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Audit and Risk Assurance Committee

External Recommendations and Welsh Health Circulars Assurance Report

23 June 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 (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board is required to meet the following revised criteria which relate to compliance with external recommendations from auditors, inspectorates and regulators:

- Financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews;
- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.



Progress since the previous report to ARAC



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A summary is provided below of the progress made against the next steps which were identified in the previous tracker report provided to ARAC in February 2026:

Next Steps	Progress Made
<p>To develop a revised plan and timescales with colleagues in the Performance team, taking into consideration capacity and existing development priorities to develop an audit tracking performance dashboard via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework. This will allow Health Board-wide access to information, and further support the escalation analysis undertaken by the Assurance and Risk Team.</p>	<p>This work had been paused due to capacity constraints within the Assurance and Risk Team, alongside competing priorities within the Performance Team. Since the last report, the dashboard specification has been reviewed and signed off by the Assurance and Risk Team, now the dashboard with the additional visuals, will be built by the performance team. The timescale to complete this work is August 2026.</p>

Audits and Inspections



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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 using a categorisation framework that assesses performance against **original completion dates**. Definitions for the categories used are included in the table below:

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

The Assurance and Risk team and 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.

Overview of the Audit Tracker



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This report provides an overview of the open audit, inspection and regulator reports based on the most recent analysis point at the time of preparation (30 April 2026).

Key movements since the previous report presented to ARAC in February 2026 (based on data extracted 31 December 2025) include:

- increase in number of open reports from 134 to 142;
- increase in number of overdue reports from 49 to 50;
- closure of 6 Internal Audit reports, 3 Audit Wales reports, 2 Mid and West Wales Fire and Rescue Service reports, 1 Peer Review, 1 Health Inspectorate Wales report, 1 Health Education and Improvement Wales report and 1 Public Service Ombudsman report.

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



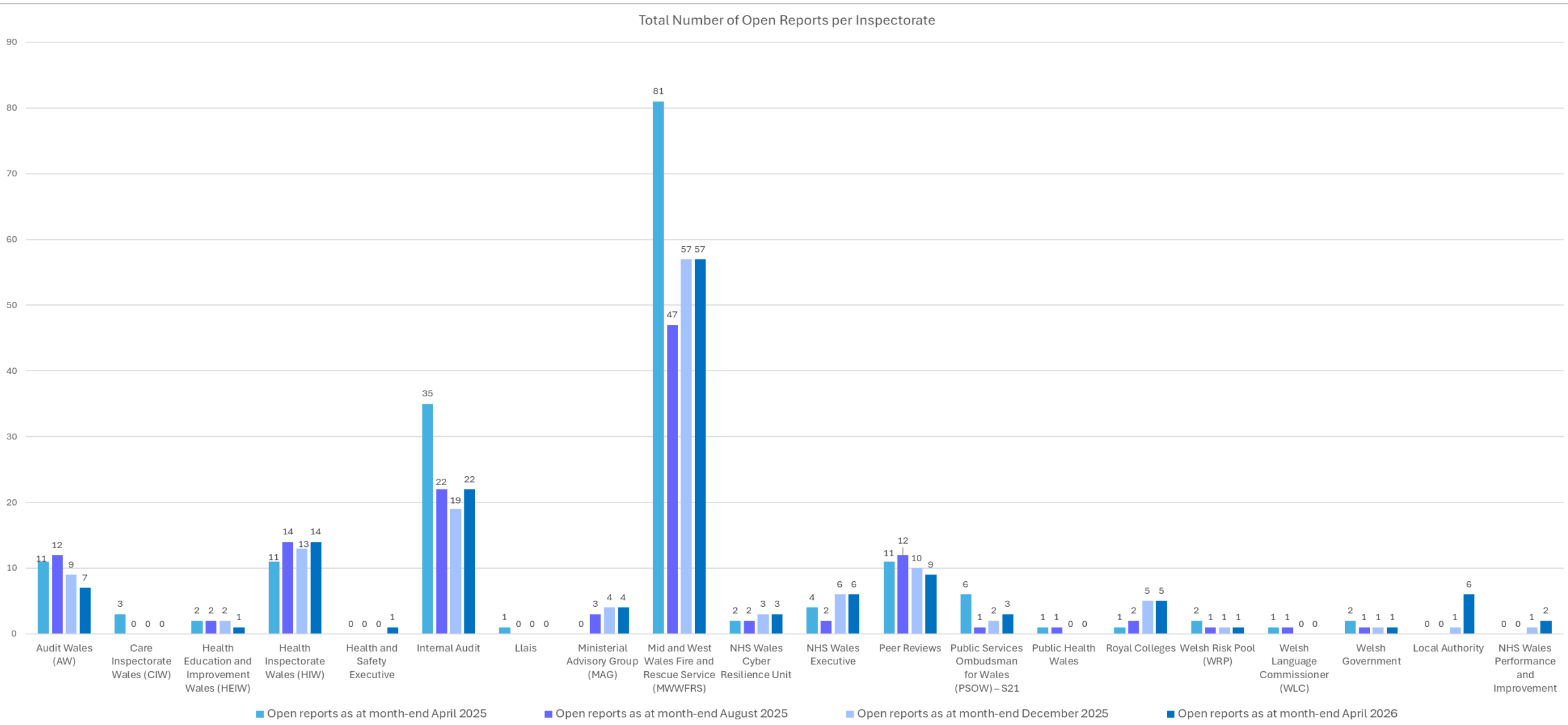
Overview of the Audit Tracker



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Total Number of Open Reports per Inspectorate



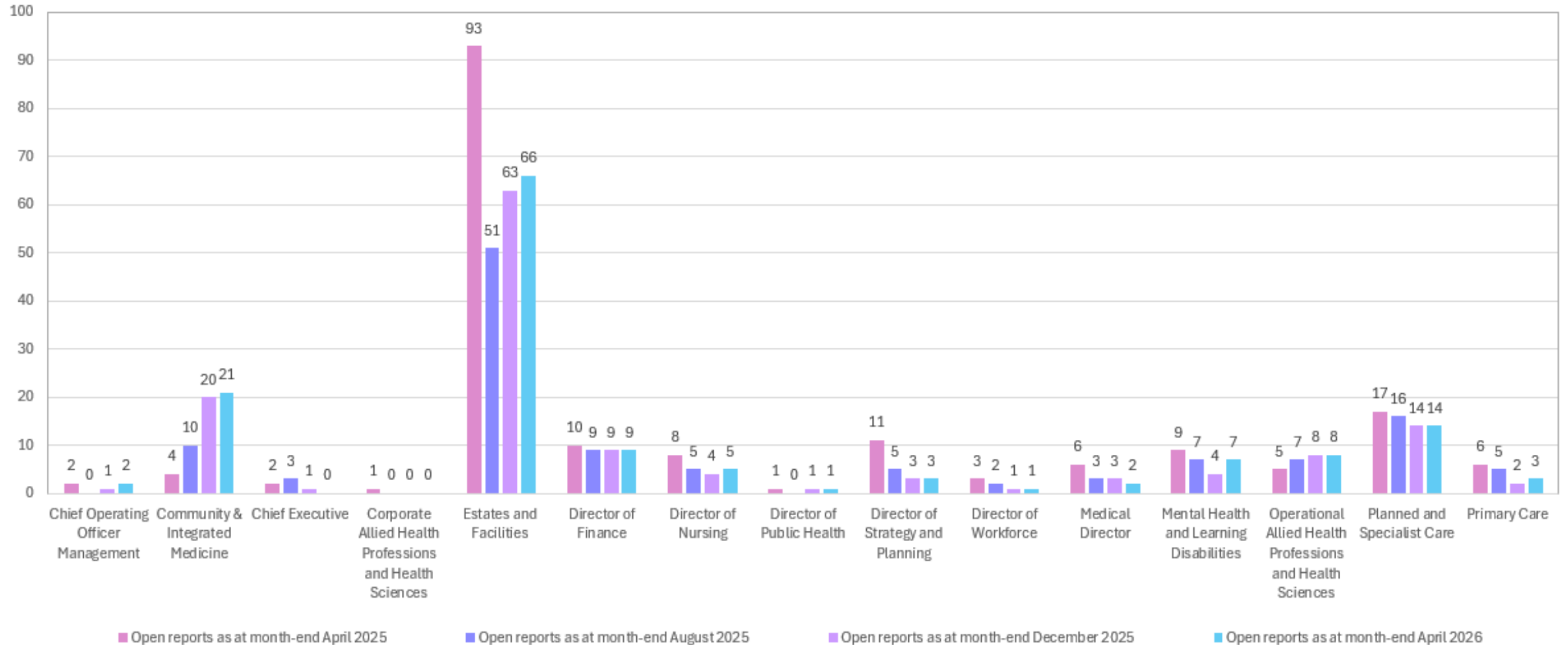
Overview of the Audit Tracker



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Total Number of Open Reports per Clinical Care Group/Executive Function



Audit Tracker Analysis – Overdue Reports



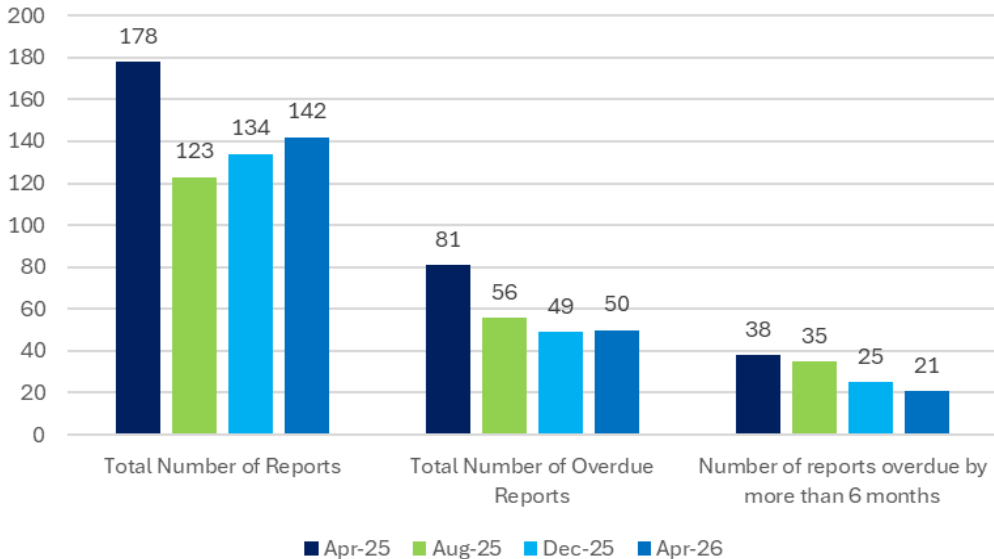
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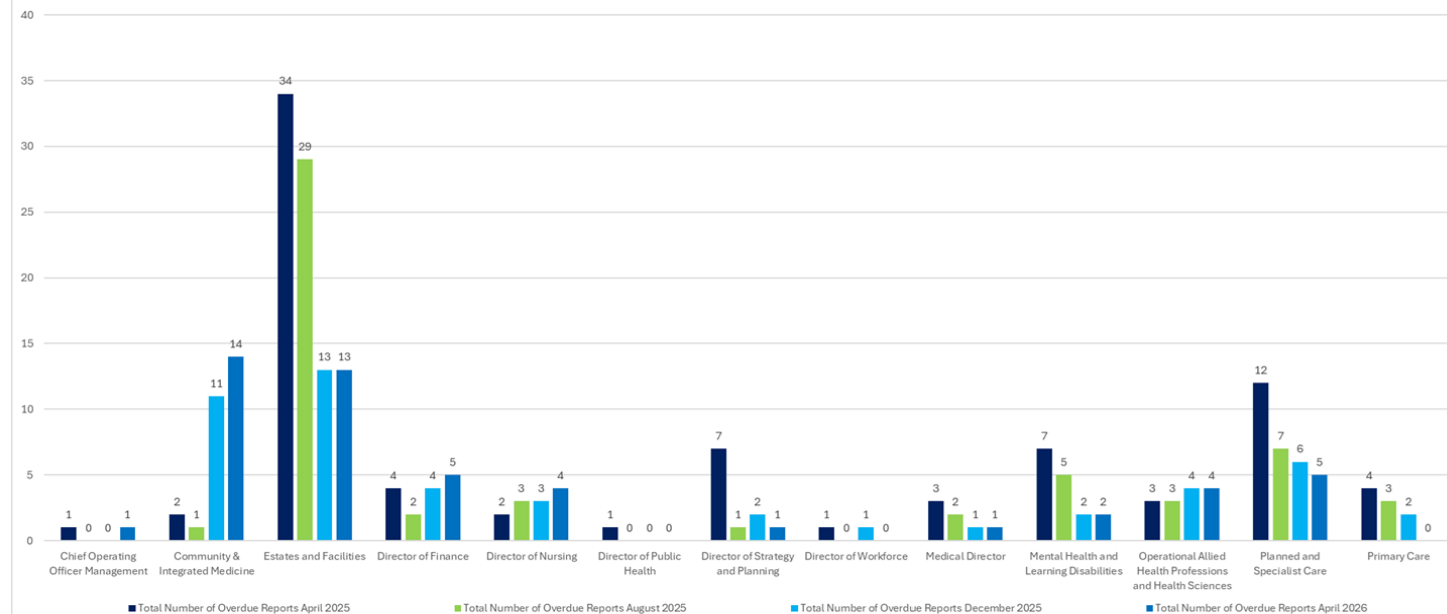
Of the current overdue reports, 21 are overdue by more than six months, a slight improvement to the 25 overdue reports reported in February 2026. These reductions reflect continued progress made in clearing the backlog of historical reports, and the graphs illustrate a sustained downward trend in both the volume and ageing of the overdue reports.

The data reflects an improving trend, with several functions demonstrating reductions in number of overdue reports. However, performance remains variable across the functions, with Community and Integrated Medicine currently holding the highest number of overdue reports at 14, an increase from 11 in the previous report. Estates and Facilities currently have 13 overdue reports, 10 of which relate to Mid and West Wales Fire and Rescue Service reports (1 Enforcement notice and 9 letters of fire safety). 7 of these reports have revised timescales of May and June 2026, 1 report has requested a capital bid, and 2 reports require progress updates to be provided on AMaT.

Overdue Reports



Overdue Reports Split Per Clinical Care Group/Executive Function



Audit Tracker Analysis – Overdue recommendations



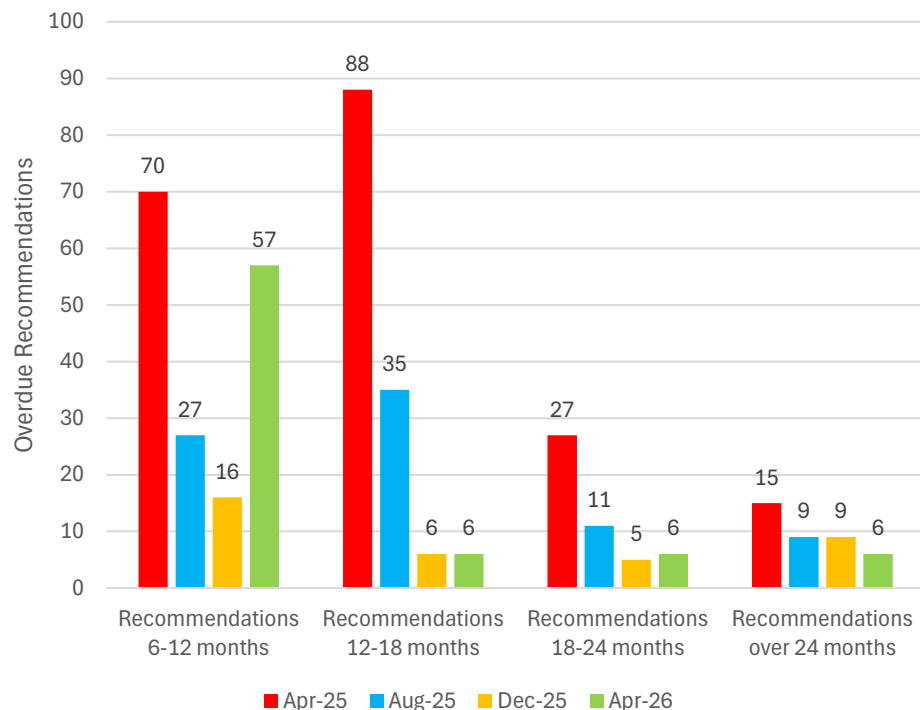
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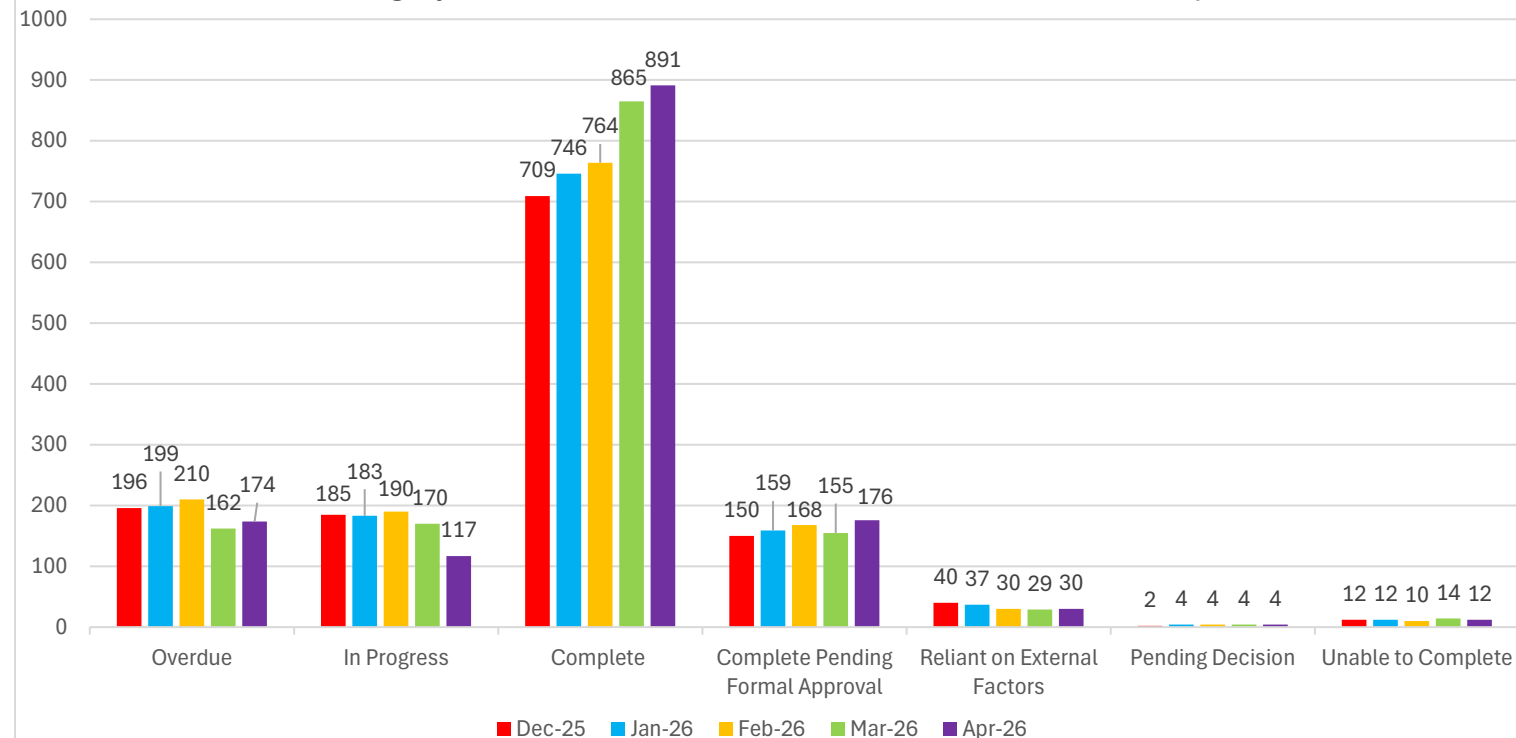
The total number of recommendations from all open reports has increased from 1,294 in February 2026 to 1,404, however the number of **open** recommendations (i.e. recommendations excluding 'Complete' or 'Complete Pending Formal Approval') has decreased from 435 to 337.

The number of **overdue** recommendations (i.e. those where the original completion date has not been met) has decreased from 196 to 174. However, the number of recommendations **overdue by more than six months** has increased significantly, rising to 75 compared to 36 in February 2026. 43 of the 75 recommendations sit with Community & Integrated Medicine, an increase from 7 reported against Community & Integrated Medicine in February 2026. The detail of recommendations overdue by more than six months by each CCG/function is shown on the next slide. The number of recommendations without revised timescales has improved slightly, decreasing from 133 to 128.

Recommendations Overdue by more than 6 months



Status Category of Recommendations between December 2025 to April 2026



Audit Tracker Analysis – Recommendations overdue by more than 6 months



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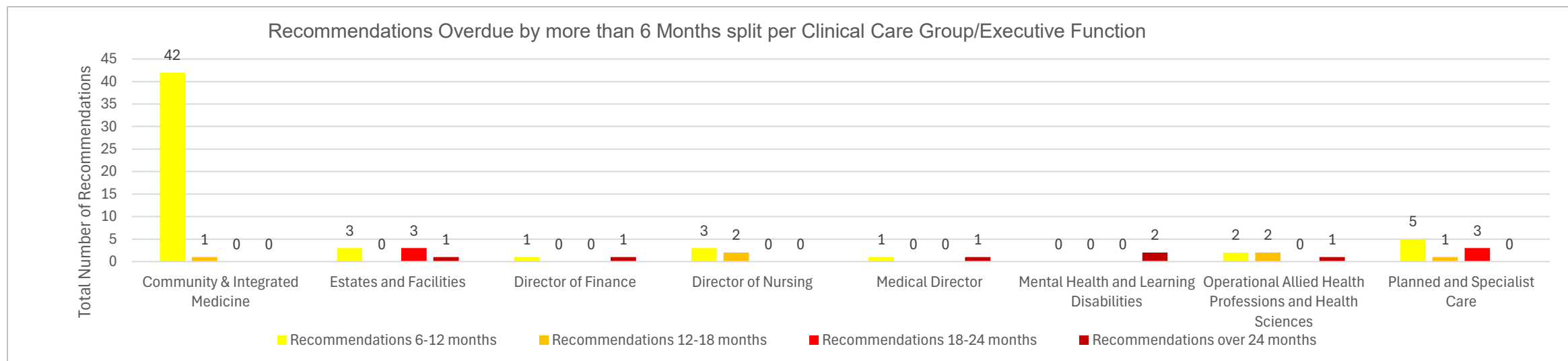
In response to new ways of working, it has been agreed to stand down the “deep dive” meetings with the relevant Executive Leads and CCG / Function leads to review recommendations overdue by more than 6 months. Responsibility for oversight of overdue recommendations has been delegated to individual Executive Leads, who will manage engagement within their respective teams, and will be accountable for driving improvements in overdue recommendations.

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

The Assurance and Risk Team provides a monthly summary of each CCG and Executive Function’s escalation status within governance reports, which are presented at each CCG / Executive Function Integrated Governance Group (IGG) meeting. These reports also highlight the actions required for each Function to progress towards achieving and/or sustaining a Level 1 assurance rating.

An Internal Audit review of Internal Escalation (Level 3 & 4 Functions) concluded that, while the “Our Improving Together” Framework is well designed, its effectiveness is currently constrained by weaknesses in governance, inconsistent escalation and action tracking, and limited evidence of impact. As a result, a *Limited Assurance* rating was assigned, with opportunities identified to streamline processes, improve integration with existing governance arrangements, and strengthen oversight and accountability to enhance performance improvement.

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



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



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12 recommendations (<1%) on the Audit & Inspection tracker are marked as “Unable to Complete” as at April 2026 (December 2025:12).

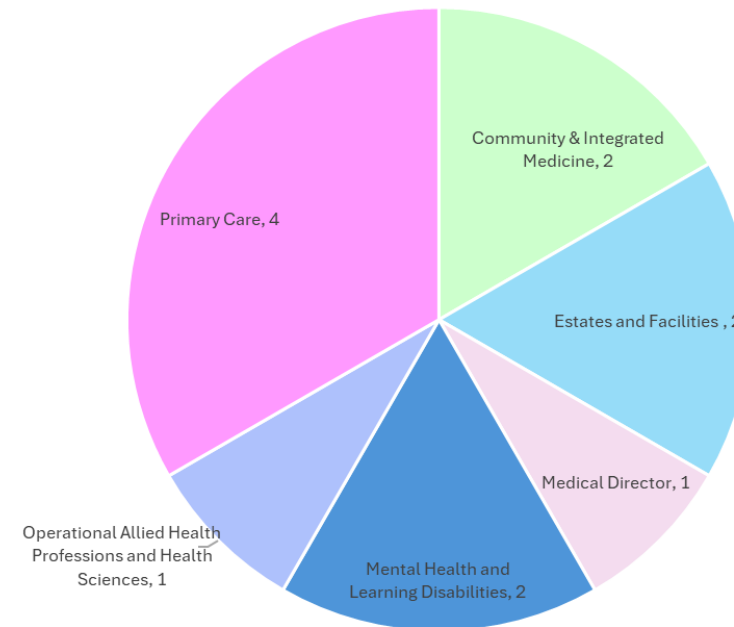
Common barriers noted for recommendations that are ‘Unable to Complete’ include:

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

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

These recommendations are then required to be escalated local operational governance arrangements. The relevant Lead Executive is required to provide approval of acceptance of these barriers prior to recommendations being closed.

Recommendations that are "Unable to Complete" Split per Clinical Care Group/Executive Function



Audit Tracker Analysis - Recommendations without revised timescales



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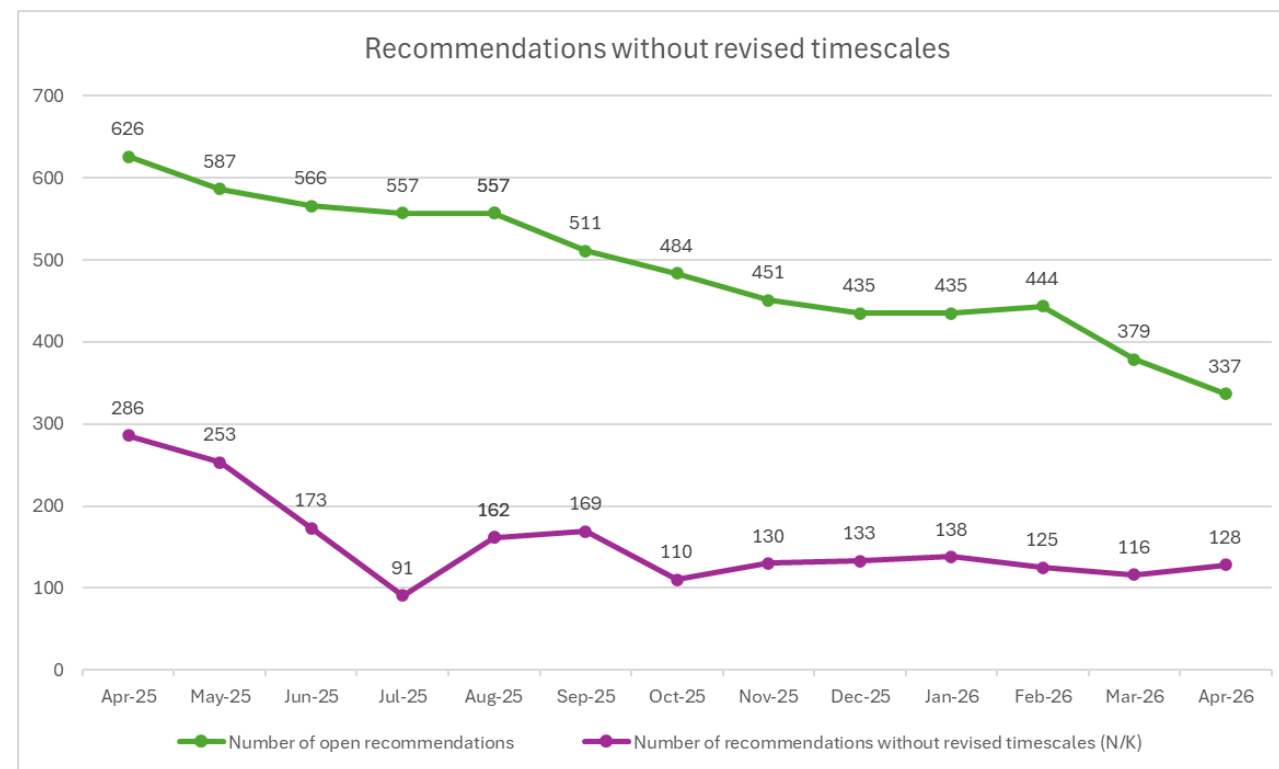
Recommendations without revised timescales are mainly attributed to the following:

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

Recommendations without revised timescales are subject to ongoing review as part of the internal escalation criteria applied to each CCG and Executive Function.

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

In the absence of a specific 'revised date' field on AMaT, the Assurance and Risk team continue to remind services of the need to include revised completion dates within the governance reports presented to CCG / CSG and Executive Function governance meetings and continue to review recommendations where progress updates have not been obtained, with the relevant business partner for those services prioritising the support offered.



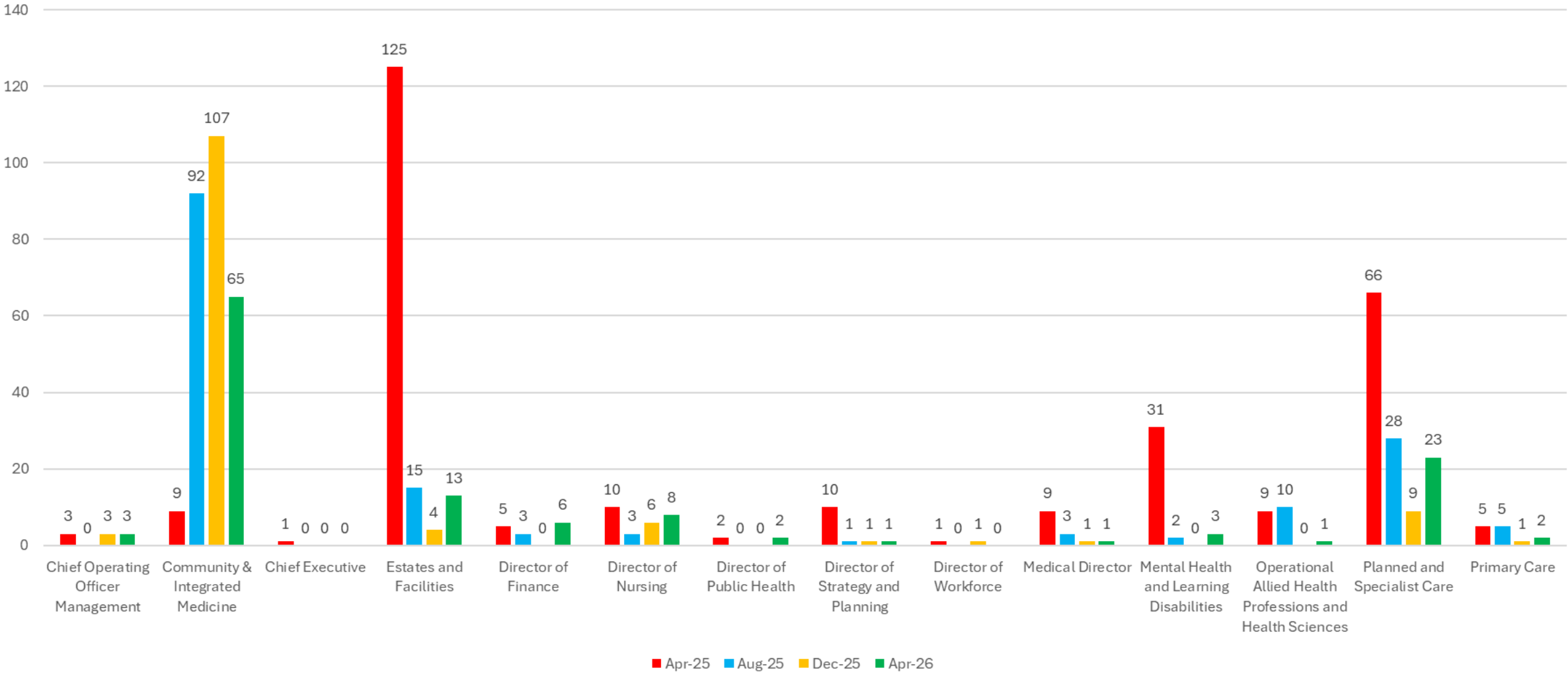
Audit Tracker Analysis - Recommendations without revised timescales



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Recommendations Without Revised Timescales per Clinical Care Group/Executive Function



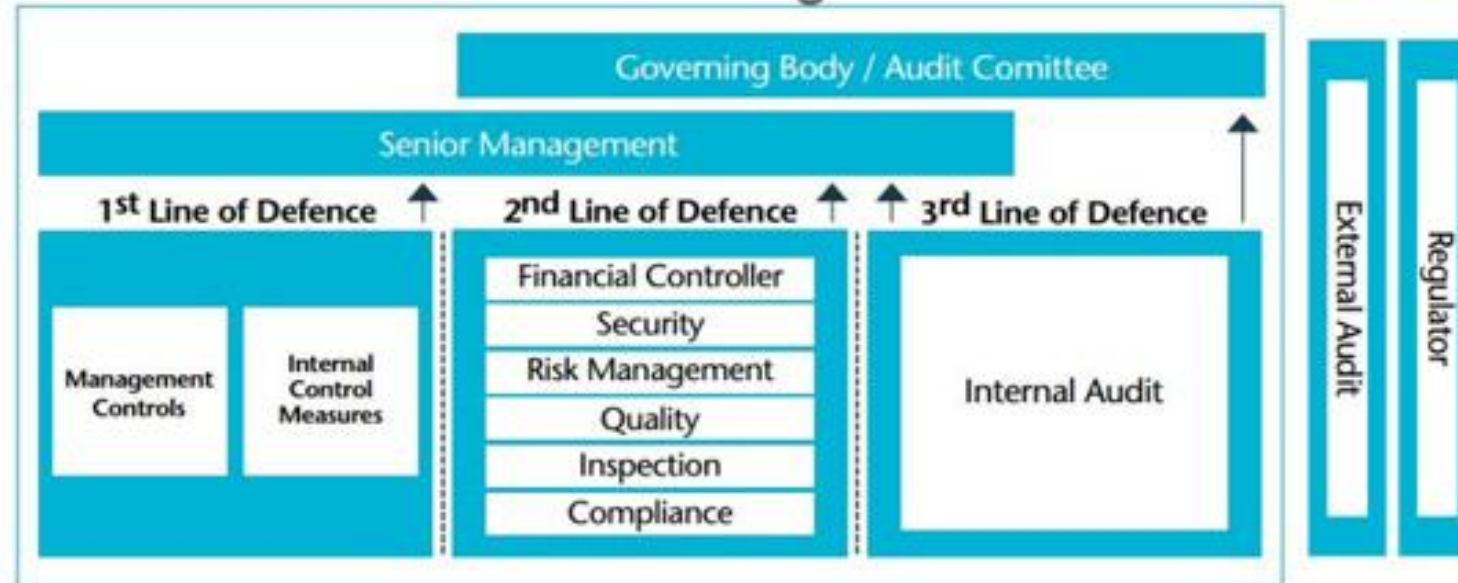
Three Lines of Defence



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



Operational Management (1st line)

First line are functions which own and manage risk, with operational staff responsible for maintaining internal controls such as processes, procedures and identifying risks, addressing as required. The first line also provides assurance that controls are in place and working.

Progress on the implementation of recommendations and WHCs are discussed at the Clinical Service Groups' (CSG) Integrated Governance Group meetings for operational areas in the first instance, and then escalated if required to their CCG Integrated Governance Group meetings. For Executive Functions (EF), recommendations are discussed within the Executive Function Services' local management meetings, and escalated as appropriate to Senior Leadership Team meetings/relevant Lead Executive as appropriate. CCG and EF governance arrangements are considered when assessing the escalation status for Governance.

Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are provided to management and service leads via e-mail which identify proposed actions for the CCG / Function to take forward to address areas of improvement or concern in respect of outstanding recommendations and Welsh Health Circulars.

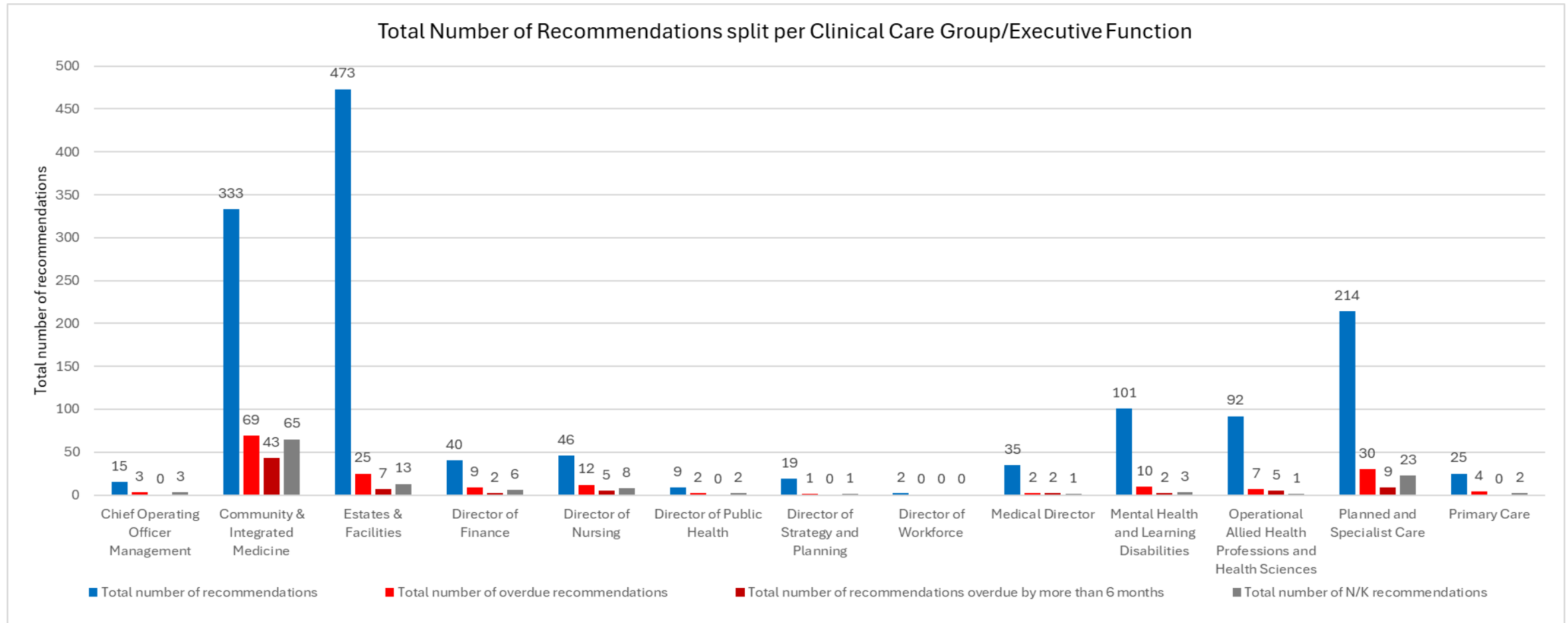
Three Lines of Defence: 1st Line – Operational management of audits and inspections



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The graph below provides an overview of open recommendations and highlights the number of overdue recommendations per CCG/ Executive Function, including those overdue by more than six months and those without revised completion dates (N/K recommendations) as at 30 April 2026. Detail on the underpinning processes have been included earlier in this report.



Three Lines of Defence – 2nd Line – Oversight and specialist function's role of audit and inspections



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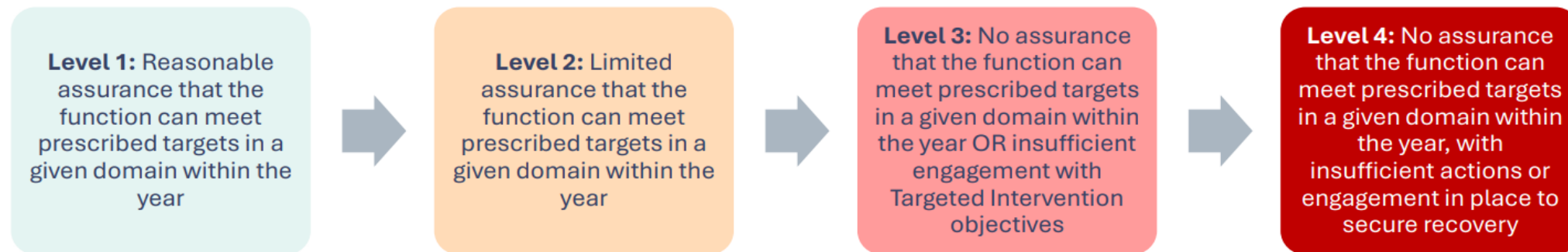
Internal Escalation (2nd Line)

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 (A&R) 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; 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.

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



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Internal Escalation - Measures to assess against the Governance Domain – Audit and Inspections

Levels are assigned based on each Function's assessment against prescribed annual targets. These criteria have been reviewed and strengthened for 2026/27 and will be reflected in the next report presented to the Audit and Risk Assurance Committee.

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	<p>No plan in place and no engagement, (e.g., no responses to recommendations raised, no revised dates where original completion dates have lapsed).</p> <p>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</p>
Level 3 – no assurance	<p>Responses to recommendations have been developed, but the function is not delivering against revised completion dates, with no realistic revised completion dates provided.</p> <p>Management responses have not been developed within a month of receipt of report.</p> <p>Less than 80% compliance with achieving original and revised completion dates stipulated against recommendations</p> <p>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</p>
Level 2 – Limited assurance	<p>Responses to recommendations have been developed, but lack of evidence that original timescales are being achieved.</p> <p>Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates.</p> <p>Between 80-90% compliance with achieving original completion dates stipulated against recommendations</p> <p>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</p>
Level 1 – Reasonable assurance	<p>Responses to recommendations have been developed and the function is delivering against original completion dates</p> <p>Over 90% compliance with achieving original completion dates stipulated against recommendations</p> <p>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</p>

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



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Service	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026
Chief Operating Officer Management	1	1	2	2	2*	2	2	1	1
Community & Integrated Medicine	3	3	3	3	3	3	3	3	3
Estates & Facilities	2	1	1	1	1	1	1	1	1
Executive Director of Allied Health Professions & Health Sciences	1	1	1	1	1	1	1	1	1
Executive Director of Finance	1	1	1	1	2*	2	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2	1	1	1	1
Executive Director of Public Health	1	1	1	1	1	1	1	1	1
Executive Director of Strategy and Planning	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
Executive Medical Director	1	1	1	1	1	1	1	1	1
Medicines Management	n/a	n/a	n/a	n/a	1	1	1	1	1
Governance and Communication	1	1	1	1	1	1	1	1	1
Mental Health and Learning Disabilities	2	2	2	1	1	1	1	1	1
Operational Allied Health Professions and Health Sciences	2	1	1	1	1	1	1	1	1
Planned and Specialist Care	3	3	2	2	2*	3	2	2	2
Primary Care	2	2	2	2	2	2	2	1	1

A summary of each CCG / Executive Function's performance for the Governance domain can be found in the opposite table.

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

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

Detailed analysis of the Community and Integrated Medicine CCG, who are the only CCG/Function assessed as Level 3 as at April 2026, is provided on the next slide, based on their performance in respect of the timely implementation of recommendations from audits and inspections.

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

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



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Community & Integrated Medicine (C&IM) CCG

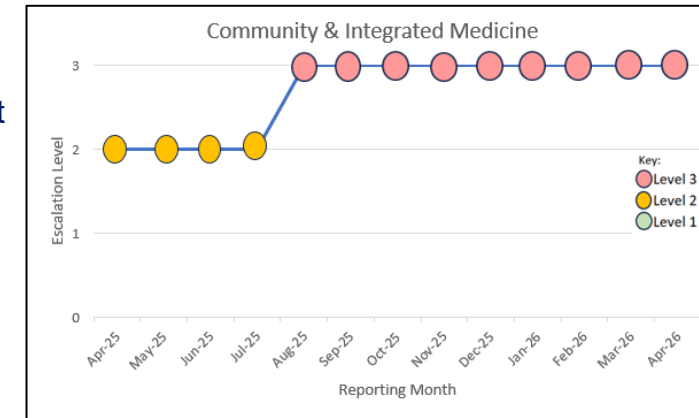
Since December 2025 there has been improvement in the number of overdue recommendations steadily declining. As of 30 April 2026, **69 of 333 (21%) recommendations assigned to the CCG are overdue**. However, the number of recommendations overdue by more than six months has increased significantly from 7 overdue between 6-12 months at December 2026, to **42 overdue between 6-12 months, and 1 overdue 12-18 months**.

Of the 69 overdue recommendations, **65 do not have a revised implementation dates (N/K)**. The lack of revised implementation dates is a combination of:

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

The breakdown by CSG of the 69 overdue recommendations are:

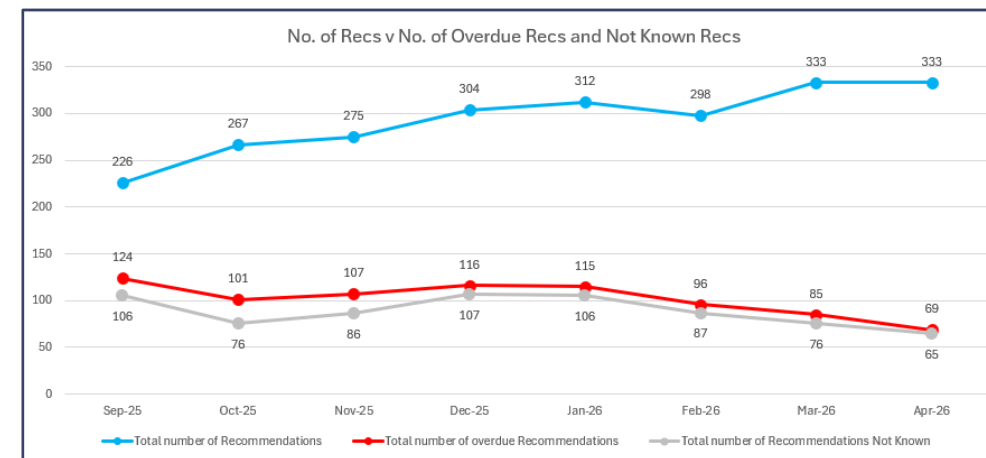
- **28 with Carmarthenshire Integrated System**, 20 of which are overdue 6-12 months. 27 of the 28 recommendations do not have revised implementation dates (N/K).
- **17 with Ceredigion Integrated System**, 16 of which are overdue 6-12 months. 15 of the 17 recommendations do not have revised implementation dates (N/K);
- **7 with Pembrokeshire Integrated System**, none of which are overdue by more than 6 months. 6 of the 7 recommendations do not have revised implementation dates (N/K); and
- **17 with the overarching Clinical Care Group**, 6 of which are overdue by 6-12 months and 1 overdue by 12-18 months. All 17 recommendations do not have implementation timescales (N/K).



Engagement varies across the CCG due to operational pressures, with the Assurance and Risk business partner offering each CSG support to review overdue recommendations.

Management responses are awaited for the following reports: Audit Wales West Wales Region Patient Flow Out Of Hospital Report, GIRFT Emergency Medicine review reports (revisits at each site), NHS Wales Performance & Improvement (P&I) - Assurance Review of Ambulance Patient Handover Process and Compliance with Guidance across NHS Wales, NHS Wales P&I National Review of Same Day Emergency Care (SDEC) in Wales, and NHS Wales P&I Winter Sprints Resets Opportunities Assessment.

Chief Operating Officer and CCG Director have been informed that this may cause further escalation by ARAC if not addressed. The Assurance and Risk business partner is meeting with the CCG Director on 10 June 2026 to agree a plan to ensure all management responses are added to AMaT by the end of June, and to support improvement in the number of recommendations overdue by more 6 months, and the number of recommendations without revised implementation dates (N/K).



Internal Escalation - Governance Domain : Level 2 – Limited Assurance



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The following services were awarded a Level 2 in terms of their audit and inspection reports as at April 2026.

Service	Reason for award of L2	De-escalation Criteria
Planned and Specialist Care	30 (14%) of recommendations overdue	To achieve de-escalation to L1, the Clinical Care Group is required to implement over 90% of recommendations and provide revised completion dates for those where completion dates have lapsed.
Executive Director of Finance	9 (23%) of recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales. Whilst the percentage of overdue recommendations is within the L3 threshold, the <u>number</u> is low in comparison to other CCGs and Functions (9/40 recommendations).

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



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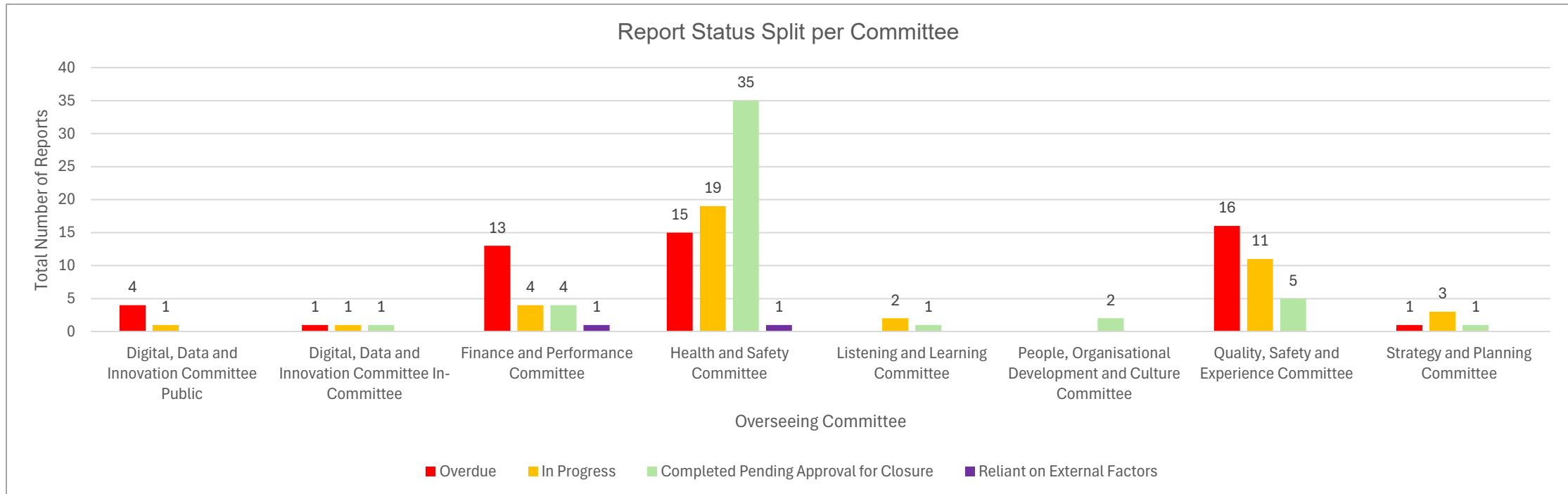
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The graph provides a breakdown of the number of reports and recommendations assigned to each Board level committee as at 30 April 2026.

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

On initial receipt of reports from inspectorates and regulators, these should be presented to the relevant committee for awareness of their findings, highlighting recommendations which have been raised. This process is followed for reports issued by Internal Audit, External Audit, Peer Reviews, HIW and Care Inspectorate Wales (CIW). Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Of the 93 open reports, 49 are awaiting Executive approval to close. The Assurance and Risk team is working closely with Executive colleagues and progressing these through the appropriate channels to support efficient and timely closure.



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



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The table below summarises actions arising from discussions held at Board-level Committees between January 2026 and April 2026, specifically in relation to progress in implementing recommendations endorsed at the respective meetings. Progress against these actions will continue to be monitored and reported through the relevant Committee Table of Actions.

Meeting Date	Committee	Minute Reference	Context	Action
15/01/2026	Digital, Data and Innovation Committee (DDIC)	DDIC(26)91	Assurance and Risk report	To confirm timings of Audit Wales dates
13/04/2026	Executive Recovery Meeting (ERM)	CIM2604-8 Governance	Concern regarding the increasing number of overdue reviews and actions for Risk and Audit & Inspection. Further work needed within the OCP2 space to ensure robust business structures will be in place to manage deadlines effectively:	Through work on OCP2 within the Task & Finish Group, review and identify robust business structures to enable completion of risk management and audit & inspection recommendations within agreed deadlines.
14/04/2026	Audit and Risk Assurance Committee (ARAC)	AC(26)66	Assurance and Risk report	To invite the Chief Operating Officer and representatives of the CIM CCG to attend a future meeting to provide an update on risks and audits
14/04/2026	Audit and Risk Assurance Committee (ARAC)	AC(26)49	Internal Escalation: Level 3 and 4 Functions (Limited Assurance)	To provide an update on the Internal Escalation: Level 3 and 4 Functions Internal Audit report to a future meeting
14/04/2026	Audit and Risk Assurance Committee (ARAC)	AC(26)48	Operational Governance Arrangements (Limited Assurance)	To provide an update on the Operational Governance Arrangements Internal Audit report to a future meeting.
14/04/2026	Audit and Risk Assurance Committee (ARAC)	AC(26)50	Estates Assurance – Space Utilisation (Advisory Report)	To prepare a management response to the report's recommendations, to facilitate tracking on the AMAT system
14/04/2026	Audit and Risk Assurance Committee (ARAC)	AC(26)45	Review of the Management of Outpatients	To consider at QSEC Recommendation 7, in relation to harm

Three Lines of Defence: 2nd Line - Thematic Analysis



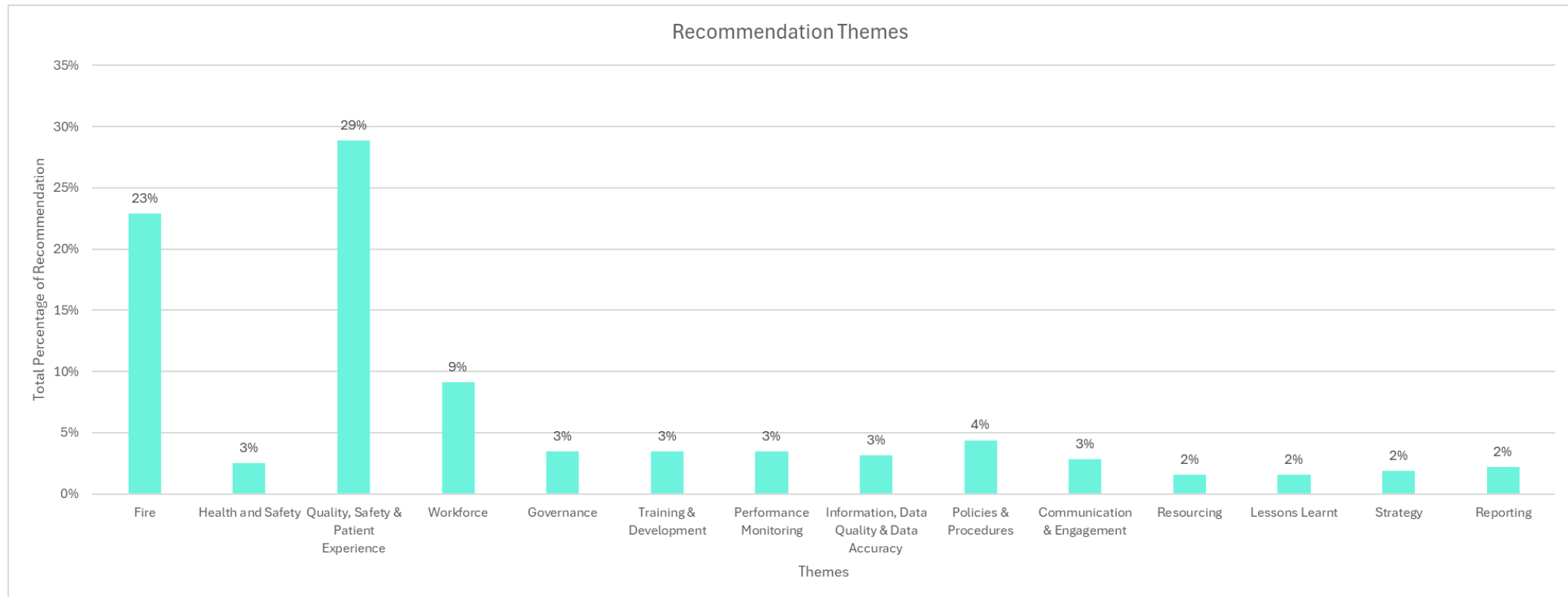
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As part of the second line of defence, each recommendation is assigned a theme, enabling the Health Board to analyse groups of similar recommendations. The Assurance and Risk team share these themed recommendations with relevant subject matter experts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

The graph below provides a thematic analysis for all open recommendations per theme as at April 2026. 29% of the open recommendations were assigned the Quality, Safety & Patient Experience theme, and 24% assigned the Fire theme.

The following themes had less than 1% of recommendations assigned to them and are therefore not shown: Cyber Security, Partnerships, Estates, Medication, Planning, Delivery & Deadline Management, Risk Management and Persons Centred.



Three Lines of Defence – 3rd Line – Independent assurance on effectiveness



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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.

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 (e.g. 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 (WHCs)



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All WHCs are added to AMaT, which provides leads with 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 identified, 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. The table below outlines the definition of each category assigned to WHCs.

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

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

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

Overview of Welsh Health Circulars



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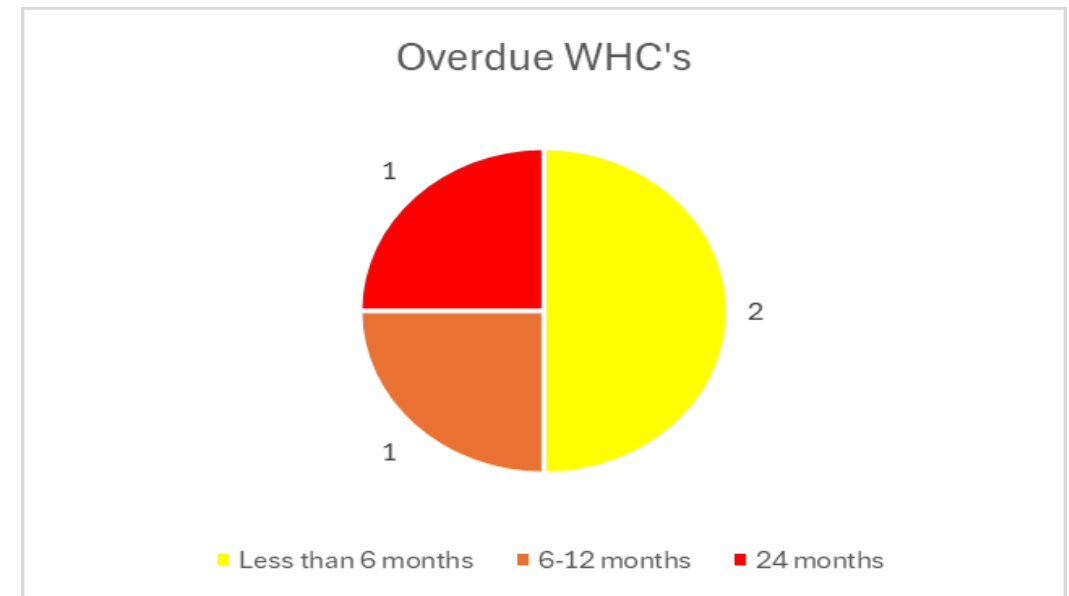
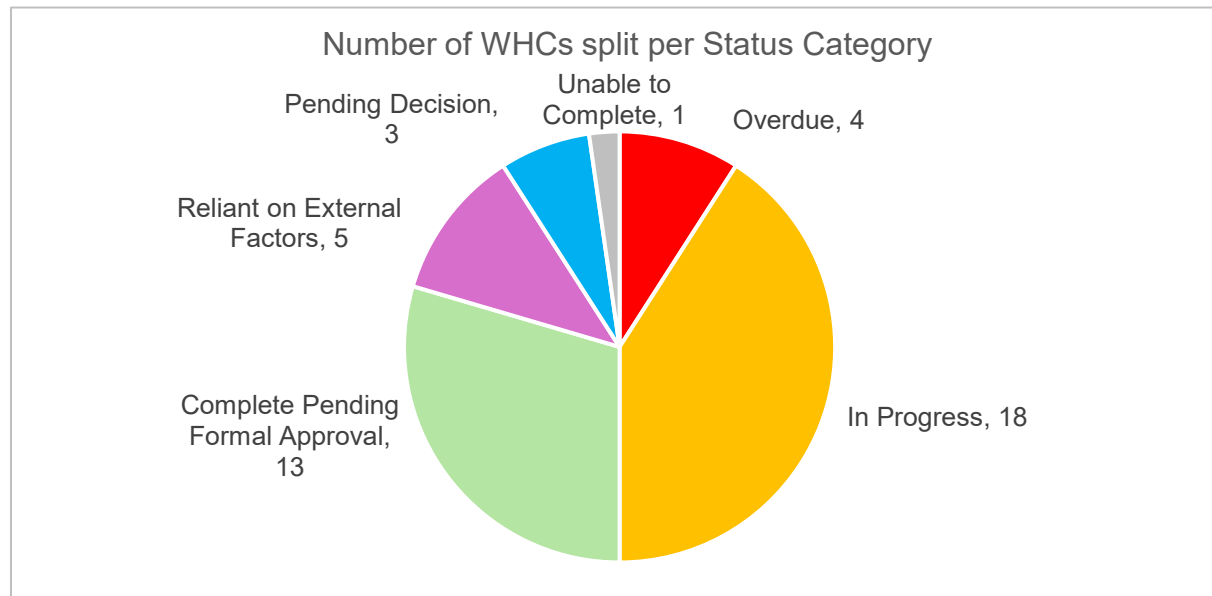
As at 30 April 2026, there were **44 open Welsh Health Circulars**, an increase from 32 in December 2025.

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

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

Where WHCs cannot be implemented, the responsible lead is required to update AMaT to clearly document the barriers to implementation and record a corresponding risk on the Clinical Service Sub-Group’s risk register within Datix, to ensure the impacts of non-compliance are appropriately managed. In addition, a Quality Impact Assessment (where appropriate) must be undertaken, as well as escalating the WHC for the attention of relevant CCG Leads via their CCG IGG meetings.

Of the four WHCs reported as overdue, one (25%) (The National Clinical Guideline for Stroke (WHC/2024/006), assigned to Community & Integrated Medicine is overdue by more than 24 months. The implementation of this WHC is currently hindered by significant resource constraints, including insufficient staffing, limited access to appropriate equipment, and a lack of suitable facilities. Financial constraints and workforce shortages are noted barriers preventing the successful implementation of the WHCs. Stroke services forms part of the Clinical Services Plan of the Health Board (see slide 29 for more details).

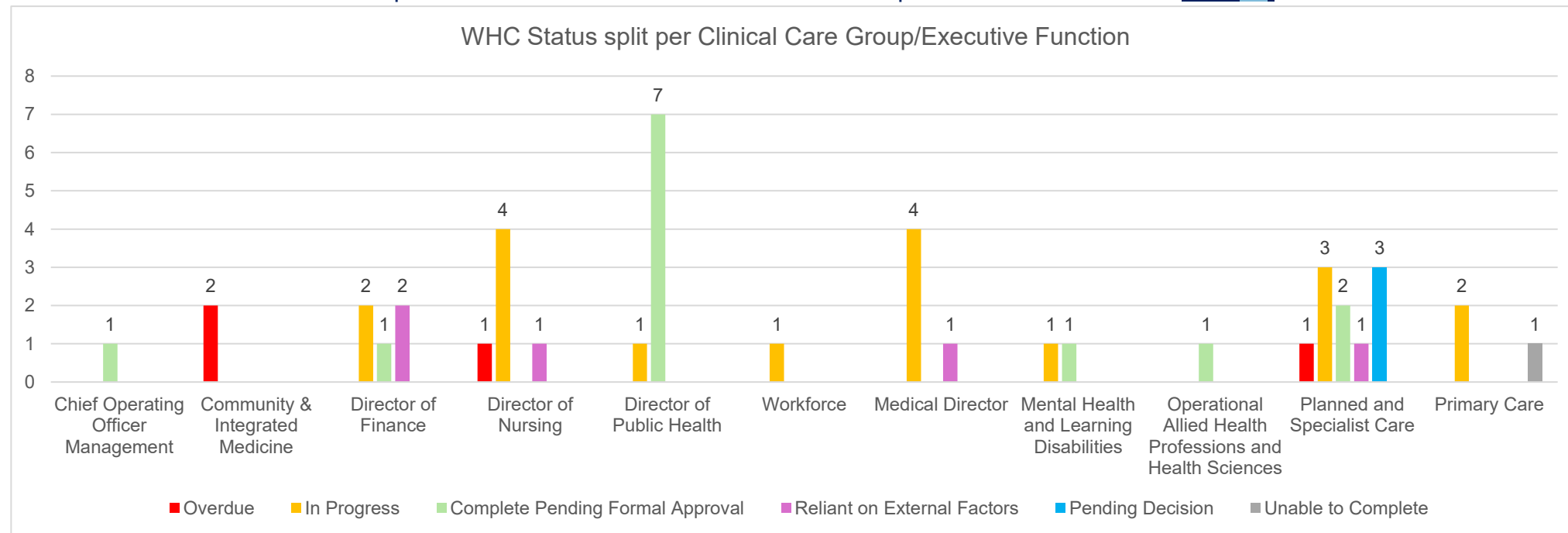


Overview of Welsh Health Circulars

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

As of the end of April 2026, three WHCs assigned to Planned and Specialist Care were recorded as “pending decision”, pending the outcome of the annual plan. Since the dataset was extracted at this time, the status of these WHCs has been reviewed: one has been updated to “completed pending formal approval”, while the remaining two are now recorded as overdue. One WHC assigned to Primary Care (WHC 026-18: Phase 2 – Primary Care Quality and Delivery Measures) is noted as “unable to complete”. This reflects that the associated national work relating to this transformational model was suspended due to the COVID-19 pandemic and has not been resumed.

A summary of each CCG / Executive Function’s performance for the Governance domain for April 2026 can be found on [slide 18](#).



The next slide outlines the minimum criteria required for a service to be assigned its escalation level based on the status of WHCs. This is followed by a detailed analysis of one Clinical Care Group (CCG) that was designated Level 3 as of April 2026.

Three Lines of Defence: 2nd Line - 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. These criteria have been reviewed and strengthened for 2026/27 and will be reflected in the next report presented to the Audit and Risk Assurance Committee (ARAC).

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

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



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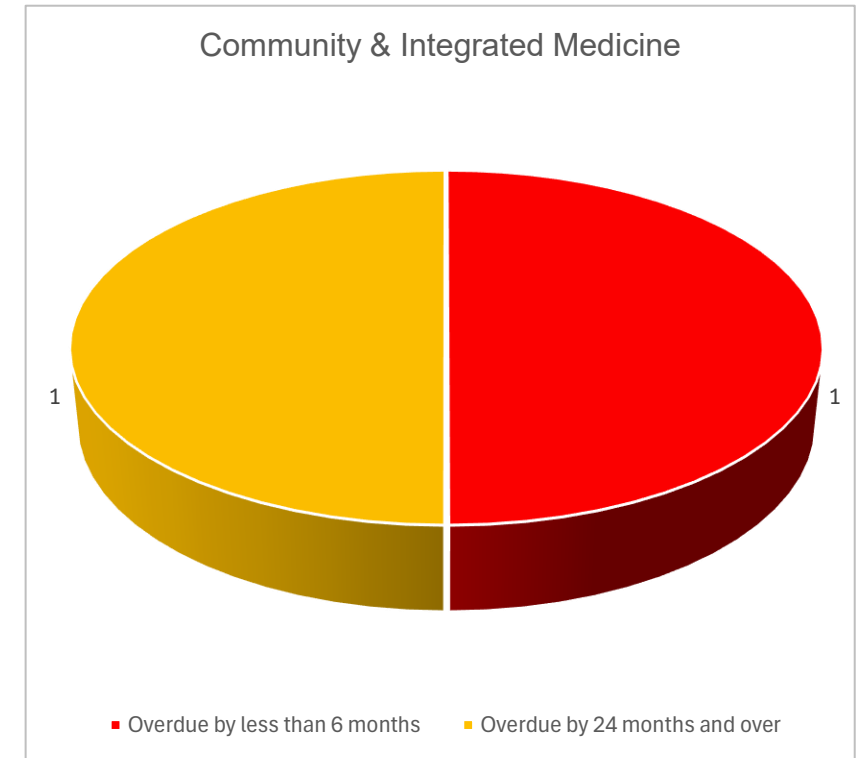
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Community & Integrated Medicine CCG

As at 30 April 2026, two Welsh Health Circulars (WHCs) are assigned to the Community & Integrated Medicine CCG.

The Ambulance Patient Handover Guidance WHC (WHC/2024/041) is overdue by less than 6 months with a meeting being scheduled with the Assistant Director of Nursing, Patient Safety, Quality to discuss evidence required to support closure of this WHC.

The National Clinical Guideline for Stroke (WHC/2024/006), received in March 2024, is overdue by over 24 months, with no confirmed implementation timescale (N/K). An associated risk is recorded on the risk register (*Risk 233 Risk of poor patient outcome due to insufficient stroke therapy staff & lack of 7 day Consultant affecting the Health Board.* Current Risk Score 12 (High)) and a revised Quality Impact Assessment (QIA) is to be submitted to the QIA panel for review. Stroke services forms part of the Clinical Services Plan which was considered at the Extraordinary Board meeting on 19 February 2026, and will be subject to further engagement with the public before a final decision could be made on the future service model for stroke services. Between 28 May and 26 July 2026, the Health Board is seeking feedback on how stroke services could be delivered across our four main hospital sites. This is the second phase of consultation for stroke services as part of the Clinical Services Plan.



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



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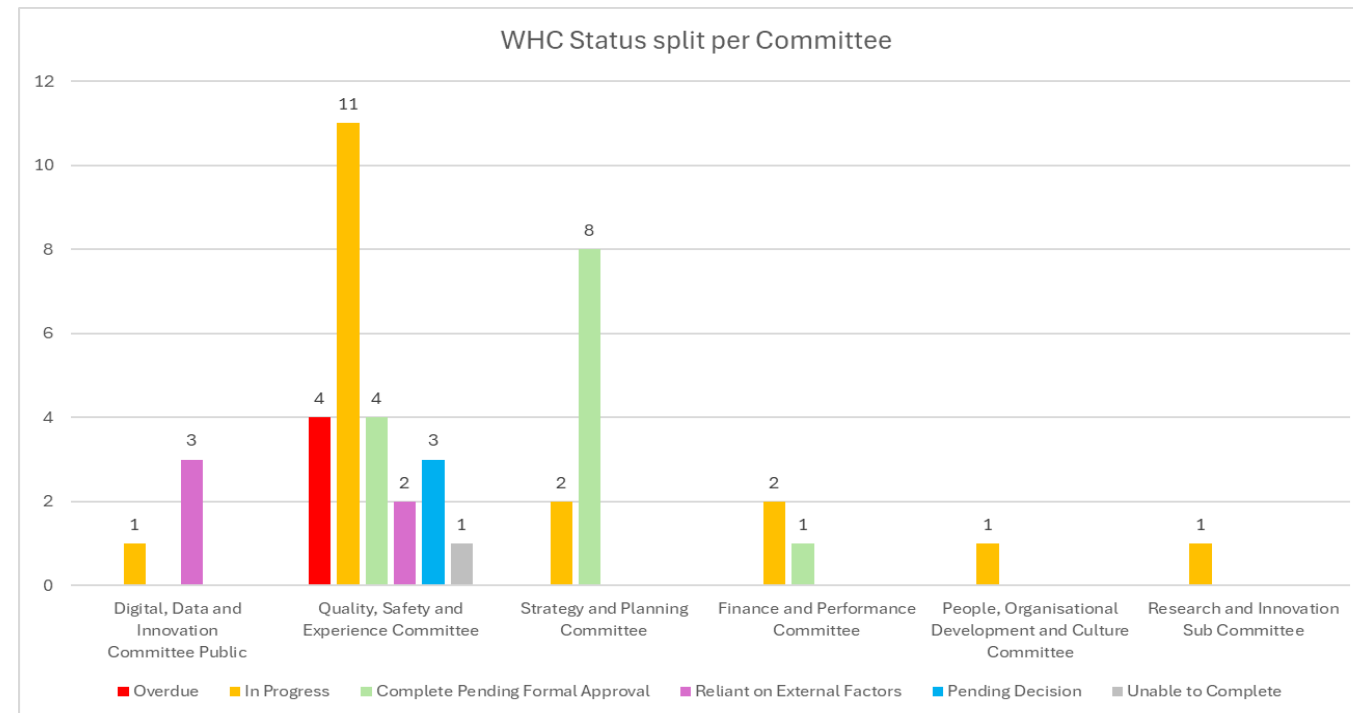
The graph provides a breakdown of the number of WHCs assigned to each Board level committee as at 30 April 2026

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

The table below summarises actions arising from discussions held at Board-level Committees between January 2026 and April 2026, in relation to progress in implementing Welsh Health Circulars endorsed at the respective meetings. Progress against these actions will continue to be monitored and reported through the relevant Committee Table of Actions.

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.

Committee	Minute Reference	Action
Quality, Safety and Experience Committee	QSEC (26) 22	To provide a status update on the overdue Welsh Health Circulars and ensure there is a risk aligned on the Datix Risk Register.



Next Steps and Recommendations



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Next Steps

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

- To agree audit and inspection 'PowerBI' dashboard specification with the Performance Team, to enable this to be built by August 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 AMaT by the end of June, and to support improvement in the number of recommendations overdue by more 6 months, and the number of recommendations without revised implementation dates (N/K).

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.



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