COFNODION Y CYFARFOD PWYLLGOR ARCHWILIO A SICRWYDD RISG CYMERADWYO
APPROVED MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE MEETING

Date of Meeting:	**10:00, Tuesday 12 August 2025**
Venue:	**Via Teams**

Present:	Mr Winston Weir, Independent Member (Committee Vice-Chair) (VC) Mr Maynard Davies, Independent Member (VC) Mrs Eleanor Marks, Vice-Chair, HDdUHB (VC)
In Attendance:	Ms Urvisha Perez, Audit Wales (VC) Mr David Williams, Audit Wales (VC) Mr James Johns, Head of Internal Audit, NWSSP (VC) Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC) Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk (VC) (deputising for Mrs Joanne Wilson, Director of Corporate Governance) Mr Huw Thomas, Executive Director of Finance (VC) Ms Rachel Williams, Head of Assurance and Risk (VC) Mr Ben Rees, Head of Counter Fraud (VC) (part) Mr Shaun Ayres, Director of Delivery (VC) (part) Mr Andrew Carruthers, Chief Operating Officer (VC) (part) Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) (part) Mrs Lisa Gostling, Executive Director of Workforce and OD/Deputy Chief Executive (VC) (part) Ms Jill Paterson, Director of Primary Care, Community and Long Term Care (VC) (part) Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (VC) (part) Ms Eldeg Rosser, Head of Capital Planning (deputising for Mr Lee Davies, Executive Director of Strategy and Planning) (VC) (part) Mr Julian Wheeler Jones, Discretionary Capital Projects Manager (VC) (part) Dr Bruce Bolam, Deputy Director Public Health (deputising for Dr Ardiana Gjini, Executive Director of Public Health) (VC) (part) Mr James Severs, Executive Director of Allied Health Professions and Health Science (VC) (part) Ms Elin Brock, Head of Research, Innovation and Improvement (VC) (part) Mr Peter Jones, Head of Facilities (VC) (part) Ms Paula Goode, Service Director for Planned and Specialist Care (VC) (part) Ms Victoria Coppack, Service Delivery Manager, Ophthalmology and Neurology (VC) (part) Ms Heather Hinkin, Assistant Director, People Management (VC) (part) Ms Janice Cole-Williams, Assistant Director of Nursing (VC) (part) Ms Amanda Legge, All Wales PPV Manager (VC) (part) Ms Sue Tillman, PPV Location Manager (VC) (part) Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action

AC(25)128 Introductions and Apologies for Absence

Mr Winston Weir, Audit and Risk Assurance Committee (ARAC) Vice-Chair, welcomed everyone to the meeting. Apologies for absence were received from:

- Cllr. Rhodri Evans, Independent Member (Committee Chair)
- Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
- Professor Philip Kloer, Chief Executive
- Mr Lee Davies, Executive Director of Strategy and Planning
- Dr Ardiana Gjini, Executive Director of Public Health
- Ms Helen Humphreys, Head of Nursing for Professional Standards and Regulation
- Mr Simon Chiffi, Head of Operations, Facilities

AC(25)129 Declaration of Interests

No declarations of interest were made.

AC(25)130 Minutes of the Meeting held on 24 June 2025

Decision: RESOLVED – the Minutes from the meeting held on 24 June 2025 were approved as an accurate record.

AC(25)131 Table of Actions

An update was provided on the Table of Actions from the meeting held on 24 June 2025 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(25)47 – Ms Sharon Daniel reminded Members that this action had arisen from a discussion on the Clinical Audit Plan, during which there had been a suggestion of a wider piece of work. For clarity, Members were advised that Clinical Audit now falls under the portfolio of the Executive Medical Director. Ms Daniel had, however, discussed, with the Chair of the Quality, Safety and Experience Committee (QSEC), the future role of that Committee in this regard. The proposal is that different clinical pathways would be taken through QSEC, with consideration of how clinical audit can be utilised in reviewing those pathways, as part of the proactive work of QSEC going forward. This work is in progress and Ms Daniel hoped that developments will be seen over the next few months.

AC(25)103 – Mr Andrew Carruthers advised that this action is being progressed. Discussions are taking place with the Executive Director of Workforce and OD around how to take forward Phase 2 of the Organisational Change Process (OCP). There are a couple of issues requiring consideration as part of Phase 2, and a report outlining these will be prepared. This may result in a delay to the process, meaning the dates provided to ARAC will require revisiting.

Noting that she had previously expressed concerns around this process, Mrs Eleanor Marks recognised that restructuring takes time and involves complex issues. Whilst she felt that the 'top layer' is relatively resolved, it was suggested that other staff are still feeling unsettled. Mrs Marks requested assurance regarding pace, together with more information on the issues causing delays. In response, Mr Carruthers advised that all Clinical Care Groups (CCGs) have received a draft of the next phase/tier of the process. Further work in terms of mapping is required for the Community and Integrated Medicine (CIM) CCG, particularly in regard to mapping community structures against existing management structures. Mr Carruthers is awaiting confirmation that this is complete. Consideration of possible gaps is also required, and some new posts have been introduced since the previous OCP. It is necessary to formalise aspects of this process, and it is preferable to undertake this once rather than multiple times. The CIM CCG element will probably take longest, given the move to the longer-term strategy around care closer to home, social model for health and wellbeing, etc.

Whilst welcoming this additional context, Mrs Marks reiterated her concerns that the Health Board is extremely dependent on the effectiveness of the new operational structure. She agreed that the approach should be a single process, rather than multiple times. However, the new structure was implemented in April; it is now August and the further work involved is likely to take until the end of the calendar year, meaning that it may be April next year before it is fully embedded. This is a longer timescale than was anticipated. Mr Weir understood that an update on this topic is due to be presented to the People, Organisational Development and Culture Committee (PODCC), and suggested that this also be copied to ARAC Members. **AC**

The Committee agreed to **ADVISE** the Board in relation to concerns around implementation of the new operational structure.

AC(25)108 – Mr Carruthers confirmed that this work is being taken forward. There are a couple of associated workstreams in progress; the accelerated Urgent and Emergency Care (UEC) work, together with a 60 day programme of work around ambulance handover. A number of the issues in relation to Discharge Management are linked to aspects of this work. The Chief Executive is keen for Clinical Executive colleagues to be more closely aligned into the UEC work, to provide additional executive oversight. There is a commitment to do so, as there is a need to make progress in this area, particularly with the upcoming change in ambulance handover target.

AC(25)118 – Members were informed that the ARAC Chair had discussed Planned Care attending a future meeting as a service of concern, being the only CCG at Level 3 for Governance at the present time. As an update, Miss Charlotte Wilmshurst advised that the service has shown improvement during the past month. It is hoped that this will be sustained; however, a decision can be

made when the Audit Tracker is next presented to the Committee, which is scheduled for October 2025. **RE/JW**

AC(25)120 – Mr Huw Thomas advised that he would issue the accounts addendum report, as soon as this is received from Audit Wales. Acknowledging the delay, Mr David Williams indicated that Audit Wales are in the process of finalising this document and that it would be available for the October 2025 meeting. In response to a query around whether this would impact on the Health Board's ability to declare their annual accounts at the Annual General Meeting in September 2025, Mr Thomas emphasised that all documents requiring finalisation had been approved by the Board in June 2025. The addendum report is not material and does not impact on the governance process, it simply considers best practice and any areas for improvement. Mr Williams confirmed that the report contains 'housekeeping' findings from the audit, none of which would impact on the audit opinion. **HT**

AC(25)132 Matters Arising not on Agenda

There were no other matters arising.

AC(25)133 Escalation Status Update Report

Mr Shaun Ayres and Ms Cathie Steele joined the Committee meeting.

Presenting the Escalation Status Update Report, Mr Shaun Ayres highlighted that a further iteration of the Escalation Framework has since been received. The main change was around Cancer services being de-escalated from Level 4 to Level 3, with a revised expectation of 63% for 3 months and a focus on the backlog. Another positive step was de-escalation of Child and Adolescent Mental Health Services (CAMHS) from Level 3 to Level 1 (Routine Monitoring). As previously mentioned, there has also been the addition of a requirement around concerns raised by Regulators, including Healthcare Inspectorate Wales (HIW). Overall, it is important to note from ARAC's perspective, that four of the six criteria are assessed as 'Assure'. The two exceptions are, firstly, the criteria around Programme and Performance Management Structure, assessed as 'Advise'. This status recognises the complexity and multiplicity of expectations and demands on staff and services, in terms of UEC, savings, planning processes, Clinical Services Plan, Primary Care and Social Model for Health and Wellbeing. The second is the criteria around Concerns Raised by Regulators, assessed as 'Alert'. Whilst it is not denied that the process around this is robust, the challenge is adherence to, and application of, the process. This includes identifying leads, time scales, milestones, and setting realistic expectations as to when the Health Board will be able to not only remedy the action set out within the HIW reports, but also share the learning, to ensure that actual practices change. For that reason, and because it was an additional amendment under Governance and Leadership, Mr Ayres had suggested the status of 'Alert'. Mitigation is via the Escalation Framework, the Executive Improving Together sessions and the recovery process.

Highlighting that Welsh Government have requested a response to the latest iteration of the Escalation Framework, Mr Thomas suggested that it remains draft in this respect. He expressed concern that the de-escalation criteria in relation to financial outturn has been altered from achievement of the Target Control Total of £31.5m deficit, to a £24m deficit; a unilateral shift. Whilst recognising that decreasing the deficit further should be and is the Health Board's ultimate aim, he suggested that introducing it as a de-escalation criteria now was somewhat unfair. The Health Board will be responding accordingly. Mr Ayres acknowledged this important point of factual accuracy. Whilst the addition of the criteria around HIW/Regulators has been accepted, along with changes to performance targets, this is not necessarily the case with regard to the financial target. Members should also be aware that the Health Board's Annual Plan was drafted on the basis of a £31.5m deficit. Any shift in this is material to the overarching Plan, and the wider implications should not be underestimated.

Mr Maynard Davies highlighted that an alteration of this magnitude to the financial outturn would involve identifying and delivering an additional £6m savings in just 7 months. This makes the need to enact potential options presented to Public Board in July 2025 more likely, no matter how 'unpalatable' they may be. In terms of the additional requirement around response to Regulators, Mr Davies enquired how this would alter the current process, suggesting that the organisation should already be making an effort to respond in a timely manner. Mr Thomas was not of the opinion that it would change the process per se, the criteria was more to recognise and emphasise the importance of compliance. With regard to the financial position, as stated during the Public Board meeting, the organisation had spent a great deal of time and effort developing the Annual Plan. The reduction in deficit represents a significant expectation in terms of improvement. To change this aspect of the Annual Plan at this stage will alter the balance, and impact on quality and equity. Whilst there may be certain options without detrimental impact, there are not many. Any option being considered will need to undergo Quality and Equality Impact Assessments. Members heard that an Extraordinary In-Committee Board meeting to discuss this matter in more detail will take place on 9 September 2025.

Returning to the issue of HIW/Regulators, Ms Daniel advised that this was part of the de-escalation criteria last year; however, the requirement has been further emphasised. Whilst there has been a significant improvement in the Health Board's closure of recommendations, this needs to be fully evidenced. In addition, there are a number of recommendations which remain open, and due to the ongoing nature of the inspection process, further recommendations are constantly being added. Services also need to ensure that actions are SMART (Specific, Measurable, Achievable, Realistic/Relevant, Timely). Certain actions involve capital investment or issues with the Health Board's estate, and may require consideration in terms of risk tolerance. It had been

pleasing, however, that a recent assessment of the Health Board's maternity services had provided a positive outcome. As has been mentioned, the organisation has a number of programmes of work, including the Clinical Services Plan, Prince Philip Hospital Minor Injury Unit, CCG establishment and OCP. These are all potential areas of concern for staff, which they may then choose to raise with HIW. Members were assured that the Health Board has regular meetings with its nominated HIW Relationship Manager.

Ms Cathie Steele confirmed that the organisation is aware it has a number of open recommendations. It should be noted that this includes recommendations from national reports, against which the Health Board decided to assess itself. Others are local only. In terms of prioritisation, the more challenging recommendations are being considered first, together with those which are most overdue. Thought is given to how these might be mitigated or closed. Finally, it is important to recognise that HIW has recruited additional Inspection Managers, which will result in increased numbers of inspections and recommendations. This effect is already being seen.

Whilst recognising the sense of frustration around the revised financial target, Mrs Marks suggested that it has been set and the organisation should take steps to meet it if possible. She also felt that the Health Board and its staff have already achieved a great deal and these positive achievements should be acknowledged. Agreeing, Mr Weir reminded Members of the introduction to this item, which had identified de-escalation in Cancer services and CAMHS. Both of which would have been evidence-based, involving a significant amount of work. In terms of financial performance, it should be recognised that the Health Board over-delivered on the Target Control Total last year. It seems that Welsh Government have translated this into an expectation for future years. Whilst this does place more pressure on the organisation, Mr Weir's sense was that there is now better 'grip and control' in this area. Mr Thomas emphasised that the ambition to reduce the Health Board's deficit to £24m (and beyond) is not the issue; it is specifically the change to the financial de-escalation metric. This makes de-escalation more and more challenging for the organisation to achieve.

Concluding discussions, the role and remit of ARAC in considering the report and Escalation Framework were clarified.

Decision: The Committee **NOTED** the Escalation Status Update.

The Committee agreed to **ADVISE** the Board in relation to the Escalation Status Update; reflecting the additional criteria around Concerns Raised by Regulators and concerns around the change to the financial de-escalation criteria.

Mr Shaun Ayres, Mr Andrew Carruthers, Ms Sharon Daniel and Ms Cathie Steele left the Committee meeting.

AC(25)134 All Wales NHS Audit Committee Chairs' Meeting Update

DEFERRED to 14 October 2025 meeting

AC(25)135 Committee Self-Assessment

Decision: The Committee **TOOK ASSURANCE** from the progress made against the actions being undertaken to improve its effectiveness.

AC(25)136 NHS Wales Shared Services Partnership's Construction Framework for Swansea Bay and Hywel Dda University Health Boards

Ms Eldeg Rosser and Mr Julian Wheeler-Jones joined the Committee meeting.

Ms Eldeg Rosser introduced the report, advising Members of the background to this item. The report seeks to provide information around establishment and application of the NWSSP Construction Framework. Members heard that this is currently subject to an extension period, and that contracts are awarded on a rotational basis. There are various assurance processes in place, detailed within the report. Ms Rosser advised that 87 contracts have been let via the Framework. The Internal Audit of Capital Systems presented to ARAC in December 2024 had included consideration of this Framework and had returned an overall rating of Reasonable Assurance. Within the audit, specific objectives around 'Selection and Appointment', and 'Value for Money and Award' had both been rated as Substantial Assurance. Members were advised that work is underway to develop a new process and framework, for implementation following the end of the extension period.

Mr Weir clarified that the report had been requested by the Chair of the Health Board and the Chair of ARAC following a recent Chair's Action meeting to approve funding for works at Bronglais Hospital. A number of concerns had been expressed regarding the process. Mrs Marks thanked Ms Rosser for her report and the assurance it provides; whilst emphasising that an important tenet remains – no matter how robust the framework, any contract in excess of £1m requires Board approval.

Decision: The Committee **TOOK ASSURANCE** that the use of the framework and awarding of contracts is undertaken in line with procurement regulations and provides value for money.

Ms Eldeg Rosser and Mr Julian Wheeler-Jones left the Committee meeting.

AC(25)137 Audit Wales Update Report

Mr Andrew Carruthers, Ms Sharon Daniel and Dr Bruce Bolam joined the Committee meeting.

Presenting the report, Mr Williams advised that the Charitable Funds accounts audit work is being undertaken, with a planned

date for consideration of December 2025. With regard to performance audit, Ms Urvisha Perez indicated that reports in relation to UEC (Discharge Planning and Patient Flow) have been issued and are out for clearance. These have been issued to health boards and local authorities, with a request for a combined response from Regional Partnership Boards. An extended timescale has been agreed with the Health Board for the local Radiology review, to accommodate resource challenges in this area. Other reviews are still at the planning stage. The report includes reference to national work and reports, and Ms Perez wished to draw Members' attention to the letter included later on the agenda. This highlights changes to the way in which Audit Wales write their reports, with the new format being applied to reports which will be presented to future meetings.

Mr Weir requested assurance that reports will be delivered according to the planned timescales, and Ms Perez confirmed they would. In response to a query around the Radiology review timescale, Ms Perez advised that a meeting to discuss the scope had taken place. The draft project brief had been issued and was with the Health Board team for agreement. Mr Carruthers confirmed that this would occur, on return from annual leave of the relevant staff member.

Decision: The Committee **NOTED** the Audit Wales Update Report.

AC(25)138 **Structured Assessment - Progress Update on Recommendations**

Miss Wilmshurst introduced the report, which provides an update on progress against recommendations made as part of the Structured Assessment process. All had been reviewed by the relevant Executive Leads, and ARAC was requested to consider the progress made.

In response to a query around Audit Wales' view on the response and progress, Ms Perez indicated that they are in the midst of fieldwork, so it would be inappropriate to comment at this stage. The latest Structured Assessment report will be submitted to the December 2025 meeting. Mr Weir recognised that this is 'work in progress', with interviews currently being conducted and thanked Audit Wales for their work. In respect of this year's Structured Assessment, Ms Perez advised that Audit Wales is undertaking a high-level review of the recommendations made in its Cost Savings and Workforce Planning reviews.

Decision: The Committee **DISCUSSED** and **CONSIDERED** progress made in respect of the recommendations from the Structured Assessments 2022, 2023 and 2024.

The Committee agreed to **ASSURE** the Board in relation to recommendations from the Structured Assessments.

Mr Andrew Carruthers, Ms Sharon Daniel and Dr Bruce Bolam left the Committee meeting.

AC(25)139 **Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)**

DEFERRED to 14 October 2025 meeting.

AC(25)140 **Review of Investment in Digital Systems**

DEFERRED to 9 December 2025 meeting.

AC(25)141 **Review of the Management of Outpatients**

DEFERRED to 14 October 2025 meeting.

AC(25)142 **Internal Audit Plan Progress Report**

Mr James Johns introduced the Internal Audit Plan Progress Report, drawing Members' attention to Section 2, which details outcomes from finalised audits. Since the previous meeting, three audits have been finalised. Two of these, Nursing Management and Sickness Management, are rated as Limited Assurance. Mr Johns felt that the existence of linked issues within these reports should be recognised. He hoped that the Committee will see the 'read-across' between the points raised. In terms of a delivery update, this year's audit work is progressing well. A number of audits are in fieldwork and planning stages. There have been discussions with the Director of Corporate Governance around inclusion of further work around Cleaning Standards later in the year. It may be that this is incorporated by utilising some of the time allocated for estates and facilities work, and by including consideration of it in other planned audits.

Mr Weir enquired whether the two audits which have returned Limited Assurance ratings will be reaudited later in the year. In response, Mr Johns advised that there are two potential approaches. Progress against the recommendations could be reviewed as part of wider recommendation-tracking work; or more detailed audit work could be conducted if required.

Decision: The Committee **TOOK ASSURANCE** with regard to the delivery of the Internal Audit plan and the outcomes of the finalised audit reports.

AC(25)143 **Standards of Cleanliness Internal Audit - Action Plan Progress**

Mr James Severs, Ms Elin Brock and Mr Peter Jones joined the Committee meeting.

Ms Elin Brock presented the Standards of Cleanliness Progress update, reminding Members of the background and context, with audits in both 2023/24 and 2024/25 returning ratings of Limited Assurance. The six management actions requiring addressing by the Health Board are outlined within the report. The most pressing of these were Actions 4 and 5, which needed to be completed by 31 July 2025. Ms Brock was pleased to advise that these had

been completed and that a governance and reporting structure has been incorporated, to enable monitoring of compliance via the Estates and Facilities CCG structure. There are also two actions which are due for completion by 31 August 2025. Both are being worked on by the team, with progress reported on a weekly basis to the Cleaning Standards Sub-Group. The team is on track to complete these by the date specified, with compliance and progress monitored, again, via the Estates and Facilities CCG structure.

A Governance Review meeting was held on 11 August 2025, with the Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience. This meeting had considered the process for reviewing governance and reporting structures for Infection Prevention and Control going forward, and the implications for terms of reference. A number of actions have been agreed between Facilities and Nursing teams, to ensure that the correct assurances around meeting cleaning standards and the relevant escalation processes are in place. Reports will continue on a weekly basis via the Cleaning Standards Sub-Group, and on a bi-weekly basis to the Estates and Facilities CCG, to ensure that actions are being progressed. Also included in the report is a brief summary of wider pieces of work currently being undertaken.

Mr Weir welcomed the positive report and thanked Mr James Severs and Ms Brock for their work. Recalling the need for additional resource identified at the previous meeting, he enquired whether this aspect has been resolved. Mr James Severs advised that an updated position statement on the audit as it stands is being taken to the Executive Team. As part of business planning for 2026/27, consideration is being given to the additional resource which might be needed. There is resource within the Facilities budget, which is being explored for the purposes of increasing supervision, as outlined on page 5 of the report. As a first step, Mr Severs will take the opportunity to examine this issue further over the next month or two. A discussion at Board Seminar is also scheduled, to consider the wider context of the Estates and Facilities function. Whilst he felt that he had sufficient support at this stage, he was also conscious that there is no Director of Estates and Facilities in post at present. Mr Severs is anticipating that a review of Estates and Facilities will be undertaken in the near future.

Noting that Estates and Facilities has been de-escalated from Level 3 to Level 2 for Governance, Mr Weir commended this positive achievement. Mr Severs stated that it was testament to the hard work and tenacity of the management team. The concern is sustaining this performance, hence the review of the senior leadership structure. Mr Davies noted that an Assistant Director has been seconded into the Facilities Service. He enquired whether this was the Consultant Practitioner of Infection Prevention (IP), or another individual. Also, their background and skillset. Secondly, with regard to Action 4 around developing

cleaning schedules, he enquired who these are agreed with in the clinical setting, to ensure they are adequate to meet requirements.

In response to the first query, Mr Severs advised that two individuals had been seconded. Ms Brock was the Assistant Director and he was confident she possesses the skills required. The Consultant Practitioner in IP is support provided with the assistance of the Executive Director of Nursing, Quality and Patient Experience. Mr Severs was, however, conscious that these roles are time-limited and progress is required in terms of substantive appointments. With regard to the second query, Ms Brock advised that there is a cleaning schedule compliance Standard Operating Procedure (SOP). This provides guidance around roles and responsibilities, duties and how compliance is monitored and measured. The SOP was agreed at the Environmental Hygiene Group in July 2025 and will be presented to the Infection Prevention Strategic Steering Group (IPSSG) this month. Colleagues in Infection Prevention and Control (IPC) sit on the Environmental Hygiene Group, and have provided advice from an IPC perspective. Whilst there are no responsibilities within the SOP for nursing, it is recognised that, as good practice, it should be discussed with nursing colleagues. This is currently in hand.

Mr Weir requested an update on progress recruiting to the Facilities Manager role. Welcoming the support which Mr Severs has already provided to the team, Mr Peter Jones advised that he and Ms Brock had met with the recruitment team. The post is now on the TRAC system and should be advertised fairly soon.

Decision: The Committee **TOOK ASSURANCE** that progress is being made to implement the actions arising from the 2024/25 internal audit report on Standards of Cleanliness.

Mr James Severs, Ms Elin Brock and Mr Peter Jones left the Committee meeting.

AC(25)144 Corporate Risk: Ophthalmology (Reasonable Assurance)

Mr Andrew Carruthers, Ms Paula Goode and Ms Victoria Coppack joined the Committee meeting.

Ms Sophie Corbett introduced the report from the Corporate Risk: Ophthalmology Internal Audit, which reviewed the key controls in place to manage and mitigate risk 1664 on the Corporate Risk Register, relating to the inability to provide a full range of Ophthalmology services across the Health Board. Progress has been made in the implementation of key controls, and actions to address and identify gaps in controls; although further work is required to fully address the risk, with 11 of the 17 controls at varying stages of implementation. No concerns were identified with the governance and oversight arrangements for the risk and identified controls. Reasonable Assurance had been concluded overall, with two medium priority actions relating to the need to review existing controls and gaps in controls, to eradicate any overlaps or discrepancies.

Mrs Marks requested confirmation that the target implementation dates for actions were achievable. She noted that Ophthalmology is an area of fragility for the Health Board and, whilst welcoming the progress identified within the report, enquired whether it will contribute positively towards this fragility. Mr Carruthers welcomed this question. Whilst it is helpful to receive an assessment of this specific corporate risk, it does not necessarily impact on the service risks. He was not able, at this stage, to provide assurance around these, or identify how this assurance might be obtained. More work is required in this regard, together with additional investment. Mr Carruthers was, however, cognisant that performance in this area is not at a sufficient level. Mrs Marks indicated that she has spent time with the Ophthalmology service at Glangwili Hospital (GGH) and received a great deal of feedback from staff there. She would welcome a further report and discussion on this area.

Members discussed which forum would be most appropriate for such a discussion, noting that the Finance and Performance Committee (FPC) or QSEC may be suitable, and that this topic is also on the agenda for the next Regional Joint Committee (RJC) meeting. It was agreed that the most appropriate forum would be determined by the relevant Executive Leads. In response to the first query, around the target implementation date, Ms Victoria Coppack advised that the risk assessment for risk 1664 has been updated, with a first draft prepared. It does, however, require discussion with the Head of Assurance and Risk. Certain of the actions within the risk are longer term, as they involve, for example, the regional programme, which will take time to develop and deliver. As such, there are no dates specified for those. **AC/JW**

Decision: The Committee **NOTED** the Corporate Risk: Ophthalmology (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Corporate Risk: Ophthalmology (Reasonable Assurance) Internal Audit report.

Mr Andrew Carruthers, Ms Paula Goode and Ms Victoria Coppack left the Committee meeting.

AC(25)145 **Sickness Management (Limited Assurance)**

Mrs Lisa Gostling and Ms Heather Hinkin joined the Committee meeting.

Ms Corbett introduced the Sickness Management Internal Audit report. This audit had reviewed the arrangements in place for managing sickness absence in compliance with the All Wales Managing Attendance at Work Policy, the training and support available to staff and line managers and the monitoring and reporting arrangements. On the basis of widespread non-compliance with the key requirements of the policy relating to Fit Notes, Return To Work (RTW) interviews and action taken in

relation to review prompts for frequent absences, the audit had concluded Limited Assurance overall. Staff interviewed as part of the audit were aware of the policy requirements, which suggests that non-compliance is due to capacity, culture or both. The policy requires periodic audits of implementation and, whilst ad hoc deep dive reviews are undertaken, these do not consider application of the policy. An action has been agreed, to develop a planned programme of service-led sickness absence reviews, to identify and address the root causes of non-compliance and ensure that service leads are held to account. The areas visited spoke highly of the support and engagement they received from the Workforce team. Whilst there is extensive information and training available, an action has been agreed to strengthen the promotion of resources and support service areas in identifying and addressing any training needs.

Mrs Lisa Gostling wished to clarify that, of the four objectives in the audit, two were rated as Reasonable Assurance, one as Substantial Assurance and one as Limited Assurance. Fundamentally, the issue was a lack of evidence that service areas were managing sickness absence appropriately in the workplace. It was confirmed in the audit that 81% of the records sampled did have the relevant documentation on file (meaning that 19% did not). 89% had completed a RTW interview. Mrs Gostling did not feel that this suggested a major problem across the whole of the organisation, particularly given the sample size. She did acknowledge, however, the need to ensure a planned programme of reviews within service areas. Since January 2025, Mrs Gostling has been contacting all of the services where there has been an improvement in the monthly sickness position, to establish the key actions undertaken which might have contributed to a reduced sickness rate.

Frequently, the feedback has been around the rigour of conducting a RTW sickness review, where service managers examine each of the cases with a member of the Workforce team, to ensure the relevant documentation is in place. She and Ms Heather Hinkin will work with service managers to establish this programme of activity. However, it is important that managers take responsibility for managing their workforce, rather than this being a centrally-led process. The centrally-led elements are those with Reasonable and Substantial Assurance. The area requiring focus will be managers meeting with staff to discuss their sickness absence, identify any support they might need, whether there is any likelihood of a recurrence, etc. In addition, via the Executive Improving Together sessions, there will be a focus on not only the sickness absence percentage, but compliance with the policy.

Ms Sharon Daniel, Ms Janice Cole-Williams and Mr Ben Rees joined the Committee meeting.

In terms of management support, Ms Heather Hinkin indicated that managers often do not have time to undertake long training programmes; their priority is the specific issue with which they are

dealing. The ‘bite-size’ training sessions will assist in this regard, with a suite of ten 5 minute sessions to support managers in managing sickness absence. A programme of work will be rolled-out over the next year, to help staff and managers to understand the process, the importance of timely intervention and the documentation. Currently, there are more than 200 live cases in which the operational Workforce team is involved. There will always be a certain level of sickness absence; however, the organisation is committed to providing all the support it reasonably can, for every case, to enable a return to work as soon as possible. If a return to the substantive role is not possible, this will include consideration of temporary redeployments. The team is also committed to learning from and sharing good practice. Ultimately, however, the Workforce team can only support service managers in supporting their staff.

Building on the comment around sample size, Mr Weir queried whether a sample size of 20 was considered sufficient and requested clarification around the sampling process. He also highlighted that 81% had the relevant documentation on file and 89% had completed a RTW interview. Ms Corbett explained that, whilst the sample consisted of 20 individuals, it involved 91 sickness absences. In response to the comment around percentages, she emphasised that the target for both is 100%. In terms of RTW interviews, nearly 30% of those that had been completed were not undertaken at the time. Some of them were completed several months after the individual had returned to work, which makes the value questionable. It is also important to highlight that, out of the 20 employees and 91 episodes, only 2 employees (8 episodes) were fully compliant with all the controls. Had the non-compliance been related to only a small number of controls, for example, the outcome may have been different.

Mrs Marks shared Mr Weir’s concerns around sample size, and remained concerned. She observed, for example, that no matter how many episodes, a sample of only 20 staff will involve the same managers. Mrs Marks would welcome a further explanation of how sample size is determined and was not convinced that assurance around the process can be taken, given the sample size in this instance. Ms Corbett reiterated that the sample size refers to the number of episodes. Sampling guidance recommends sample size, based on the frequency of a control operation. In this case, guidance suggested approximately 40, with the actual sample size being 91. Ideally, the number of staff sampled would have been larger; however, there are also time constraints in conducting the fieldwork for an audit. To support the approach taken, the same testing has been undertaken as part of the Nursing Management audit, but focused on nursing staff. The findings of the testing for both audits are consistent. Adding the two sample groups together produces a larger population which has been evaluated.

Referencing page 3 of the report, ‘Compliance with the All Wales Managing Attendance at Work Policy’ Mr Weir highlighted the

following: *Managers are required to proactively manage absence where the pattern or frequency gives rise to concern, with the Policy outlining three review prompts. 48% of the sickness episodes triggering a review prompt did not have evidence of appropriate action and escalation in line with Policy.* Noting that records can be both paper-based and electronic, he queried whether there had been any consideration of whether managers had actioned this via the Electronic Staff Record (ESR) system. In response, Ms Corbett indicated that, for these specific prompts, the expectation was for the evidence to be on the employee's file. For example, notes of review meetings held. There was no such evidence on file for the instances of non-compliance. For the other controls, for example RTW interviews, records on ESR had been considered. If there was no RTW form on the employee's file, checks were made to establish whether a RTW interview date was noted on ESR.

Mr Weir was of the opinion that this area was one which probably justified a follow-up audit later in the year. This view was echoed by Mrs Marks, who remained unconvinced by responses around sample size. Mr Weir agreed that the sample used for any future audit should be larger. It was suggested by Mr Thomas that there be a focus at a future meeting on the guidance and principles involved in determining sample size. Ms Hinkin highlighted that three wards were included within the Sickness Management audit, due to absence levels. Meaning that there was potentially some correlation between this sample and the Nursing Management audit. **JJ/SC**

Decision: The Committee **NOTED** the Sickness Management (Limited Assurance) Internal Audit report

The Committee agreed to **ADVISE** the Board in relation to the Sickness Management (Limited Assurance) Internal Audit report.

AC(25)146 Nursing Management (Limited Assurance)

Ms Corbett introduced the report from the Nursing Management Internal Audit, which was a full re-audit following the Nursing Management review undertaken in 2024/25. The audit had focused on rostering processes and absence management, and had concluded Limited Assurance overall. Whilst the findings of this audit were broadly consistent with the 2024/25 review, an improving trend in rostering controls and practices was observed. The objective around absence management reflected a deterioration in sickness management and widespread non-compliance with key requirements of the All Wales Managing Attendance at Work Policy, and had concluded Limited Assurance. Following an earlier comment, Ms Corbett wished to clarify that the Sickness Management audit involved non-nursing staff, whilst this review involved nursing staff. Meaning that there are two distinct samples of staff; however, findings were consistent across the two reviews. For this reason, the same high priority action is included within both reports. Only 10% of the sample was fully compliant, all of which were based in Prince

Philip Hospital. The agreed action has, therefore, been extended to include process mapping good practice there into a guidance document for sharing more widely across the Health Board. Two medium priority findings were also identified, in relation to annual leave utilisation and the approval of agency requests.

Ms Daniel thanked the team for both undertaking the audit, and for the constructive conversation which had taken place as part of the feedback session. As indicated, the previous review had been finalised in November 2024 and this was a further full audit of the system and controls. Ms Daniel wished to highlight improving trends in rostering controls and practice, resulting in Reasonable Assurance for this objective. An improvement in the management of annual leave, with significantly less reliance on temporary staff to backfill was also identified, suggesting a greater stability in the establishment. An improving trend in relation to the review and scrutiny of rosters had resulted in Substantial Assurance for that objective. The Limited Assurance rating in terms of sickness absence is, however, disappointing.

Ms Janice Cole-Williams indicated that the audit had covered eight areas, across all sites, and had identified reasonably consistent practice. The agreed actions are ongoing actions to those already specified. The first, around annual leave utilisation, has been completed by means of an Availability Dashboard. This extends beyond annual leave to include study leave, parental leave and sick leave. Each area can view its own staff allocation and availability. The data is populated from the rostering system on a weekly basis and is, therefore, relatively ‘live’ in terms of its status. The system includes acceptable parameters and will highlight any deviation from these. Thereby identifying over- or under- allocation of annual leave, which places a pressure elsewhere in the rostering process. The dashboard went live at the beginning of August and is now available to all roster areas.

In terms of the next action, as part of the response to the first audit six months ago, an SOP has been developed around rostering and escalation of unfilled shifts to on-contract agency. This does involve escalation to the Head of Nursing or nominated deputy within the services, and work is underway to refine the authorisation process. It is not necessarily clear currently who adds the authorised shift to the Allocate system. The team is working on an electronic authorisation process, which will identify and confirm authorisation at each level and will also provide a clear and robust audit trail. It is anticipated this action will be completed within the agreed timescales.

The final action relates to the sickness and absence management, which the Committee has been discussing in more general terms. The sample size for this audit was 32 employees, a total of 183 episodes, resulting in a working sample of 148 following removal of the incomplete documentation. The Nursing and Workforce teams are working on training programmes and applying the QI methodology to identify and share good practice. Following the

first audit, there had been a focus on raising awareness of the process. The aim going forward is to ensure a focus on application of the process, as opposed to awareness.

Mr Weir noted that this was the second audit of this area which had received a rating of Limited Assurance. Whilst there appears to be 'buy in' from corporate nursing, he requested assurance that this exists within the operational parts of the organisation; in each hospital site and each senior nursing team. In response, Members heard that a Task and Finish Oversight Group has been established, which includes operational nursing representation at Head of Nursing and Assistant Director level. There is also a rostering group, aimed at roster managers and senior nurses. A more targeted approach has been taken to repeated issues around roster management during the last six months. With the new CCG structure, there is potential to focus it even further. Ms Daniel indicated that, in addition to the targeted approach, which will be continued, the 'appreciative inquiry' approach will also be utilised. This will identify where processes are working well and share that best practice across the organisation, focusing on continuous improvement.

Impressed that the Availability Dashboard has been implemented ahead of schedule, Mr Weir enquired whether this data is shared routinely with operational teams, to open a dialogue on this topic. Ms Cole-Williams advised that the data is available on a 'rolling' basis to roster managers and, additionally, a monthly report is produced. Returning to the issue around approval of agency requests, Mr Weir understood that agency usage is now intended to be low. In view of this, he queried whether it should, in fact be a relatively senior member of staff inputting agency requests, if their use is being discouraged. Ms Cole-Williams clarified that the process is in place for senior authorisation (by a Head of Nursing). The issue is the actual data entry of an approved shift on the roster, and whether this is an appropriate use of their time. Conversely, without this, there can be a perception that the shift has not been approved. Hence the work to make the authorisation process more transparent, and potentially electronic.

Regardless of debates around sample size, etc, Mr Davies highlighted that the organisation has received two Limited Assurance reports which have received that rating for one reason – sickness absence management. It was further highlighted that these will be reported to Welsh Government; there is a clear need for action. Mr Weir agreed, emphasising the common thread between the two reports, and queried how they should be taken forward. Mrs Marks shared these views, with the audits clearly indicating an issue around sickness management which must be recognised, 'owned' and addressed by the Health Board. Nevertheless, she remained concerned around sample size, and the fact that a Limited Assurance opinion has been extrapolated from this, which will be reported to Welsh Government.

In terms of how this matter will be progressed, it was suggested that it could be referred to PODCC. However, there was also a sense that there may need to be consideration of the operational controls in place such as SOPs, which may require a more audit-based approach. Ms Daniel emphasised that it is possible for the policy to be implemented as intended; as evidenced within the audit. She reiterated the value of the 'appreciative inquiry' and Quality Improvement approach, process-mapping examples of good practice. If upscaled within nursing areas alone, it would offer the opportunity to influence significant numbers. Mrs Gostling echoed this view, emphasising the need for a different focus – on the sickness absence and policy rather than percentages. She also highlighted that the policy actually states RTW interviews should be undertaken as soon as possible after the return, not a week; meaning that it might be longer, if (for example) a manager is on annual leave. This is an example of where there needs to be care to ensure that audits utilise the same metrics as policies, etc. The Health Board can work with Internal Audit to support this.

Decision: The Committee **NOTED** the Nursing Management (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Nursing Management (Limited Assurance) Internal Audit report.

AC(25)147 Financial Assurance Report

Mr Thomas presented the Financial Assurance Report, highlighting that the format has been changed to reflect the reporting approach utilised for FPC and the Board. In terms of 'Advise' items, he drew Members' attention to breaches of Standing Financial Instructions (SFIs) and the use of retrospective Purchase Orders, reported in Appendix 1c. An active programme is in place to address these; however, they remain a challenge. He also wished to advise the Committee around the level of salary overpayments. Whilst the number has increased, the average recovery period continues to decrease compared to the last two months. The report also provides assurance around compliance with the No PO, No Pay Policy and Public Sector Payment Policy; management of Single Tender Actions (none since March 2024); and compliance with employment tax requirements.

Mr Weir welcomed the new report format and the clarity that it provides. Noting that breaches of SFIs were a concern for the Committee, he enquired whether these occur in the same, or different service areas. Whilst recognising the need to highlight these to ARAC, Mr Thomas emphasised that the SFIs reported are not material in nature. Generally, there is no consistency in their occurrence. However, if repeated breaches are evident, there is a programme of education in place. Observing that, despite working groups, etc, overpayments of salary are continuing to occur, Mr Weir requested assurance that there is progress in this area. In response, Mr Thomas suggested that there is limited scope for action, until a digital system is fully implemented. Members were reminded that a new ESR system is due for roll-

out. However, even with digitalisation, Mr Thomas was concerned that those areas where there are most issues will remain challenging. As explained previously, one of these is Estates and Facilities, where there is a small number of supervisors (not senior managers) for large numbers of Band 2 and 3 staff. The latter are extremely 'mobile' in terms of skillset and notice period required, and sometimes leave without working their notice. It is, therefore, challenging to manage the processes associated with this workforce. The team will, however, continue to explore opportunities for improvement.

Decision: The Committee:

- **DISCUSSED** the breaches of SFIs as detailed.
- **DISCUSSED** the staff overpayments as detailed and **TOOK ASSURANCE** that actions to control them are sufficiently embedded.
- **DISCUSSED** losses as detailed, noting that there were none requiring approval.
- **TOOK ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO, No Pay policy; to ensure Public Sector Payment Policy (PSPP) compliance; to manage Single Tender Actions (STAs) and to ensure National Minimum Wage (NMW) compliance.
- **SCRUTINISED** the award of contracts listed.

The Committee agreed to **ADVISE** the Board in relation to Breaches of SFIs.

AC(25)148 Counter Fraud Update

Mr Ben Rees introduced the Counter Fraud Update report, drawing Members' attention to the 'Inform and Involve' section. An increase in staff reading Counter Fraud alerts via Viva Engage has been noted, with more than 5,000 individuals viewing the posts. As a result, the team is planning to adopt an approach to raising awareness which will consist of 'bite-size' information issued via this platform, similar to Instagram or Facebook. In terms of 'Prevent and Deter', a proactive exercise has been conducted around Nursing and Healthcare Support Workers (HCSW) agency and Bank staff; in response to a Fraud Prevention Notice and identified risk. This had involved the verification of ward-based procedures and identification checks. Further detail is included as part of the In-Committee report, and a full report will be provided to the next meeting.

Members also heard that the Counter Fraud team is taking steps to develop further data analytics, to identify potential fraud trends. This will assist in identifying areas of weakness, proactive work and actions required. Appendix A outlines some of the data collated since 1 April 2024. The report is in its infancy, and the team will work with others to develop it further to make the format more accessible. Ultimately, the intention would be to utilise the data in developing future fraud prevention activities, and ideally in

addressing risks before they arise. It may identify patterns in certain types of fraud or behaviour, for example. Finally, Mr Rees advised that a review of the Counter Fraud, Bribery and Corruption Policy has been undertaken, this being the next agenda item.

Mr Weir commended the proactive exercise undertaken, and welcomed the move to include more data analytics; especially the presentation of the latter, and the potential it offers to identify areas of concern. He noted, for example, that the graph outlining Fraud Cases by Site Location highlighted higher numbers at GGH than the other hospital sites. Mr Rees agreed that the intended use of analytics will allow detailed consideration of data such as this, to establish whether targeted work is required.

Decision: The Committee **RECEIVED** for information the Counter Fraud Update Report and appended items.

AC(25)149 Counter Fraud, Bribery and Corruption Policy Review

Members were advised that the Policy had been reviewed and amended to reflect recent changes in legislation. It had also been subject to the required consultation process, and as a result, further minor amendments had been made.

Decision: The Committee **REVIEWED** and **APPROVED** the Health Board's Counter Fraud, Bribery and Corruption Policy (815).

Mr Ben Rees left the Committee meeting.

AC(25)150 Risk Assurance Report

Miss Wilmshurst introduced the Risk Assurance Report, noting that this is intended to provide assurance on the effectiveness of the Risk Management Framework and implementation of the Risk Management Strategy. The figures in the report are as at the end of June 2025; there are 579 open risks on DATIX, with Estates and Facilities and Planned Care reporting the most risks. There has been an improvement in risk reviews, a concern previously raised by the Committee, with very few overdue by more than a month. However, there will continue to be a focus on this area. In terms of Planned Care (previously in escalation for risk management), as at the end of June this service area has reached 95% compliance. There are improvements in terms of the average age of a risk, with 21% of these being pre COVID-19 and the average risk age being approximately 3 years and 5 months. Most of the older risks on DATIX are in Facilities and Estates; however, they are reviewing their risk register and undertaking a cleanse of risks. The majority of risks relate to the aging infrastructure and equipment, with an inability to address these due to limited capital and other priorities. Since introduction of the mandatory requirement around rationale for Target Risk Score (TRS) and the date services expect to achieve this, many are citing the lack of available funds as a barrier to setting and achieving a lower TRS.

Mr Davies noted that the Target Risk Score for Risk 1032 (Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity) has increased from 16 to 20. He enquired regarding the process in terms of that risk, once the TRS is achieved. In response, Miss Wilmshurst advised that once the TRS is reached, there should be consideration of whether the service is satisfied with it being set at that level, or whether it needs to be further treated or escalated, if this is not within its gift to manage. This specific issue was highlighted by the Executive Team (ET) during their risk session at the beginning of the month. Mr Carruthers had committed to speak to the service and establish whether there are any further actions which can be taken, to set a lower TRS. Mr Thomas confirmed this discussion, emphasising that ET had not been satisfied with the response and had requested this be considered further. It should be recognised as a positive, however, that the Health Board is participating in more mature discussions around risk.

Mrs Marks highlighted page 11 of the report, and the 'Level 3 – No Assurance' section around Planned and Specialist Care. In view of the obvious issues in this area, she would have welcomed a comment from the relevant Executive Lead and team, to provide assurance around how they will improve this level. She requested that this feedback be flagged to the Chief Operating Officer. Mr Weir suggested that the data on page 10 of the report is extremely powerful and that it reflects earlier comments around the organisation undertaking more mature discussions regarding risk. Whilst the risk might not necessarily diminish or disappear, it is being examined in a more integrated way. He enquired regarding risk management training across the organisation and whether the 'Four T's' approach (Treat, Tolerate, Terminate, Transfer) is embedded and understood. In other words, whether risks are recognised, owned and managed by services; as opposed to being simply added to a risk register. Whilst accepting that there is always more which could be done, Miss Wilmshurst emphasised that the Assurance and Risk team does provide this type of support to services. **CW**

With regard to Mr Davies' comment around high TRS, Miss Wilmshurst indicated that this type of issue requires services to undertake further discussion to determine the approach to be taken in managing the risk. Whether they will try to access more treatment, or whether they accept that risk score and escalate it through their corporate governance or operational governance structures, up through IQFPD to ET and to the Board. The team also support services with this aspect. In response to Mrs Marks' comment, and in terms of action taken, the escalation criteria has been strengthened. In addition to the number of reviews being undertaken or compliance figures; it is recognised that there are risks being managed by CCGs or executive functions which are not on risk registers. Consideration is also given to whether risks are being escalated through governance structures, where there are concerns. As indicated by Mr Thomas, this forms part of a

general approach of establishing a more intelligent dialogue with services about their risk management.

Decision: The Committee **TOOK ASSURANCE** on risk management arrangements and processes in order to report progress to the Committee, including the revised performance management arrangements.

AC(25)151 Risk Management Framework and Strategy

Miss Wilmshurst presented the Risk Management Framework, which has been amended to reflect changes to the operational structure and includes a training needs analysis. This has been considered by ET and subject to the Written Control Document process, with suggested amendments incorporated.

Decision: The Committee **APPROVED** the Risk Management Framework, prior to its submission to the Board for onward ratification on 25 September 2025.

Miss Wilmshurst presented the Risk Management Strategy, to which three new risk management objectives have been added. This will be supported by an implementation plan and updates on progress will be provided through the Risk Assurance report going forward. Again, this has been considered by ET.

Decision: The Committee **APPROVED** the Risk Management Strategy, prior to its submission to the Board for onward ratification on 25 September 2025.

AC(25)152 Post Payment Verification (PPV) Annual Report

Ms Amanda Legge, Ms Sue Tillman and Ms Jill Paterson joined the Committee meeting.

Mr Thomas and Ms Amanda Legge introduced the Post Payment Verification (PPV) Annual Report. Ms Legge advised that a significant programme of work had been undertaken in 2024/25, in recognition of the need to address outstanding visits, an issue nationally. Whilst this has been achieved for the routine visits that were due, a recovery plan for the revisits is being explored. PPV teams have been requested by Welsh Government to undertake new service checks in relation to COVID-19 and Respiratory Syncytial Virus (RSV) vaccinations. Programmes of work for Ophthalmic and Pharmacy services are generally up to date. There has been a reform in relation to the Welsh General Ophthalmic Services (WGOS), resulting in new service checks for WGOS 4; glaucoma and retinal reviews. Information on urgent prescribing for independent prescribers will be included on reports going forward, as there will be potential recoveries this financial year. New national initiatives to avoid clinical waste and save money are being explored. Locally, training continues with all relevant parties, and there is close working with Counter Fraud. As indicated in the report, there were two significant recoveries, which were in the same practice (Practice 1 and Practice 16). The

Health Board is aware of the issue and there has been liaison with Counter Fraud.

Mr Davies queried the variation in amount recovered between Practice 1, 5 and 16. In Practice 1, there were 178 errors and a recovery of 99.4%; in Practice 5, there were 245 errors, but a recovery of only 7.83%; in Practice 16, there were 243 errors, with a recovery of 62.95%. In response, Ms Legge advised that revisits will always check 100% of the service that was flagged as an over 10% error rate during a routine visit. A high error rate generally indicates an issue in terms of learning or education required; it may be a new specification, for example. Practice 1 was such a revisit, checking only the minor surgery specification. Of the 179 minor surgeries checked, only 1 was correct and appropriately claimed and paid, the other 178 were erroneous. Ms Legge agreed that this was exceptionally high, and understood that discussions are taking place between the Health Board and practice to clarify the issue.

The team was requested by the Health Board (based on a high error percentage) to undertake another routine visit within the year; recorded as Practice 16. Being a routine visit, the 243 was a set from each actual individual service specification. The overall (the 62.95%) was in relation to minor surgery. Ms Sue Tillman, who had undertaken this visit, was asked to clarify further. She confirmed that this was correct, adding that the recovery percentage is taken out of the amount of what is visited. So in reference to Practice 5, the reason for a recovery of 7.83% was that out of 3,127 claims checked, there were 245 errors. Recognising that this query had arisen from a misinterpretation of the figures, Mr Thomas suggested that the relevant column title be changed in future reports to read ‘Error Percentage’.

Mr Weir further suggested that future reports adopt the ‘3As’ format utilised in other Health Board and ARAC reports. Also, that year-end reports include a trend analysis across the year, to assess whether there have been improvements. These changes would assist the Committee in judging whether it can take assurance in this area. Ms Legge committed to consider and act on all feedback. She suggested that the increased workload within Primary and Community Care could also be reflected in the year-end report, by the addition of a comparison between years. **AL/ST**

Decision: The Committee **NOTED** and **TOOK ASSURANCE** from the contents of the Post Payment Verification (PPV) Annual Report.

AC(25)153 **Primary Care PPV Report**

Ms Jill Paterson presented the Primary Care PPV Report, emphasising that figures are consistent between this and the wider PPV report discussed under the previous item. The Primary Care PPV Report, however, provides additional context around training, development and educational activities undertaken, etc. One of the common themes within the reports is a lack of

supporting evidence for claims. This is a key area of work for the Primary Care team to pursue with practices. Ms Paterson wished to assure Members that learning from PPV visits and reports is recognised and addressed. The report also highlights that there have been a number of Community Pharmacy PPV visits with no recoveries, and a small number of recoveries for General Ophthalmic Services. As mentioned in the previous item, the new Eye Care pathways were implemented in October 2024. The next round of visits in ophthalmic services will begin to reflect those new pathways and the associated claims.

Referencing the issue noted on page 15 of the report around practice migrations from VISION to EMIS, Mr Davies enquired whether this is being addressed for future migrations. Ms Paterson advised that a great deal of learning is being obtained from previous migrations. Whilst she was not aware of a recurrent theme in terms of this particular issue, she assured Members that it would be monitored. Mr Weir thanked Ms Legge, Ms Tillman and Ms Paterson for their contributions.

Decision: The Committee:

- **NOTED** the information contained within the Primary Care PPV Report.
- **NOTED** that the Primary Care team continues to work with all contractors and their professional representative bodies on the quality of claiming and continues to respond to individual claiming queries from the outset. PPV is discussed at GMS Contractual Assurance visits and training is offered by the PPV Team.
- **TOOK ASSURANCE** that appropriate liaison is undertaken with the Counter Fraud Team when there are any concerns, or information needs to be queried.

Ms Amanda Legge, Ms Sue Tillman and Ms Jill Paterson left the Committee meeting.

AC(25)154 Audit Wales - Letter regarding Future Report Writing Style

Discussed under AC(25)137, Audit Wales Update Report.

AC(25)155 ARAC Workplan 2025/26

The Committee **NOTED** the Audit Work Programme 2025/26, which will be updated in line with discussions and to align with Audit Wales and Internal Audit Plans.

AC(25)156 Any Other Business

There was no other business reported.

AC(25)157 Matters and Risks for Escalation to the Board

As noted.

AC(25)158 Date and Time of Next Meeting

9.30am, 14 October 2025