evidence being collated to support the closure the recommendation.

Next step:

- Review definition and strengthen underpinning processes to escalate recommendations noted as pending decision

Unable to Complete

14

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.

14 recommendations can no longer be delivered as per the action described in their original management response, with the largest concentrations as follows:

- Primary Care: 4
- Estates and Facilities: 3
- Planned and Specialist Care: 3

Common reasons cited as barriers include **capital funding constraints**, dependency on national programmes and external organisations, **workforce capacity** and **recruitment challenges**, and **reliance on wider service redesign programmes**.

Next steps:

- Document the barriers and associated risk and progress via appropriate escalation and approval route.
- Review definition and strengthen underpinning processes to escalate recommendations noted as unable to complete

Three Lines of Defence



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BOARD / ARAC | Receives, challenges and triangulates assurance across all three lines



Management owns delivery → oversight functions monitor and escalate → independent review validates effectiveness

First Line of Defence: Overview of the Audit Tracker per Function

139

Open reports

68

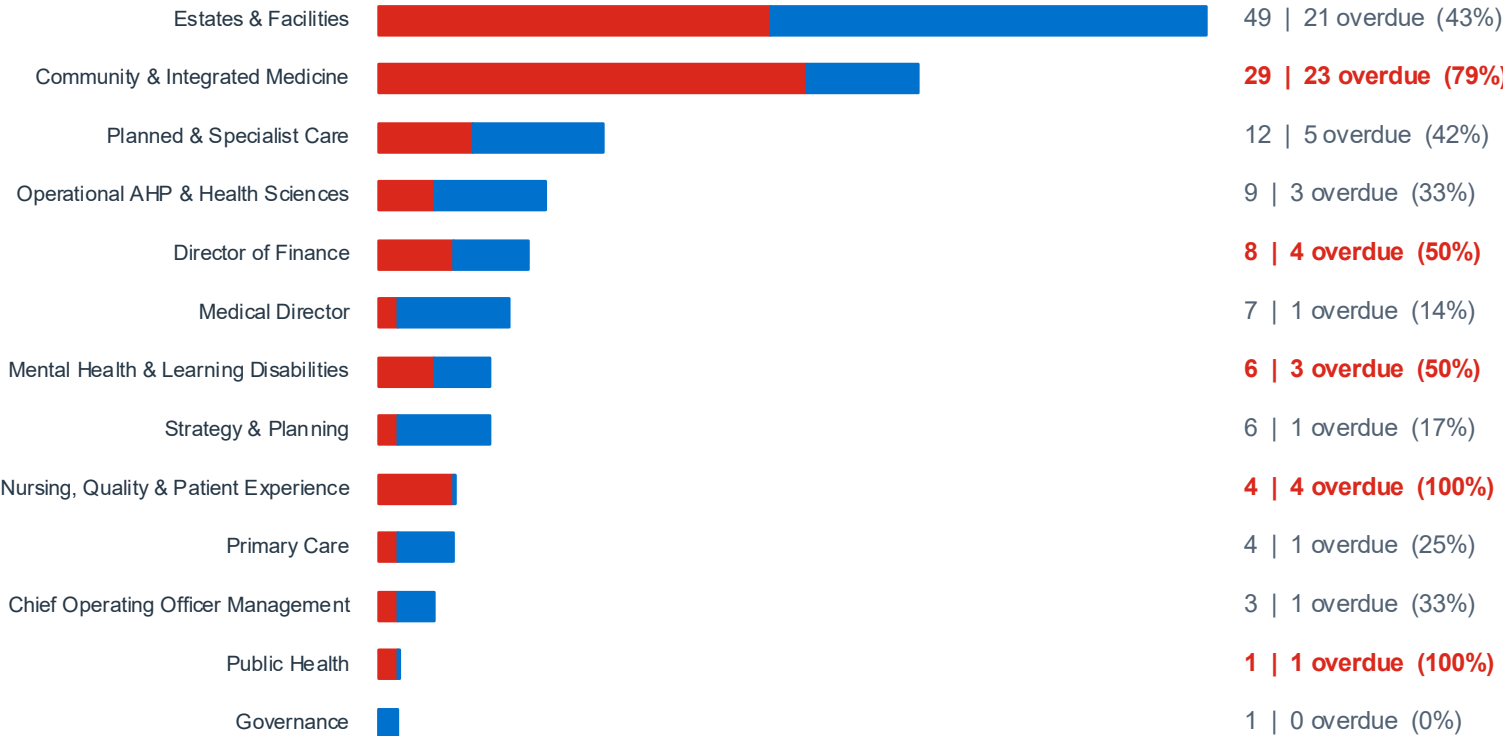
Overdue reports

48.9%

Overall overdue rate

Open reports by CCG / Executive Function

Overdue reports shown in red; remaining open reports shown in blue



Scale: number of open reports

Analysis

The open and overdue report profile is largely **concentrated within a small number of functions managing complex delivery challenges**.

Review of overdue recommendations indicates that delays are most associated with recruitment challenges, infrastructure and estate limitations, funding constraints, dependencies on national programmes and partner organisations, and recommendations linked to wider transformation programmes where implementation is dependent upon strategic decisions or future investment. A smaller but significant proportion also remain overdue pending management responses, evidence submission or formal closure processes.

Many of these issues are reflected within existing risk registers and governance arrangements, indicating that the principal barriers to implementation are generally understood. The continued growth in overdue recommendations suggests that, whilst areas of concern are being identified and monitored, escalation and oversight have not consistently translated into timely implementation to secure the support necessary to achieve delivery.

Second Line of Defence: Governance Domain Levels



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Service	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026
Chief Operating Management	1	2	2	2	2	2	1	1	1	1	1	1
Community and Integrated Medicine	3	3	3	3	3	3	3	3	3	3	3	3
Estates and Facilities	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Finance	1	1	1	2	2	2*	2	2	2	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	2*	2	2	1	1	1	1	1	2	2	2
Executive Director of Public Health	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Strategy and Planning	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	1	1	1	1	1	1	1	1	1	1
Medical Director	1	1	1	1	1	1	1	1	1	1	1	1
Medicines Management	n/a	n/a	n/a	1	1	1	1	1	1	1	1	1
Governance and Communication	1	1	1	1	1	1	1	1	1	1	1	1
Mental Health and Learning Disabilities	2	2	1	1	1	1	1	1	1	1	1	1
Operational Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1	1	1	1
Planned and Specialist Care	3	2	2	2	3	2	2	2	2	2	2	2
Primary Care	2	2*	2	2	2	2*	1	1	1	1	1	1

Level 1 / reasonable assurance

Level 2 / limited assurance

Level 3 / no assurance

Level 4 / no assurance and insufficient actions/engagement

Levels are assigned based on each Function's assessment against prescribed annual targets. Detail on how escalation levels are awarded can be found in [Appendix 3](#).

Implementation of recommendations, alongside governance, risk management, engagement, and compliance with WHCs and MDs has been a key factor in assessing escalation levels.

Since the previous report to ARAC in June 2026, escalation Level 4 has been activated.

Detailed analysis of the **Community and Integrated Medicine CCG** position is provided on the next slide, having sustained a Level 3 position since in August 2025 in respect of the timely implementation of recommendations from audits and inspections.

The escalation framework provides assurance that areas of non-compliance are identified, visible, and subject to enhanced scrutiny through executive and governance arrangements.

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

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



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Community & Integrated Medicine

446

Total recommendations

100

Overdue

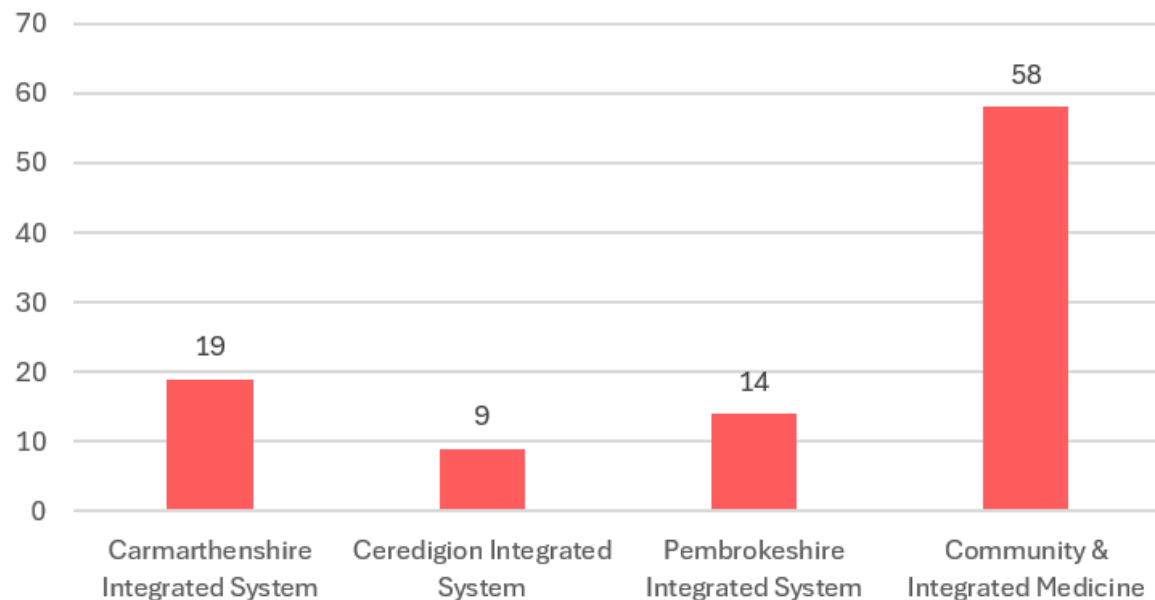
35

Overdue >6 months

80

No revised dates

Overdue recommendations split by system



Key causes

- Barriers to implementing recommendations within original completion dates include **workforce shortages** and **recruitment difficulties**, **dependency on wider organisational programmes/decisions** and **financial constraints**.
- Delays in management responses being provided on AMaT, accounting for 41 of the 100 overdue recommendations.
- Several recommendations have limited AMaT updates and a lack of clear revised completion dates, reflecting the operational pressures within urgent and emergency care.

Next Steps

- Assurance and Risk business partner meeting with CCG Triumvirate team and each integrated system monthly to support improvement of quality of updates on AMaT, including revised dates, where appropriate, and clear barriers to implementation noted.
- As agreed at ARAC in August 2026, all outstanding management responses to be recorded on AMaT by September 2026, with further progress made on their implementation by December 2026
- A formal progress update from the CCG due to be provided to ARAC at a future meeting.

Internal Escalation - Governance Domain: Level 2 – Limited Assurance



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Function	Reason for Level 2	De-escalation criteria
Planned and Specialist Care	27 recommendations overdue (14%) across 7 reports as at 31 August 2026. 11 recommendations are overdue by more than 6-12 months, 2 by 12-18 months, 1 by 18-24 months and 1 by more than 24 months. 18 (9%) overdue recommendations do not have revised implementation dates. <i>Correspondence has been sent directly to the Chief Operating Officer in August 2026 to notify of required actions to support de-escalation.</i>	Implement over 90% of recommendations and provide revised dates for lapsed actions.
Executive Director of Finance	8 recommendations overdue (22%) across 5 reports as at 31 August 2026. 3 of these were long-standing recommendations that have been completed since the data was extracted for this report. 4 outstanding recommendations (spanning 2 reports) are overdue by less than 6 months and 1 recommendation is overdue by 6-12 months. <i>Correspondence has been sent directly to the Director of Finance in August 2026 to notify of required actions to support de-escalation.</i>	Achieve 90% implementation within agreed timescales; volume is low but percentage is above threshold.
Executive Director of Nursing, Quality and Patient Experience	Compliance has remained below 80% for more than 12 months with 10 recommendations overdue (23%) across 4 open reports. <i>Correspondence has been sent directly to the Director of Nursing, Quality and Patient Experience in August 2026 to notify of required actions to support de-escalation.</i>	Implement over 90% of recommendations, provide revised dates for lapsed actions and clearly identify any barriers to completion.

Board and Committee Oversight Audit and Inspections



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Both ARAC and the Quality, Safety and Experience Committee (QSEC) have raised concerns regarding the organisation's delivery of assurance and improvement activity, resulting in correspondence being sent by the Chairs of each Committee to Executives. These concerns have also been escalated to the Board by other Committee Chairs.

ARAC has also raised concerns about early requests in this financial year to defer four internal audits, warning that continued delays risk creating a backlog of reviews and reducing the level of assurance being provided.

QSEC has expressed concern regarding the significant number of overdue audit, inspection and regulatory recommendations, alongside issues relating to ownership, accountability and quality of implementation plans. QSEC noted that progress is not being achieved at the expected pace, with repeated slippage against agreed timescales risking confidence in the Health Board's ability to translate learning into sustainable improvement.

Both Committees have called for strengthened executive oversight, clearer accountability and improved delivery to ensure audits process as planned, and recommendations are implemented in a timely and effective manner.

The Assurance and Risk team continue to support Clinical Care Groups and Executive Functions via a business partnering approach, which include:

- presentation of Assurance and Risk reports at local governance meetings, which details any areas of concern (including Audits and Inspections) via the 3As approach;
- 1-2-1 meetings with report and recommendation leads to support the development of management responses, and the provision of progress updates; and
- AMaT system training.

Performance is monitored via the Health Board's internal escalation framework, further detail of which is contained [later in this report](#). Actions raised at Committee meetings are recorded and presented at subsequent meetings, with progress visible via the "Our Actions" dashboard.



Third Line of Defence

Independent assurance on effectiveness



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Independent Assurance (Third line)

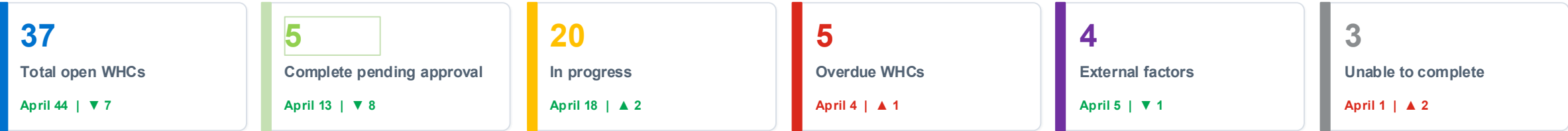
The third line of defence relates to those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies.

The Health Board obtains third line assurance on its systems and processes for tracking and implementing audit, inspectorate and regulatory recommendations through independent internal and external scrutiny. This includes work undertaken by Internal Audit, External Audit and relevant regulators/inspectorates (for example, HIW), alongside formal assurance reporting to ARAC. These mechanisms provide objective evaluation of the effectiveness of the Health Board's tracking arrangements, governance processes and compliance, and enable triangulation of assurance alongside first- and second-line sources.

There are a number of ways this is provided:

1. Internal Audit - Internal Audit provide an independent review of the documentation submitted on AMAT to evidence the implementation of internal audit recommendations
2. External Audit (Audit Wales) – Through the Structured Assessment process, Audit Wales reviews the Health Board's corporate governance and performance arrangements and in its most recent report in December 2025, reported that 'the Health Board continues to have robust arrangements for tracking audit and review recommendations'. Follow up reviews will also review whether previous recommendations have been implemented in practice.
3. Regulators and Inspectorates - Re-inspections, follow-ups and thematic reviews will validate whether recommendations have been implemented in practice.
4. Formal ARAC oversight - ARAC receives the audit and inspection / WHC assurance reports which provides assurance and the robustness of tracking system.

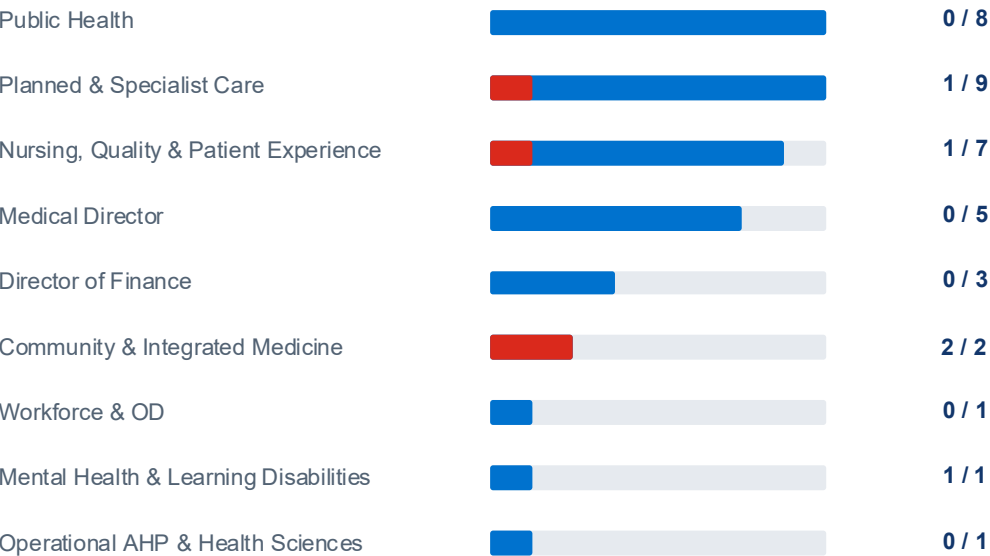
Welsh Health Circulars Summary



Definitions of these categories can be found in [Appendix 1](#)

Open WHC profile

Total WHCs / overdue



Figures show total WHCs / overdue WHCs.

Common barriers to implementing Welsh Health Circulars (WHCs) include **workforce shortages, recruitment difficulties, service capacity constraints** and a **lack of recurrent funding** to support implementation.

3 overdue WHCs have risks noted linked to current non-compliance with their requirements. These relate to ambulance patient handover arrangements, delivery of national guidance for stroke services, and implementing the Welsh standards for competency assurance of non-medical prescribers.

The status of 3 WHCs related to hearing screening pathways and persistent pain services have been updated from "Pending Decision" to "Unable to Complete" since the previous report, reflecting the absence of approved funding required to deliver the outstanding actions necessary to be fully compliant with the requirements of the WHCs.

A summary of the noted WHCs is set out on the next slide.

The principal challenge remains the Health Board's ability to achieve full compliance in areas affected by workforce fragility, estate limitations, funding pressures and reliance on national programmes or external partners.

Welsh Health Circulars: Exception Analysis



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Overdue WHCs

5

The WHC is behind schedule to the timescale provided by the lead officer.

Delays in the implementation of WHCs are a result of several factors including **workforce and service-capacity pressures**, dependencies on **wider transformation plans**, and the need for **input from multiple services** across the Health Board.

In some cases, the requirements of the WHC have been progressed, however revised completion dates are not consistently noted, and others are unable to be closed due to delays in the uploading of relevant supporting evidence.

Associated risks are required to be recorded on Datix where non-compliance presents an ongoing risk.

Next steps:

- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Reliant on External Factors

4

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.

Full implementation of these WHCs are dependent on decisions or developments out of the Health Board's direct control. These principally include **national digital systems and programmes**, publication of **national guidance** and delivery arrangements, **external approvals**, and the **availability of capital funding**.

Dependencies should continue to be actively monitored and updated, reflected within governance and risk arrangements, and escalated where appropriate.

Next steps:

- Remind services to document external factors, and to continually review and update should external factors change, and progress via appropriate escalation routes
- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Unable to Complete

3

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.

The outstanding requirements of these WHCs have been noted by leads as being unable to deliver due to workforce and financial constraints, limited service capacity, or the absence of an approved and sustainable delivery model.

Further progress is likely to require additional investment, an alternative delivery approach, or confirmation that the original requirement remains relevant.

These WHCs should be subject to review and escalation via appropriate operational governance arrangements to ensure appropriate oversight and action.

Next steps:

- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Governance Domain : Level 3 - No Assurance (Welsh Health Circulars)



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Community & Integrated Medicine

2	WHCs assigned	2	WHCs overdue	1	No confirmed revised date	2	Associated risks recorded
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WHC/2024/041 Ambulance Patient Handover Guidance

Reported as overdue by less than six months

Revised implementation date
30th November 2026

- Linked to corporate risk 1027 (Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity), current risk score 20.
- Ambulance Handover 45 group established between Welsh Ambulance Services University (WAST), Health Board and Local Authority. Site based Ambulance Handover 45 plans developed.

Next Steps:

Programme Plan will be agreed between Health Board and WAST, detailing timescales and owners of actions. Any delay in progress to be escalated through UEC Programme Group and National escalation meetings.

WHC/2024/006 National Clinical Guideline for Stroke

No confirmed implementation timescale

Revised implementation date
N/K

- Linked to operational risk 2409 (Risk of poor outcomes for stroke patients due to fragility of service), current risk score 20.
- Implementation is dependent on the Clinical Services Plan.

Next Steps:

- Ensure the remaining barriers to completion are clearly captured and understood for the Stroke WHC.

Next Steps and Recommendations



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Next Steps

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

- Review the definitions and governance process for recommendations and Welsh Health Circulars that have been categorised as either “Pending Decision” or “Unable to Complete”, and to communicate with Functions across the Health Board to improve oversight; and
- To launch the Audit and Inspection Dashboard for the Health Board by November 2026.

Recommendations

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE**:

- on the effectiveness of processes in place across the Health Board to track the progress made to implement recommendations identified by auditors, inspectorates and regulators, and implement Welsh Health Circulars (WHCs) issued by Welsh Government.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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Appendix 1: Definition Status Audits and Inspections and WHCS



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All reports from audits, reviews and inspections carried out across the Health Board, as well as Welsh Health Circulars received from Welsh Government, are logged and tracked on the AMaT (Audit Management and Tracking) system, with progress updated by relevant service leads against each recommendation to demonstrate progress, with the requirement to upload evidence of full implementation.

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

Progress is monitored using a categorisation framework to assess performance against **original completion dates**. Definitions for each category are included in the table below:

Status Category	Definition
Overdue	The report / recommendation / WHC is behind schedule to the timescale provided by the lead officer (or as stipulated in the WHC), or an original implementation date has not yet been provided.
Unable to Complete	The report / recommendation / 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	The report / recommendation / 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 recommendation is overdue or not whilst decision pending.
In Progress	The report / recommendation / WHC is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The report / recommendation / 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	The CCG / Function have completed the report / recommendation / WHC and currently awaiting formal approval to close.
Complete	The report / recommendation / WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

The Assurance and Risk team and the 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 implementation 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.

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

Appendix 2: Internal Escalation Processes Governance Domain



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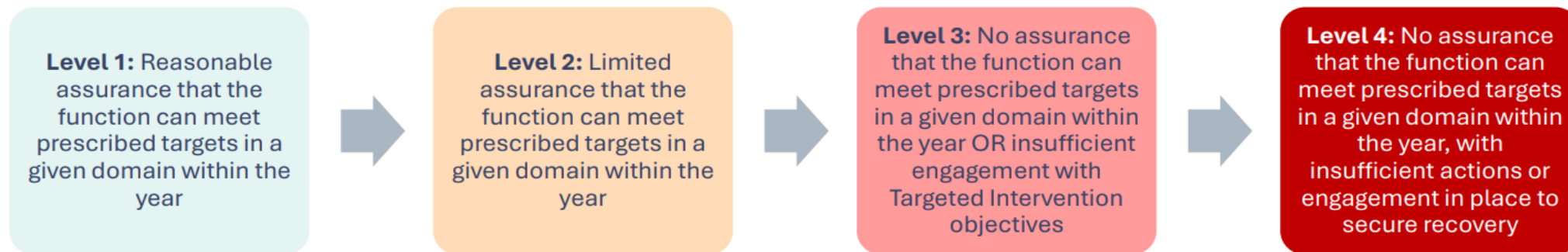
Internal Escalation (Second Line)

The second line relates to the internal oversight mechanisms and specialist functions that are independent of operational delivery, which sets frameworks, monitors compliance and provides expert oversight to provide assurance that controls are appropriate and applied consistently.

All audit, inspectorate, and regulatory reports are aligned to a designated committee to provide assurance that recommendations are implemented within agreed timescales. Progress is monitored and reported through Audit and Risk reports, which are submitted to each committee on a triannual basis.

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;
- Up to date Written Control Documentation; 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.

Appendix 3: Internal Escalation Measures to assess against the Governance Domain - Audit and Inspections



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Levels are assigned based on each Function's assessment against prescribed annual targets.

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

Appendix 3: Internal Escalation Measures to assess against the Governance Domain – Welsh Health Circulars



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

Levels are assigned based on each Function's assessment against prescribed annual targets.

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.