Pwyllgor Sicrwydd ac Archwilio Llawn (Agored)

Tue 12 April 2022, 10:20 - 12:30

Agenda

10:20 - 10:30
10 min

1. MATERION RHAGARWEINIOL

1.1. Croeso a Chyflwyniadau

Cadeirydd/Llafar

1.2. Ymddiheuriadau am Absenoldeb

Cadeirydd/Llafar

1.3. Datganiadau o Ddiddordeb

Cadeirydd/Llafar

1.4. Cofnodion drafft cyfarfod y Pwyllgor Archwilio a Sicrwydd a gynhaliwyd ar 7 Chwefror 2022

Cadeirydd/Atodiad

1.4 - Cofnodion Drafft Cyfarfod AAC 220207 (Agored)(F).pdf (9 pages)

1.5. Cofnod o Gamau Gweithredu o gyfarfod y Pwyllgor Archwilio a Sicrwydd a gynhaliwyd ar 7 Chwefror 2022

Cadeirydd/Atodiad

1.5 - Cofnod o Gamau Gweithredu AAC 220207 (Agored)(F).pdf (1 pages)

1.6. Materion yn Codi

Cadeirydd/Llafar

10:30 - 12:25
115 min

2. MATERION I'W HYSTYRIED

2.1. Proses Gymeradwyo ar gyfer Comisiynu Addysg fel rhan o'r Adolygiad Strategol o Gam 2 Addysg (SREP2)

Ysgrifennydd y Bwrdd/Atodiad

2.1 - Y Broses Gymeradwyo ar SREP2 - AAC 220412 (F).pdf (4 pages)

2.2. Ymholiadau Archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli

Cyfarwyddwr Cyllid/Atodiadau

English Cathedral 04/11/2022 11:27:41

2.2a - Ymholiadau Archwilio - AAC 220412 (F).pdf (3 pages)
2.2b - Audit Enquiries - Appendix 1 - AAC April 22 (F).pdf (20 pages)

2.3. Archwilio Mewnol

2.3.1. Adroddiad Cynnydd

Archwiliad Mewnol/Atodiadau

- 2.3.1a - Archwilio Mewnol Adroddiad Cynnydd - AAC 220412 (F).pdf (2 pages)
- 2.3.1b - IA Progress Report - AAC April 22 (F).pdf (5 pages)
- 2.3.1c - Project Management Internal Audit Report (F).pdf (17 pages)
- 2.3.1d - Risk Management Internal Audit Report (F).pdf (16 pages)

2.3.2. Drafft Cynllun Blynyddol 2022/23

Archwiliad Mewnol/Atodiadau

- 2.3.2a - Cynllun Blynyddol 202223 Drafft - AAC 220412 (F).pdf (2 pages)
- 2.3.2b - IA Audit Plan 2022 - AAC April 22 (F).pdf (24 pages)

2.4. Archwilio Cymru

Cyfarwyddwr Caffael PCGC/Cyflwyniad

2.4.1. Adroddiad Cynnydd

Archwilio Cymru/Atodiad

- 2.4.1a - Archwilio Cymru Adroddiad Cynnydd - AAC 220412 (F).pdf (1 pages)
- 2.4.1b - Audit Wales Progress Report - AAC April 22 (F).pdf (8 pages)
- 2.4.1c - Audit Wales Review of Annual Commissioning - AAC April 22 (F).pdf (22 pages)

2.4.2. Cynllun Archwilio Blynyddol a Ffi 2022

Archwilio Cymru/Atodiad

- 2.4.2a - Cynllun Archwilio Blynyddol 2022 a Ffi - AAC 220412 (F).pdf (1 pages)
- 2.4.2b - Audit Wales 2022 Audit Plan - AAC April 22 (F).pdf (12 pages)

2.5. Adroddiad Cydymffurfiad Caffael

Cyfarwyddwr Cyllid & Pennaeth Caffael/Atodiadau

- 2.5a - Adroddiad ar Gydymffurfiaeth Prosesau Caffael - 220412 (F).pdf (5 pages)
- 2.5b - Procurement Compliance Report - Appendix 1 and 2 - AAC March 22 (F) .pdf (5 pages)
- 2.5c - Procurement Compliance Report - Appendix 3 - AAC March 22 (F).pdf (2 pages)

2.6. Adroddiad Cynnydd a Chylchlythyr Gwrth-Dwyll

Rheolwr Gwrth-Dwyll/Atodiadau

- 2.6a - Gwrth-Dwyll Adroddiad Cynnydd - AAC 220412 (F).pdf (4 pages)
- 2.6b - Counter Fraud Progress Report Appendix 1 - AAC April 2022 (F).pdf (12 pages)

2.7. Adolygiad o'r Adroddiad Blynyddol

Ysgrifennydd y Bwrdd/Atodiad

- 2.7a - Datganiad Llywodraethu 202122 - AAC 220412 (F).pdf (3 pages)
- 2.7b - Draft Governance Statement 2021-22 - AAC April 22 (D).pdf (27 pages)

2.8. Adroddiadau Llywodraethu Gwybodaeth a Rheoli Gwybodaeth

Ysgrifennydd y Bwrdd/Atodiadau

English,Catherine
04/11/2022 11:41:41

- 2.8.1 - Adroddiad ar Faterion Allweddol IGIMG - AAC 220412 (F).pdf (5 pages)

2.9. Adolygiad o Effeithiolrwydd y Pwyllgor 2021/22

Ysgrifennydd y Bwrdd/Atodiadau

2.9a - Adolygiad o Effeithiolrwydd Pwyllgorau 202122 - AAC 220412 (F).pdf (3 pages)
2.9b - Appendix 1 - Checklist - AAC April 22 (F).pdf (10 pages)

2.10. Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd 2021/22

Ysgrifennydd y Bwrdd/Atodiadau

2.10a - Adroddiad Blynyddol Pwyllgor Archwilio a Sicrwydd 202122 - AAC 220412 (F).pdf (3 pages)
2.10b - AAC Annual Report 2021-22 (D).pdf (10 pages)

2.11. Cofrestr Risg Corfforaethol

Ysgrifennydd y Bwrdd/Atodiadau

2.11a- Cofrestr Risg Corfforaethol - AAC 220412 (F).pdf (6 pages)
2.11b - Appendix 1 - Corporate Risk Register (F).pdf (7 pages)
2.11c - Appendix 2 - Strategic Risks (F).pdf (2 pages)

2.12. System Tracio Argymhellion Archwiliad

Ysgrifennydd y Bwrdd/Atodiadau

2.12a - System Tracio Argymhellion Archwiliad - AAC 220412 (F).pdf (6 pages)
2.12b - HEIW Audit Tracker (March 22).pdf (4 pages)

12:25 - 12:25
0 min

3. ER GWYBODAETH

Dim

12:25 - 12:30
5 min

4. CLOI

4.1. Unrhyw Fater Arall

Cadeirydd/Llafar

4.2. Dyddiad y Cyfarfod Nesaf

Cadeirydd/Llafar

English,Catherine
04/11/2022 11:17:41

HEB EU CADARNHAU

Cofnodion y Pwyllgor Archwilio a Sicrwydd
a gynhaliwyd ar 7 Chwefror 2022 rhwng 10:30 a 12:30
Trwy Zoom

Yn bresennol:

Gill Lewis	Aelod Annibynnol (Cadeirydd)
Dr Ruth Hall	Aelod Annibynnol
Dr Heidi Phillips	Aelod Annibynnol

Yn bresennol:

Dafydd Bebb	Ysgrifennydd y Bwrdd
Rhiannon Beckett	Cyfarwyddwr Cyllid Dros Dro
Sian Richards	Cyfarwyddwr Digidol (Rhan)
Martyn Pennell	Pennaeth Cyfrifyddu Ariannol
Paul Dalton	Pennaeth Archwilio Mewnol (PCGC)
Emma Samways	Dirprwy Bennaeth Archwilio Mewnol (PCGC)
Kenneth Hughes	Rheolwr Archwilio (PCGC)
Nigel Price	Arbenigwr Atal Twyll Lleol
Helen Goddard	Rheolwr Archwilio (Archwilio Cymru)
Clare James	Cyfarwyddwr Cyfrifon Dros Dro (Archwilio Cymru)
Catherine English	Rheolwr Llywodraethu Corfforaethol (Ysgrifenyddiaeth)

RHAN 1	MATERION RHAGARWEINIOL	Cam Gweithredu
AAC: 0702/1.1	**Croeso a Chyflwyniadau**	
	Croesawodd y Cadeirydd bawb i'r cyfarfod, yn enwedig Rhiannon Beckett a oedd yn mynychu ei chyfarfod Pwyllgor cyntaf yn ei rôl newydd fel Cyfarwyddwr Cyllid Dros Dro. Cadarnhawyd bod y cyfarfod yn llawn.	
AAC: 0702/1.2	**Ymddiheuriadau am absenoldeb**	
	Cafwyd ymddiheuriadau gan Urvisha Perez, Rheolwr Archwilio (Archwilio Cymru).	
AAC: 0702/1.3	**Datganiadau o Fuddiannau**	
	Nid oedd unrhyw ddatganiadau o fuddiannau.	
AAC: 0702/1.4	**Cofnodion y cyfarfod a gynhaliwyd ar 21 Hydref 2021**	
Wedi'i ddatrys	Derbyniwyd cofnodion y cyfarfod a gynhaliwyd ar 21 Hydref 2021 a'u cymeradwyo fel cofnod cywir o'r cyfarfod.	
AAC: 0702/1.5	**Cofnodion Gweithredu**	

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	Derbyniodd y Pwyllgor y cofnodion gweithredu a **nododd** fod y camau gweithredu wedi'u cwblhau.	
Wedi'i ddatrys	**Nododd** y Pwyllgor y Cofnodion Gweithredu.	
AAC: 0702/1.6	**Materion yn Codi**	
	Nid oedd unrhyw faterion yn codi.	
RHAN 2	**MATERION I'W HYSTYRIED**	
AAC: 0702/2.1	**Cynllun Cyfrifon Blynyddol**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Martyn Pennell ei fod yn rhoi trosolwg o'r cynllun arfaethedig i gau'r cyfrifon ar gyfer blwyddyn ariannol 2021/22 ac yn tynnu sylw at y materion ariannol a thechnegol allweddol a allai effeithio ar gau'r cyfrifon. Cadarnhawyd bod y cynllun i gau'r cyfrifon wedi bod yn destun mân fireinio i adlewyrchu'r gwelliannau a ddynodwyd yn y tîm a thrwy argymhellion archwilio. Nodwyd bod Archwilio Cymru wedi dechrau ei adolygiad cychwynnol o gyfrifon 2021/22 ac y bydd y prif archwiliad yn dechrau ddydd Llun 2 Mai, ar ôl i'r cyfrifon drafft gael eu cyflwyno. Gan dynnu sylw at drefniadau Lwfans Blynyddol y Dreth Bensiynau, eglurodd Martyn Pennell fod AaGIC, yng nghyfrifon 2020/21, wedi datgelu rhwymedigaeth ddigwyddiadol amhenodol yn ymwneud â threth pensiwn clinigwyr. Ar ddyddiad cymeradwyo'r cyfrifon, nid oedd digon o ddata ynghylch y defnydd o'r cynllun i alluogi i asesiad rhesymol gael ei gynnal o'r defnydd a wneir ohono yn y dyfodol. Nodwyd, er bod gwaith yn parhau i ddynodi p'un a oedd unrhyw atebolrwydd o'r fath yn bodoli ar gyfer AaGIC, pe bai angen darpariaeth, roedd perygl y byddai cyfrifon AaGIC yn gymwys gan mai barn yr Archwilydd Cyffredinol oedd y byddai unrhyw drafodion a gynhwyswyd yn natganiadau ariannol yr Awdurdod i gydnabod yr atebolrwydd hwn yn afreolaidd ac yn berthnasol yn ôl eu natur. Ystyriodd y Pwyllgor effaith gwyliau blynyddol a Chynllun Prynu'n Ôl Cymru Gyfan ar y cyfrifon a sicrhawyd y dylai costau cywir fod ar gael erbyn diwedd mis Chwefror.	
Wedi'i ddatrys	**Nododd** y Pwyllgor yr adroddiad er sicrwydd.	
AAC: 0702/2.2	**Adroddiad Cynnydd yr Archwiliad Mewnol**	
	Derbyniodd y Pwyllgor yr adroddiadau. Wrth gyflwyno'r adroddiad, cadarnhaodd Paul Dalton fod dau adroddiad wedi'u cwblhau ers cyfarfod diwethaf y Pwyllgor, a bod gwaith maes yn mynd rhagddo mewn dau faes arall.	

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	Yn ystod y cyfnod, roedd Adroddiad Archwilio Mewnol ar Gynllunio Ariannol ac Adroddiad Archwilio Mewnol ar y System Ail-ddilysu Arfarnu Meddygol (MARS) wedi'u cyhoeddi, gan gael sicrwydd 'cadarn' a 'gweddol sicr', yn y drefn honno. Cadarnhawyd bod y rhaglen waith ar gyfer 2021/22 yn parhau ac y byddai trafodaethau cynllunio gydag AaGIC ar gynllun archwilio 2022/23 yn dod i ben o fewn yr wythnosau nesaf. Nodwyd y byddai cynllun 2022/23 yn cael ei gyflwyno i'r Pwyllgor yn ei gyfarfod ym mis Ebrill. Wrth grynhoi'r adroddiad ar Gynllunio Ariannol, cadarnhaodd Kenneth Hughes fod un argymhelliad o flaenoriaeth isel wedi'i dynodi a bod yr archwiliad wedi cael sicrwydd 'cadarn'. Wrth grynhoi adroddiad y System Ail-ddilysu Arfarnu Meddygol, cadarnhaodd Kenneth Hughes un flaenoriaeth uchel, pedair blaenoriaeth ganolig, ac roedd un argymhelliad o flaenoriaeth isel wedi'i dynodi. Cadarnhawyd bod yr holl argymhellion wedi'u derbyn, a bod yr archwiliad wedi cael sicrwydd 'gweddol sicr'. Ystyriodd y Pwyllgor nifer yr adolygiadau a oedd yn weddill ar gyfer 2021/22, a chadarnhawyd bod gwaith yn mynd rhagddo ynghylch sut y gallem wella'r ffordd y gallwn gyfleu'r rhaglen archwilio i dimau i sicrhau eu bod wedi'u paratoi'n ddigonol. Pwysleisiodd y Pwyllgor bwysigrwydd sicrhau bod staff nid yn unig yn ymwybodol o'r rhaglen archwilio ond o'u rôl a'r hyn y gallant ei ddisgwyl fel rhan o'r broses archwilio. Ystyriodd y Pwyllgor a oedd yr archwiliad yn rhoi sicrwydd bod y System Ail-ddilysu Arfarnu Meddygol yn bodloni ei phrif ddiben o sicrhau bod meddygon yn cael y wybodaeth ddiweddaraf a'u bod yn gweithio'n ddiogel. Cadarnhawyd nad oedd hyn wedi bod o fewn cwmpas yr archwiliad ond y gellid ei gynnwys mewn archwiliad yn y dyfodol. Cytunodd y Pwyllgor ar ddarn dilynol o waith archwilio a fyddai'n ddefnyddiol edrych ar p'un a oedd y System Ail-ddilysu Arfarnu Meddygol yn bodloni ei brif amcanion ac argymhellodd y dylai'r Archwiliad Mewnol ymchwilio ymhellach i hyn.	
Wedi'i ddatrys English Catherine 04/11/2022 11:17:41	Gwnaeth y Pwyllgor • **nodi** Adroddiad Cynnydd Archwilio Mewnol er sicrwydd • **nodi** Adroddiad Archwilio Mewnol ar Gynllunio Ariannol (Sicrwydd Cadarn) • **nodi** Adroddiad Archwilio Mewnol MARS (Sicrwydd Rhesymol) • **argymell** y dylai'r mater o gael sicrwydd bod y System Ail-ddilysu Arfarnu Meddygol yn cyflawni ei phrif amcanion gael ei hystyried ymhellach gan Archwilio Mewnol.	
AAC: 0702/2.3.1	**Adroddiad Cynnydd Archwilio Cymru**	

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	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Clare James ei fod yn rhoi'r wybodaeth ddiweddaraf am waith cyfredol ac arfaethedig Archwilio Cymru. Cadarnhawyd bod y gwaith cynllunio i archwilio cyfrifon 2021/22 wedi dechrau ac y byddai profion dros dro yn dechrau cyn bo hir. Nodwyd ei bod yn ofynnol i gyfrifon drafft gael eu cynhyrchu erbyn 29 Ebrill 2022. Nodwyd bod y gwaith cynllunio ar gyfer 2022/23 yn parhau, a byddai Cynllun Archwilio 2022/23 yn cael ei gyflwyno i'r Pwyllgor Archwilio a Sicrwydd yn ei gyfarfod ym mis Ebrill. Eglurodd Clare James mai prif ffocws Archwilio Cymru yn ystod 2021/22 oedd yr Asesiad Strwythuredig. Cadarnhawyd bod adroddiad Cam 1 yn ystyried trefniadau cynllunio gweithredol AaGIC a'i fod wedi'i gyflwyno i'r Pwyllgor ym mis Gorffennaf. Cadarnhawyd bod Cam 2 yr Asesiad Strwythuredig 2021 wedi ystyried sut mae trefniadau llywodraethu corfforaethol a rheolaeth ariannol wedi addasu dros y 12 mis diwethaf. Tynnwyd sylw at y ffaith mai prif ffocws y gwaith oedd y trefniadau corfforaethol ar gyfer sicrhau bod adnoddau'n cael eu defnyddio'n effeithlon, yn effeithiol ac yn economaidd. Yn gyffredinol, roedd yr adroddiad yn gadarnhaol, a chanfu Archwilio Cymru fod AaGIC yn cael ei lywodraethu'n dda gyda threfniadau clir ac effeithiol i reoli ei gyllid. Wrth roi diweddariad byr ar Adroddiad Gofalu am y Gofalwyr, eglurodd Clare James ei fod yn disgrifio sut yr oedd cyrff y GIG wedi cefnogi lles eu staff yn ystod pandemig COVID-19, gan ganolbwyntio'n benodol ar drefniadau ar gyfer diogelu staff sydd mewn mwy o berygl o gael COVID-19. Tynnwyd sylw at y ffaith bod holl gyrff y GIG wedi rhoi trefniadau ar waith i gyflwyno Adnodd Asesu Risg COVID-19 Cymru Gyfan ar gyfer y gweithlu fel rhan o'u hymdrechion ehangach i ddiogelu aelodau o staff sydd mewn mwy o berygl o gael COVID-19. Fodd bynnag, roedd cyfraddau cwblhau'r Adnodd Asesu Risg drwy'r Cofnod Staff Electronig (ESR) wedi amrywio'n sylweddol rhwng cyrff unigol y GIG. Cadarnhawyd bod y rheolwyr yn ystyried Argymhellion a Rhestr Wirio Gofalu am y Gofalwyr, a byddai'r adroddiad yn dychwelyd i'r Pwyllgor ym mis Ebrill i gael ei ystyried ymhellach. Croesawodd y Pwyllgor yr adroddiadau ac fe'i calonogwyd gan ganfyddiadau Cam 2 yr Asesiad Strwythuredig. Ystyriodd y Pwyllgor oblygiadau'r adroddiad Gofalu am y Gofalwyr ar gyfer AaGIC a nododd y cyfle a gollwyd i gysylltu iechyd a gofal cymdeithasol.	
Wedi'i ddatrys	Gwnaeth y Pwyllgor: • **nodi** Adroddiad Cynnydd Archwilio Cymru er **sicrwydd**.	

English Catherine 04/11/2022 11:17:41

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	• **nodi** Asesiad Strwythuredig 2021 er **gwybodaeth;** • **nodi'r** Adroddiad Gofalu am y Gofalwyr a Rhestr Wirio'r GIG er **gwybodaeth**.	
AAC: 0702/2.3.2	**Adroddiad Blynyddol Archwilio Cymru 2021/22**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Clare James ei fod yn crynhoi canfyddiadau gwaith archwilio a wnaed gan Archwilio Cymru yn 2021 yn Addysg a Gwella Iechyd Cymru (AaGIC), a gynhaliwyd i gyflawni eu cyfrifoldebau o dan y Ddeddf Archwilio Cyhoeddus (Cymru) 2004. Cadarnhawyd bod cyfrifon AaGIC wedi'u paratoi'n briodol a'u bod yn sylweddol gywir a chyhoeddodd Archwilio Cymru farn archwilio ddiamod. Ni ddynododd Archwilio Cymru unrhyw wendidau perthnasol yn rheolaethau mewnol AaGIC, a chyflawnodd AaGIC falans ariannol ar gyfer y flwyddyn a ddaeth i ben ar 31 Mawrth 2021. Tynnwyd sylw at y ffaith bod trefniadau AaGIC ar gyfer paratoi cynlluniau gweithredol a monitro'r modd y'u cyflawnir yn gadarn a bod gan AaGIC drefniadau bwrdd a phwyllgor effeithiol o hyd, system dda o sicrwydd, a'i fod yn gwella ei drefniadau rheoli ansawdd hyfforddiant ac addysg. Croesawodd y Pwyllgor yr adroddiad ac roedd y canfyddiadau cadarnhaol yn galonogol.	
Penderfyniad	**Nododd** y Pwyllgor Adroddiad Blynyddol Archwilio Cymru 2021/22 er **sicrwydd**.	
AAC: 0702/2.4	**Cymorth Caffael i AaGIC**	
	Cyflwynodd Jonathan Irvine, Cyfarwyddwr Caffael PCGC, gyflwyniad ar ddyfodol cymorth caffael i AaGIC.	
Wedi'i ddatrys	**Nododd** y Pwyllgor yr wybodaeth ddiweddaraf.	
AAC: 0702/2.5	**Adroddiad Cydymffurfio â Chaffael**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Christine Thorne fod yr adroddiad yn rhoi'r wybodaeth ddiweddaraf am weithgarwch caffael a gynhaliwyd yn ystod y cyfnod rhwng 24 Medi a 17 Ionawr 2022. Gan roi'r wybodaeth ddiweddaraf am Weithred Tendr Sengl Tracy Mahill (STA), eglurodd Christine Thorne, er bod y gwiriadau safonol arferol wedi'u cynnal, nad oedd y STA coll wedi'i gofnodi'n llawn ar y Gofrestr Contract ac felly nid oedd wedi'i gynnwys yn yr adroddiad cydymffurfio. Eglurwyd y bu absenoldeb sylweddol ar draws y tîm ar yr adeg y digwyddodd y camgymeriad, a fyddai wedi bod yn ffactor cyfrannol. Cadarnhawyd, er mwyn lliniaru'r risg y byddai'n digwydd eto, byddai'r Pennaeth Caffael yn sicrhau bod pob eitem yn cael ei dilysu'n llawn yn erbyn y gofrestr ac yn cynnal gwiriadau pellach yn erbyn copïau o Weithredoedd Tendr Sengl a gedwir yn y ffeiliau.	

English Catherine 04/11/2022 11:17:41

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	Gan roi diweddariad am Gynllun Gwella'r Gwasanaeth Caffael, eglurodd Christine Thorne fod cydweithwyr ym maes Caffael ac AaGIC yn parhau i gyfarfod yn rheolaidd a bod un cam gweithredu yn parhau heb ei gwblhau mewn perthynas â chynnal y clinigau caffael. Cadarnhawyd bod 11 o Weithredoedd Tendr Sengl a dyfarnwyd 3 Estyniad i Gontract yn ystod y cyfnod. Tynnwyd sylw at y ffaith bod y cyfrif o 11 Weithredoedd Tendr Sengl yn cynnwys yr hepgoriad o'r Adroddiad blaenorol y Pwyllgor Archwilio a diwygiad yr STA pellach fel cyflwyniad 'ailadroddus' yn hytrach na chyflwyniad 'cyntaf' ar gyfer Tracy Myhill Associates. Nodwyd er bod 'Amberwing' yn STA cyflwyniad cyntaf, bu gwariant blaenorol gydag 'Amberwing' heb fod o dan STA ac roedd ffigwr yr STA yn adlewyrchu'r gwariant cyfunol. Eglurodd Christine Thorne, er bod nifer o STA gwerth uchel, eu bod wedi cael eu harchwilio'n briodol. Ystyriodd y Pwyllgor yr adroddiad a nodwyd y nifer uchel o STA. Eglurwyd bod nifer uchel o STA sy'n gysylltiedig â fferyllfeydd i'w priodoli i'r rhaglen newid sydd ar waith ar hyn o bryd o fewn yr adran Fferylliaeth. Nodwyd bod pob STA yn cael ei harchwilio ar sail unigol ac yn cael eu trafod yn helaeth gyda'r gwasanaeth i sicrhau bod pob STA yn cael eu dyfarnu yn unol â rheolau caffael a Chyfarwyddiadau Ariannol Sefydlog. Trafododd y Pwyllgor bwysigrwydd sicrhau gwerth am arian drwy gystadleuaeth agored a phwysleisiodd bwysigrwydd monitro nifer yr STA yn ofalus. Sicrhawyd y Pwyllgor bod pob STA yn cael eu monitro a'u trafod fel mater o drefn gydag arweinwyr gweithredol a bod rheolaethau priodol bellach ar waith i sicrhau bod unigolion yn adrodd yn gywir wrth edrych tua'r dyfodol.	
Wedi'i ddatrys	**Nododd** y Pwyllgor yr adroddiad er **sicrwydd**.	
AAC: 0702/2.6	**Diweddariad Cynnydd ar Atal Twyll**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, cadarnhaodd Nigel Price ei fod yn rhoi'r wybodaeth ddiweddaraf am holl waith Atal Twyll y GIG a wnaed ar gyfer AaGIC rhwng 1 Hydref 2021 a 31 Rhagfyr 2021. Nodwyd bod y Gwasanaeth Atal Twyll wedi cwblhau 37 diwrnod o waith Atal Twyll ar gyfer AaGIC yn erbyn dyraniad o 50 diwrnod. Eglurwyd bod 15 diwrnod wedi'i ddyrannu ar gyfer gwaith ymchwilio adweithiol ond gan na fu unrhyw achosion yr oedd angen ymchwilio iddynt, gellid ailddyrannu'r diwrnodau hynny gyda chytundeb y Cyfarwyddwr Cyllid. Cadarnhawyd bod y cyflwyniadau ar Atal Twyll yn cael eu cynnal, ac roedd yr adborth wedi dangos bod 95.5% o'r rhai a oedd wedi rhoi adborth yn teimlo'n fwy cyfforddus i godi pryderon yn ymwneud ag atal twyll yn dilyn yr hyfforddiant.	

English Catherine 04/11/2022 11:17:41

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	Cadarnhawyd bod gwaith ar y gweill i adolygu'r gwiriadau diwydrwydd dyladwy y mae asiantaethau cyflogaeth yn eu defnyddio cyn cyflenwi staff i AaGIC ac y byddai adroddiad cynnydd yn cael ei gyflwyno i gyfarfod nesaf y Pwyllgor Archwilio a Sicrwydd. Ystyriodd y Pwyllgor yr adroddiad, a chadarnhawyd mai Martyn Pennell oedd Pencampwr Twyll AaGIC. Cadarnhawyd bod rhai o'r diwrnodau a ddyrannwyd ar gyfer gwaith ymchwilio adweithiol wedi'u hail ddyrannu i gynnwys y gwaith ar y gwiriadau diwydrwydd dyladwy ac y byddai unrhyw ddiwrnodau pellach yn cael eu hailddyrannu mewn trafodaeth â'r Cyfarwyddwr Cyllid.	
Wedi'i ddatrys	**Nododd** y Pwyllgor y Cylchlythyr a'r Adroddiad Cynnydd ar Atal Twyll er **gwybodaeth**.	
AAC: 0702/2.7	**Adroddiadau Llywodraethu Gwybodaeth a Rheoli Gwybodaeth**	
AAC: 0702/2.7.1	**Adroddiad ar Faterion Allweddol**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Dafydd Bebb ei fod yn rhoi diweddariad ar faterion a ystyriwyd gan y Grŵp Llywodraethu Gwybodaeth a Rheoli Gwybodaeth yn ei gyfarfod ar 28 Medi. Cadarnhawyd bod 7 cais Rhyddid Gwybodaeth wedi dod i law yn ystod y cyfnod adrodd, ac yr ymatebwyd i bob un ond un o fewn amser. Cyfradd cydymffurfio'r ceisiadau a dderbyniwyd oedd 86% a chafwyd un cais am adolygiad mewnol yn ystod y cyfnod. Ar ôl cael ei adolygu gan y Cadeirydd yn unol â'n gweithdrefn adolygu fewnol, tynnwyd sylw at y ffaith y cadarnhawyd y penderfyniad gwreiddiol. Cadarnhawyd bod AaGIC hefyd wedi derbyn hysbysiad gan Swyddfa'r Comisiynydd Gwybodaeth (ICO) eu bod wedi derbyn cwyn am y ffordd yr ymdriniwyd ag un cais rhyddid gwybodaeth. Ar ôl cynnal asesiad cychwynnol o'r achos, roedd Swyddfa'r Comisiynydd Gwybodaeth o'r farn ei fod yn gymwys i'w ystyried yn ffurfiol o dan adran 50 o'r Ddeddf Rhyddid Gwybodaeth.	
Wedi ei ddatrys	**Nododd** y Pwyllgor yr adroddiad **er sicrwydd.**	
AAC: 0702/2.7.2	**Diweddariad Pecyn Cymorth Llywodraethu Gwybodaeth**	
English Catherine 04/11/2022 11:17:41	**Derbyniodd** y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Sian Richards ei fod yn rhoi diweddariad ar Gynllun Cyflawni Llywodraethu Gwybodaeth. Yn dilyn sgôr cydymffurfio lefel isel yn y cyflwyniadau gwirfoddol ym mis Mawrth 2021, datblygwyd cynllun cyflawni ar gyfer gwella gyda'r nod o gynyddu sgôr cydymffurfio AaGIC pan fydd cyflwyniad y Pecyn Cymorth wedi'i gwblhau ym mis Mawrth 2022.	

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	Cadarnhawyd bod y cynllun gweithredu yn cynnwys 76 o gamau gweithredu. O'r rhain, aseswyd bod 63 wedi'u cwblhau ac yn wyrdd, roedd 12 yn felyn, ac roedd 1 yn goch. Nodwyd bod y camau gweithredu melyn yn parhau i gael eu datblygu a bod y sefyllfa gyffredinol yn gadarnhaol. Gan roi'r wybodaeth ddiweddaraf am gyflwyniad y Pecyn Cymorth Llywodraethu Gwybodaeth, eglurodd Sian Richards, er bod cynnydd sylweddol wedi'i wneud i sicrhau cydymffurfiaeth bellach, roedd y cynllun gwaith yn cynnwys amrywiaeth eang o gamau gweithredu ar draws AaGIC, ac roedd yn ofynnol i gydymffurfio'n llawn ar draws yr holl gamau gweithredu ar gyfer Lefel er mwyn i'r lefel gael ei dyfarnu. Cadarnhawyd bod y cynllun yn anelu at gyflawni Lefel Un, gyda rhai meysydd yn symud ymlaen i Lefel Dau, ond y bydd methu â chyflawni unrhyw agwedd ar Lefel Un yn golygu na chyflawnir Lefel Un yn gyffredinol. Tynnwyd sylw at y ffaith y byddai'r cyflwyniad yn dangos cynnydd sylweddol ar draws pob thema yn y pecyn cymorth. Croesawodd y Pwyllgor yr adroddiad ac fe'i calonogwyd gan y cynnydd a wnaed hyd yma.	
Wedi'i ddatrys	**Nododd** y Pwyllgor y cynnydd a wnaed o ran gweithgareddau a amlinellir yn y cynllun ar gyfer chwarter un, dau a thri.	
AAC: 0702/2.8	**Y Gofrestr Risg Gorfforaethol**	
	Derbyniodd y Pwyllgor yr adroddiad. Cyflwynodd Dafydd Bebb yr adroddiad gan nodi bod y Gofrestr Risg Gorfforaethol (CRR) yn cynnwys cyfanswm o 10 risg, 1 risg statws coch, 8 risg statws melyn ac 1 risg statws gwyrdd. Mae'r risg goch gyntaf yn ymwneud â seiberddiogelwch, ac roedd cynnydd da yn parhau i gael ei wneud o ran rhoi'r Cynllun Gweithredu Seiberddiogelwch ar waith. Roedd y Pwyllgor yn cefnogi'r awgrym i ddileu'r risg gwyrdd oddi ar y Gofrestr Risg Gorfforaethol.	
Wedi'i ddatrys	**Gwnaeth y Pwyllgor:** • **Nodi'r** adroddiad er sicrwydd; a • **Cymeradwyo** i ddileu'r risg statws 'gwyrdd', risg 16, o'r Gofrestr Risg Gorfforaethol.	**Cwblhawyd**
AAC: 0702/2.9	**Traciwr Argymhellion Archwilio**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, eglurodd Dafydd Bebb fod y Traciwr Argymhellion Archwilio yn cynnwys y camau gweithredu cyfredol y cytunwyd arnynt mewn ymateb i'r argymhellion mewn adroddiadau archwilio a dderbyniwyd gan Archwilio Mewnol ac Archwilio Cymru.	

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	Cadarnhawyd bod y Traciwr Archwilio Mewnol yn cynnwys 25 o argymhellion ar hyn o bryd, ac aseswyd bod 13 ohonynt yn 'wyrdd'. Aseswyd bod 10 yn hwyr. Cadarnhawyd bod rhai o'r camau gweithredu hwyr yn ymwneud â gweithgarwch o ran recriwtio o fewn y Gyfarwyddiaeth Gweithlu a Datblygu Sefydliadol, ac y byddai'r gwaith ar y Cynllun Capasiti yn mynd i'r afael â'r argymhellion hyn. Ystyriodd y Pwyllgor yr adroddiad a thynnodd sylw at bwysigrwydd sicrhau bod camau gweithredu wedi'u cwblhau cyn iddynt gael eu marcio'n wyrdd.	
Wedi'i ddatrys	Gwnaeth y Pwyllgor: • **nodi'r** adroddiad; a • **cytuno** y byddai'r argymhellion gwyrdd, yr aseswyd eu bod wedi'u cwblhau, yn cael eu dileu o'r Traciwr.	**Cwblhawyd**
RHAN 3	**ER GWYBODAETH**	
	Ni dderbyniwyd unrhyw eitemau er gwybodaeth.	
RHAN 4	**CYFARFOD YN DOD I BEN**	
AAC: 0702/4.1	**Unrhyw Fater Arall**	
	Nid oedd unrhyw eitemau eraill o fusnes.	
AAC: 0702/4.2	**Dyddiad y Cyfarfod Nesaf**	
	Dyddiad y cyfarfod nesaf i'w gynnal ddydd Mawrth 12 Ebrill 2022 am 10am i'w gadarnhau naill ai drwy Microsoft Teams neu Ystafell Gyfarfod AaGIC 1, Tŷ Dysgu	

....

Gill Lewis (Cadeirydd) **Dyddiad:**

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Pwyllgor Archwilio a Sicrwydd (Agored)
7 Chwefror 2022
Cofnod o Gamau Gweithredu

(Mae'r Daflen o Gamau Gweithredu hefyd yn cynnwys camau y cytunwyd arnynt mewn cyfarfodydd blaenorol o'r Pwyllgor Archwilio a Sicrwydd ac sy'n aros i gael eu cwblhau neu wedi'u hamserlennu i'w hystyried gan y Pwyllgor yn y dyfodol. Mae'r rhain wedi'u tywyllu yn yr adran gyntaf. Pan gânt eu cymeradwyo gan y Pwyllgor Archwilio a Sicrwydd, bydd y camau gweithredu hyn yn cael eu tynnu oddi ar y daflen weithredu treigl.)

Cyfeirnod y Cofnod	Cam Gweithredu y cytunwyd arno	Arweinydd	Dyddiad Targed	Cynnydd / Wedi'i gwblhau
AAC: 0702/2.8	**Cofrestr Risg Corfforaethol**			
	• Y risg statws 'gwyrdd', risg 16, i'w ddileu o'r Gofrestr Risg Gorfforaethol.	Ysgrifennydd y Bwrdd	1 wythnos	Wedi'i gwblhau
AAC: 0702/2.9	System Tracio Argymhellion Archwiliad			
	• Bod yr argymhellion gwyrdd, yr aseswyd eu bod wedi'u cwblhau, yn cael eu dileu o'r System Tracio	Ysgrifennydd y Bwrdd	1 wythnos	Wedi'i gwblhau

English Catherine
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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.1**
Teitl yr Adroddiad	**Proses Gymeradwyo ar gyfer comisiynu addysg fel rhan o'r Adolygiad Strategol o Addysg (Cam 2) (SREP2)**		
Awdur yr Adroddiad	Martin Riley, Dirprwy Gyfarwyddwr Comisiynu ac Ansawdd Addysg		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Lisa Llewelyn, Cyfarwyddwr Nyrsio ac Addysg Proffesiynol Iechyd		
Pwrpas yr Adroddiad	Rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor am y broses gymeradwyo y cytunwyd arni ar gyfer comisiynu addysg newydd fel rhan o Adolygiad Strategol Addysg (SREP2).		
Prif Faterion	• Mae'r papur yn amlinellu'r broses gymeradwyo ar gyfer SREP2, sy'n cydymffurfio â Rheolau Sefydlog AaGIC a chytunwyd arno gan y Bwrdd ar 31 Mawrth 2022. • Mae proses gymeradwyo glir, gytûn yn rhagofyniad conglfaen i hwyluso cynllunio prosiect yr Adolygiad Strategol o Addysg (Cam 2) (SREP2). • Mae'n ofynnol i Lywodraeth Cymru nodi contractau lle mae cyfanswm gwerth y contract yn fwy nag £1miliwn oni bai ei fod wedi'i gymeradwyo fel rhan o'r cynllun comisiynu addysg a hyfforddiant blynyddol. • Mae'r adroddiad hwn wedi'i ystyried a'i gefnogi gan y Tîm Gweithredol. • Argymhellodd y Pwyllgor Comisiynu ac Ansawdd Addysg yn ei gyfarfod ar 23 Chwefror bod y Bwrdd yn cymeradwyo'r broses gymeradwyo ar gyfer SREP2. • Cymeradwyodd y Bwrdd y broses gymeradwyo yn ei gyfarfod ar 31 Mawrth 2022.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
	✓			
Argymhellion	Gofynnir i'r Pwyllgor **nodi'r** broses ar gyfer comisiynu contractau addysg newydd fel rhan o SREP2 fel y manylir ym mharagraff 4 o'r adroddiad hwn.			

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PROSES GYMERADWYO AR GYFER COMISIYNU ADDYSG FEL RHAN O'R ADOLYGIAD STRATEGOL O ADDYSG (Cam 2)(SREP2)

1. **Rhagarweiniad**

Mae'r adroddiad hwn yn crynhoi'r broses gymeradwyo ar gyfer comisiynu addysg newydd fel rhan o Adolygiad Strategol Addysg (Cam 2) (SREP2). Mae'r broses yn bodloni anghenion presennol a dyfodol gweithwyr gofal iechyd proffesiynol ôl-gofrestru ac mae wedi'i hamlinellu gan werth y contract (<£5m a >£5m) yn unol â therfynau cymeradwyo ariannol dirprwyedig presennol AaGIC fel yr amlinellir yn Rheolau Sefydlog y sefydliad.

2. Cefndir

Bydd SREP2 yn cwmpasu mwy nag 20 o ymarferion caffael ar wahân a fydd yn amrywio yng nghyfanswm gwerth a chymhlethdod y contract o £100mil i £23miliwn. Mae'r broses gymeradwyo yn cyd-fynd â'r Rheolau Sefydlog a'r canllawiau diweddaraf gan Lywodraeth Cymru. Ar hyn o bryd, mae angen rhoi gwybod i Lywodraeth Cymru am gontractau gwerth cyfanswm o £1 filiwn oni bai eu bod eisoes wedi'u cymeradwyo gan Lywodraeth Cymru o dan y cynllun comisiynu addysg a hyfforddiant blynyddol. Dylai Aelodau nodi bod ein Cyfarwyddiadau Ariannol Sefydlog yn cael eu hadolygu ar hyn o bryd gyda Llywodraeth Cymru ac efallai y bydd angen inni hysbysu Llywodraeth Cymru yn y dyfodol hyd yn oed pan fo contract wedi'i gynnwys yn y cynllun addysg a hyfforddiant blynyddol.

Mae sefydlu'r broses gymeradwyo yn hanfodol ar ddechrau unrhyw gaffael gan y bydd hyn yn effeithio ar amserlenni ar gyfer:

• Ymgysylltu â rhanddeiliaid
• Gwerthuso tendr
• Gwobr – sicrhau bod gan ddarparwyr llwyddiannus ddigon o amser i ysgrifennu, achredu addysg, recriwtio a dechrau darpariaeth ar y dyddiad gofynnol

Mae'n hanfodol cynllunio'r defnydd o adnoddau tîm prosiect yn effeithiol, gan gynnwys:

• Rheolwr y Rhaglen
• Y Tîm Caffael
•Ymgynghorydd Cyfreithiol

3. Ymgysylltu

Datblygwyd y broses gymeradwyo gan Uwch Swyddog Risg SREP2, ymgynghorydd cyfreithiol ac arweinwyr caffael; Ysgrifennydd Bwrdd AaGIC a'r Rheolwr Llywodraethu Corfforaethol. Yn ogystal, mae'r Pennaeth Cyfrifyddu Ariannol wedi cynnal cyfarfodydd gyda Llywodraeth Cymru.

Mae'r broses gymeradwyo wedi'i derbyn, ei thrafod, ei hadolygu, a'i hargymell i'w chymeradwyo gan Fwrdd Rhaglen SREP2. Mae Templed Sicrwydd taith addysg SREP2 wedi'i brofi trwy ddogfen Tendr Lefel 4 HCSW, a gymeradwywyd gan y Tîm Gweithredol; ei gymeradwyo gan y Bwrdd a'i gyflwyno i'r Pwyllgor Comisiynu ac Ansawdd Addysg (ECQC) am sicrwydd. Cafodd cynllun y ddogfen ei groesawu a bydd yn sail i ddogfennaeth cymeradwyo caffael yn y dyfodol.

4. Y Broses Cymeradwyo

Mae Rheolau Sefydlog AaGIC yn nodi – yn adran Penderfyniadau a Neilltuwyd ar gyfer y Bwrdd, rhif 33 – Strategaeth a Chynllunio:

[Y Bwrdd] *"Yn cymeradwyo contractau unigol (ac eithrio contractau GIG) uwchlaw'r cyfyngiad a ddirprwywyd i'r Prif Weithredwr a nodir yn y Dirprwyaethau Ariannol."*

Mae'r cyfyngiad ariannol dirprwyedig ar gyfer y Prif Weithredwr, fel y nodir yn yr adran Cynllun Dirprwyo yn y Rheolau Sefydlog, yn nodi, o ran contractau Addysg a Hyfforddiant, bod y cyfyngiad "hyd at £5m".

Felly, mae dau lwybr cymeradwyo Caffael wedi'u mapio;

• contractau lle mae cyfanswm eu gwerth yn llai na £5m a
• contractau lle mae cyfanswm eu gwerth yn fwy na £5m

Gan fod angen hysbysu Llywodraeth Cymru ar hyn o bryd am rai contractau gwerth dros £1m (ac y gallai hyn newid i bob contract fel rhan o'r adolygiad o SFIs), mae'r categori llai na £5m wedi'i rannu'n ddau lwybr caffael;

• contractau lle mae cyfanswm eu gwerth yn llai na £1m a
• contractau lle mae cyfanswm y gwerth rhwng £1m a £5m

I grynhoi, gellir crynhoi'r tri llwybr ar gyfer awdurdod i osod tendr fel;

Out to Tender

	PSG	Exec Team	ECQ Comm	Board	NWSSP Proc.	WG
<£1m	Recommends	Approves	Assurance	Noting	yes	No
<£5m	Recommends	Approves	Assurance	Noting	yes	YES
>£5m	Recommends	Recommends	Assurance	Approval	yes	YES

Ac wedi ei grynhoi ynghylch y penderfyniad i ddyfarnu fel;

Award	PSG	Exec Team	ECQ Comm	Board	NWSSP Proc.	WG
<£1m	Reviews & Recommends	Approved	noting	noting	yes	No
<£5m	Reviews & Recommends	Approved	noting	noting	yes	YES
>£5m	Reviews & Recommends	Recommends	Assurance	Approved	yes	YES

Documentation
High level Summary (Journey/Benefits)
Full ITT, Tender & High level Summary
Standard procurement paper

Mae pob llwybr yn cymryd gwahanol gyfnodau o amser ar y cam cymeradwyo i dendro ac ar y cam cymeradwyo i ddyfarnu a chymerir camau i reoli'r broses mor effeithlon â phosibl.

Mae SREP2 wedi'i grwpio'n 20 caffaeliad / "bwndel" addysg. Gall hyn gynyddu wrth i feysydd angen eraill godi, er enghraifft, addysg yn y Cynllun Iechyd Meddwl. O'r 20 maes a nodir ar hyn o bryd, amcangyfrifir ar hyn o bryd y bydd gan bum gyfanswm gwerth contract o fwy na £5m. Fel yr amlinellwyd uchod, bydd angen i'r contract mwy hwn gael ei ystyried gan yr ECQC yn ogystal â'r Bwrdd.

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Bydd yr Aelodau'n ymwybodol bod y Pwyllgor ECQC yn cyfarfod bob chwarter ar hyn o bryd. I gefnogi bod y contractau £5m yn cael eu hystyried yn gyflym gan yr ECQC, cytunwyd y byddai dau gyfarfod ychwanegol y flwyddyn o'r Pwyllgor yn cael eu trefnu pe bai angen.

Bydd Bwrdd rhaglen SREP2 yn goruchwylio'r gwaith o gynhyrchu dogfennaeth allweddol yn amserol ac yn effeithiol, er mwyn lleihau'r oedi wrth dendro/caffael rhaglenni addysg.

5. Risgiau

Gan y bydd SREP2 yn cwmpasu mwy nag 20 o ymarferion caffael ar wahân, a fydd yn amrywio o ran gwerth a chymhlethdod o £100mil i £23miliwn, bydd yn her sylweddol i AaGIC a'r tîm caffael i reoli proses gomisiynu lwyddiannus a sicrhau gwerth am arian.

Mae proses gymeradwyo glir, y cytunwyd arni'n rhagofyniad conglfaen i hwyluso cynllunio prosiect ar gyfer Cyfnod 2 yr Adolygiad Strategol o Addysg (SREP2) a lliniaru'r risg.

6. Argymhelliad

Gofynnir i'r Pwyllgor nodi'r broses ar gyfer comisiynu contractau addysg newydd fel rhan o SREP2 fel y manylir ym mharagraff 4 o'r adroddiad hwn.

<table>
<tr><th colspan="4">Llywodraethu a Sicrwydd</th></tr>
<tr><td rowspan="4">Dolen i nodau strategol IMTP
(ticiwch ✓)</td><td>Nod Strategol 1:
Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni 'Cymru Iachach'.</td><td>Nod Strategol 2:
Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.</td><td>Nod Strategol 3:
Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel</td></tr>
<tr><td></td><td>✓</td><td></td></tr>
<tr><td>Nod Strategol 4:
Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.</td><td>Nod Strategol 5:
Bod yn gyflogwr da ac yn le gwych i weithio</td><td>Nod Strategol 6:
Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Ansawdd, Diogelwch a Phrofiad Cleifion</td></tr>
<tr><td colspan="4">Mae AaGIC yn comisiynu addysg o ansawdd uchel i sicrhau y darperir gofal diogel i gleifion. Bydd AaGIC yn ceisio sicrwydd ynghylch ansawdd yr addysg yn unol â Fframwaith Ansawdd AaGIC</td></tr>
<tr><td colspan="4">Goblygiadau Ariannol</td></tr>
<tr><td colspan="4">Nid oes unrhyw oblygiadau ariannol yn gysylltiedig â'r adroddiad hwn.</td></tr>
<tr><td colspan="4">Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)</td></tr>
<tr><td colspan="4">Mae'r cynnig wedi'i ddatblygu yn unol â SFI AaGIC</td></tr>
<tr><td colspan="4">Goblygiadau o ran Staff</td></tr>
<tr><td colspan="4">Nid oes unrhyw oblygiadau i staff AaGIC wedi'u nodi.</td></tr>
<tr><td colspan="4">Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Hanes yr Adroddiad</td><td colspan="2">Ystyriwyd yr adroddiad gan y Bwrdd ar 31 Mawrth 2022.</td></tr>
<tr><td colspan="2">Atodiadau</td><td colspan="2">Ddim yn berthnasol</td></tr>
</table>

English Caption 04/11/2021 17:41

Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.2**
Teitl yr Adroddiad	**Ymholiadau Archwilio i'r rhai sy'n gyfrifol am Lywodraethu a Rheoli**		
Awdur yr Adroddiad	Martyn Pennell, Dirprwy Gyfarwyddwr Dros Dro Cyllid		
Noddwr yr Adroddiad	Rhiannon Beckett, Cyfarwyddwr Dros Dro Cyllid		
Cyflwynwyd gan	Rhiannon Beckett, Cyfarwyddwr Dros Dro Cyllid		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Mae'n ofynnol i Archwilio Cymru gynnal archwiliad ariannol blynyddol o AaGIC yn unol â'r gofynion a nodir yn y Safonau Archwilio Rhyngwladol. Fel rhan o'r gofynion hyn, mae Archwilio Cymru wedi ysgrifennu at y 'rhai sy'n gyfrifol am lywodraethu a rheoli' yn AaGIC i geisio sicrwydd ar dri maes penodol, sef twyll, cyfreithiau a rheoliadau a materion sy'n ymwneud â phartïon cysylltiedig. Mae'r papur hwn yn nodi'r ymateb drafft i'r llythyr hwn, y mae angen ei gyflwyno i'r archwilydd erbyn 29 Ebrill 2022.		
Prif Faterion	Mae Atodiad 1 yn nodi'r ymateb ffurfiol i Archwilio Cymru i'w lythyr 'Ymchwiliadau Archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli' ar gyfer 2021/22.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth** ✓	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd: • **Adolygu'r** ymateb drafft i'r llythyr 'Ymchwiliadau archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli' ar gyfer y cyfnod 1 Ebrill 2021 i 31 Mawrth 2022, a chynnig diwygiadau yn ôl yr angen; a • **Cymeradwyo** i gyflwyno'r llythyr i Archwilio Cymru.		

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YMHOLIADAU ARCHWILIO I'R RHAI SY'N GYFRIFOL AM LYWODRAETHU A RHEOLI

1. RHAGARWEINIAD

Mae'r papur hwn yn nodi'r ymateb ffurfiol i Archwilio Cymru i'w lythyr 'Ymholiadau Archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli' ar gyfer 2021/22 i'w ystyried gan y Pwyllgor Archwilio a Sicrwydd.

2. CEFNDIR

Mae'n ofynnol i Archwilio Cymru gynnal archwiliad ariannol blynyddol o AaGIC yn unol â'r gofynion a nodir yn y Safonau Archwilio Rhyngwladol. Fel rhan o'r gofynion hyn, mae Archwilio Cymru wedi ysgrifennu at y 'rhai sy'n gyfrifol am lywodraethu a rheoli' yn AaGIC i geisio sicrwydd ar dri maes penodol, sef twyll, cyfreithiau a rheoliadau a materion sy'n ymwneud â phartïon cysylltiedig.

Mae'r papur hwn yn nodi'r ymateb drafft i'r llythyr hwn, y mae angen ei gyflwyno i'r archwilydd erbyn 29 Ebrill 2022.

3. CYNNIG

Mae'r ymateb arfaethedig i lythyr Archwilio Cymru wedi'i gynnwys yn atodiad 1 i'w ystyried.

4. MATERION LLYWODRAETHU A RISG

Mae'r llythyr drafft sydd wedi'i gynnwys yn atodiad 1 yn nodi'r ddealltwriaeth gyfredol o'r sefyllfa lywodraethu yn y sefydliad.

5. GOBLYGIADAU ARIANNOL

Nid oes goblygiadau ariannol yn gysylltiedig â'r papur hwn.

6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd:

- **Adolygu'r** ymateb drafft i'r llythyr 'Ymchwiliadau archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli' ar gyfer y cyfnod 1 Ebrill 2021 i 31 Mawrth 2022, a chynnig diwygiadau yn ôl yr angen; a
- **Cymeradwyo** cyflwyno'r llythyr i Archwilio Cymru.

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Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
	✓	✓	✓
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓	✓	✓

Ansawdd, Diogelwch a Phrofiad Cleifion	
Nid oes unrhyw effaith ar ansawdd, diogelwch a phrofiad y claf.	
Goblygiadau Ariannol	
Nid oes unrhyw oblygiadau ariannol o ganlyniad i'r papur hwn.	
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)	
Nid oes unrhyw oblygiadau cyfreithiol.	
Goblygiadau o ran Staff	
Nid oes unrhyw oblygiadau staffio uniongyrchol.	
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)	
Nid oes unrhyw oblygiadau hirdymor.	
Hanes yr Adroddiad	Dim ar gyfer blwyddyn ariannol 2021/22
Atodiadau	Atodiad 1 - Ymholiadau archwilio i'r rhai sy'n gyfrifol am lywodraethu a rheoli 2021/22

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Rhiannon Beckett
Interim Director of Finance

Gill Lewis
Chair of Audit and Assurance Committee

Health Education and Improvement Wales

Via e-mail

Reference: HEIW/TCWG 2022

Date issued: 8 March 2022

Dear Rhiannon and Gill

Health Education and Improvement Wales – year ended 31 March 2022

Audit enquiries to those charged with governance and management

As you will be aware, we are required to conduct our financial audit in accordance with the requirements set out in International Standards on Auditing (ISAs). As part of the requirements of the ISAs I am writing to you to formally seek your documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements. These considerations are relevant to both Health Education and Improvement Wales management and 'those charged with governance' the Audit and Assurance Committee.

I have set out in the attached appendices the areas of governance on which we are seeking your views.

The information you provide will inform our understanding of Health Education and Improvement Wales and its business processes and support our work in providing an audit opinion on your financial statements for the period ended 31 March 2022.

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I would be grateful if you could complete the tables in the attached Appendices, which should be formally considered and communicated to us on behalf of both management and those charged with governance by 29 April 2022. In the meantime, if you have queries, please me on 029 2032 0642 or helen.goddard@audit.wales.

Yours sincerely

Helen Goddard
Financial Audit Manager

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Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK and Ireland) 240 covers auditors responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Special Health Authority is the Audit and Assurance Committee. Management, with the oversight of (those charged with governance), should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud. for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

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Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons?	The risk that the financial statements are materially misstated due to fraud is considered to be low. The reasons for this assessment are given in the responses to questions 2 to 6 below.	The risk that the financial statements are materially misstated due to fraud is considered to be low. The reasons for this assessment are given in the responses to questions 2 to 6 below.
2. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements?	A range of processes are adopted in HEIW to minimise the risk of fraud including, but not limited to: • The Local Counter Fraud Service is provided to HEIW through a SLA with Cardiff & Vale University Health Board. On an annual basis the scope and the required resources for the service are agreed by the Director of Finance and the plan is submitted to the Audit & Assurance Committee for approval. • The Audit & Assurance Committee provide advice and assurance to the Board and the Chief Executive (who is the Accountable Officer) on whether effective arrangements are in place. This is done through the design and operation of HEIW's assurance framework – which provides support in decision making and in discharging the relevant accountabilities for securing the achievement of its objectives, in	A range of processes are adopted in HEIW to minimise the risk of fraud including, but not limited to: • The Local Counter Fraud Service is provided to HEIW through a SLA with Cardiff & Vale University Health Board. On an annual basis the scope and the required resources for the service are agreed by the Director of Finance and the plan is submitted to the Audit & Assurance Committee for approval. The plan includes an allowance for deterrence activities, including reviewing and developing strategies, and also pro-active detection exercises. The plan for 2021-22 was approved by the Committee at the meeting held on 7th April 2021. During the year no instances of fraud were identified and no investigations were required. • HEIW participates in the biennial National Fraud Initiative exercise. The results of the

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	accordance with the standards of good governance determined for the NHS in Wales. The Committee receives a range of reports to support their role, including updates provided by the Local Counter Fraud Manager. The Committee is required to meet at least quarterly and during 2020/21 has met on: • 1st April 2020 • 6th May 2020 • 26th May 2020 • 16th July 2020 • 20 October 2020 • 18 January 2021	2020-21 scheme were reported to the Audit & Assurance Committee on 21st October 2021, where the Counter Fraud Manager confirmed no cases of fraud had been identified. • The Audit & Assurance Committee provide advice and assurance to the Board and the Chief Executive (who is the Accountable Officer) on whether effective arrangements are in place. This is done through the design and operation of HEIW's assurance framework. This provides support in decision making and in discharging the relevant accountabilities for securing the achievement of its objectives, in accordance with the standards of good governance determined for the NHS in Wales. The Committee receives a range of reports to support their role, including updates provided by the Local Counter Fraud Manager. The Committee is required to meet at least quarterly and during 2021/22 has met on: • 7th April 2021 • 6th May 2021 • 9th June 2021 • 21st July 2021 • 21st October 2021 • 7th February 2022

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Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
	• A comprehensive overview of the counter fraud system and processes relevant to theorganisation has been presented at the HEIW corporate induction sessions, giving all staff an understanding of fraud and how it can be minimised and reported. Further sessions have been provided virtually to management teams. For 2021/22 there is a 'Teams' awareness session booked for each month until December 2021. • During the financial year all Financial Control Procedures (FCPs) were reviewed and all required amendments were approved by the Audit & Assurance Committee in October 2020. An annual review process is in place for all FCPs helping to ensure that all staff are aware of their responsibilities. The organisation is subject to both Internal and External Audit scrutiny. The 2020/21 Internal Audit review of the financial systems was presented to the January 2021 Audit & Assurance Committee and was given a 'Reasonable Assurance' rating	• As required under the Government Functional Standard 'GovS 013: Counter Fraud' HEIW nominated a Fraud Champion during 2021/22. The role of the Fraud Champion is to support and promote the fight against fraud at a strategic level and with other colleagues within their own organisation. The champion will also support the Local Counter Fraud Specialists. The champion has attended a number of training sessions during the year in order to understand the requirements of the position, and a formal plan is being prepared to fully implement the role from 2022/23. • All Financial Control Procedures were fully reviewed during the year and the revised documents were approved at the Audit & Assurance Committee on 21st October 2021. • The organisation is subject to both Internal and External Audit scrutiny. Internal Audit reviewed the financial planning process during 2021/22, which was given a 'Substantial Assurance' rating.

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Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
3. What arrangements are in place to report fraud issues and risks to the Audit and Assurance Committee?	HEIW has approved a 'Counter Fraud Policy and Response Plan' (FCP 13) outlining the process to be taken with suspected cases of theft, fraud or corruption in the organisation. This document sets out the roles and responsibilities of officers and support organisations in dealing with fraud. It also contains a number of flow-charts showing the process from how to report a potential fraud through to any required investigation. The FCPis available on the organisation's intranet site. There is a Counter fraud section on the HEIW_intranet site detailing the contact details for reporting potential fraud. A counter fraud progress report is a standing agenda item at the Audit & Assurance Committee, which details all counter fraud work undertaken on behalf of the organisation. An officer attends each meeting to present the report and to respond to any questions.	HEIW has approved a 'Counter Fraud Policy and Response Plan' (FCP 13) outlining the process to be taken with suspected cases of theft, fraud or corruption in the organisation. This document sets out the roles and responsibilities of officers and support organisations in dealing with fraud. It also contains a number of flow-charts showing the process from how to report a potential fraud through to any required investigation. The FCP is available on the organisation's intranet site. A counter fraud progress report is a standing agenda item at the Audit & Assurance Committee, which details all counter fraud work undertaken on behalf of the organisation. An officer attends each meeting to present the report and to respond to any questions. Relevant updates are published on the HEIW intranet site, including a regular counter fraud newsletter. The most recent newsletter was issued in January 2022.

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Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
4. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	A comprehensive overview of the counter fraud system and processes relevant to HEIW is provided at the organisations' induction sessions, giving all staff an understanding of fraud and how it can be reported. HEIW has a Standards of Behaviour policy that sets out the expectations of employees and independent members in practicing the highest standards of conduct and behaviour. The ratification of the Standing Orders and Standing Financial Instructions were announcedas part of the Chief Executive update on 18 October 2018 and a link is provided to the documents on the intranet. The Standing Orders were revised at Board on 28 January 2021. Regular counter fraud updates and links to relevant policies are published on the HEIW intranet in response to specific issues. HEIW has approved a 'Counter Fraud Policy and Response Plan' (FCP 13) that sets out theresponsibilities of individuals should there be a suspected case of fraud.	A comprehensive overview of the counter fraud system and processes relevant to HEIW is provided at the organisations' induction sessions, giving all staff an understanding of fraud and how it can be reported. These were held virtually during 2021/22. HEIW has a Standards of Behaviour policy that sets out the expectations of employees and independent members in practicing the highest standards of conduct and behaviour. The ratification of the Standing Orders and Standing Financial Instructions were announced as part of the Chief Executive update on 18 October 2018 and a link is provided to the documents on the intranet. The Standing Orders were revised at Board on 29 July 2021. Regular counter fraud updates and links to relevant policies are published on the HEIW intranet in response to specific issues. HEIW has approved a 'Counter Fraud Policy and Response Plan' (FCP 13) that sets out the responsibilities of individuals should there be a suspected case of fraud. During July 2021 staff were asked to review and

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		update their 'Declarations of Interest' form. As part of this exercise the Standards of Behaviour policy was provided, which sets out the expected requirements and responsibilities of all staff employed by HEIW.

Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body for the period ended 31 March 2022?	One case of suspected fraud was investigated during the year. This has been discussed at the closed Audit & Assurance committee sessions where Audit Wales have been in attendance. The case was closed following legal advice.	HEIW is not aware of any actual, suspected or alleged fraud within the audited body for the period ended 31 March 2022.
6. Are you aware of any fraud within the NHS Wales Shared Services Partnership (NWSSP) and Digital Health & Care Wales (DHCW) for the period ended 31 March 2022?	HEIW is not aware of any occurrences of fraud within the NHS Wales Shared Services Partnership (NWSSP) and NHS Wales Informatics Services (NWIS) for the period ended 31 March 2021.	HEIW is not aware of any occurrences of fraud within the NHS Wales Shared Services Partnership (NWSSP) and Digital Health & Care Wales (DHCW) for the period ended 31 March 2022. HEIW has written to both organisations to confirm this position and an update will be provided with submission of this letter.

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Enquiries of those charged with governance – in relation to fraud

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
1. How does the Audit and Assurance Committee, exercise oversight of management's processes foridentifying and responding to the risks of fraud within the audited body and the internal control that management has established to mitigate those risks?	The Audit & Assurance Committee receives regular reports from across the organisation and from external support services in order to discharge its responsibilities including, but not limited to: • Internal & External Audit - Provides a programme of work identifying key areas for review during the financial year and also completed audit reports for review and consideration. The Committee will review and approve management actions in response to any issues raised. • Counter Fraud – Provides a work plan setting out the service to be provided as agreed by the Director of Finance and the Counter Fraud Manager. Regular update reports are presented for consideration. • Standing Orders, Standing Financial Instructions & Financial Control Procedures –The Committee will review and recommend any proposed changesto the Board for approval	The Audit & Assurance Committee receives regular reports from across the organisation and from external support services in order to discharge its responsibilities including, but not limited to: • Internal & External Audit - Provides a programme of work identifying key areas for review during the financial year and also completed audit reports for review and consideration. The Committee will review and approve management actions in response to any issues raised. • Counter Fraud – Provides a work plan setting out the service to be provided as agreed by the Director of Finance and the Counter Fraud Manager. Regular update reports are presented for consideration. Standing Orders, Standing Financial Instructions & Financial Control Procedures –The Committee will review and recommend any proposed changes to the Board for approval

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Enquiries of those charged with governance – in relation to fraud		
Question	**Response for the period 1 April 2020 to 31 March 2021**	**Response for the period 1 April 2021 to 31 March 2022**
	The Chair of the Audit & Assurance Committee is an Independent Member of the Board.	The Chair of the Audit & Assurance Committee is an Independent Member of the Board.
2. Are you aware of any instances of actual, suspected or alleged fraud with the audited body for the period ended 31 March 2022	One case of suspected fraud was investigated during the year. This has been discussed at the closed Audit & Assurance committee sessions where Audit Wales have been in attendance. The case has been closed following legal advice.	HEIW is not aware of any actual, suspected or alleged fraud within the audited body for the period ended 31 March 2022.

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Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance the Audit and Assurance Committee, is responsible for ensuring that the Special Health Authority's operations are conducted in accordance with laws and regulations, including compliance with those that determinethe reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures, we are required to make inquiries of management and the Audit and Assurance Committee as to whetherthe Special Health Authority is in compliance with relevant laws and regulations. Where we become aware of information of non- compliance or suspected non-compliance, we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

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Enquiries of management – in relation to laws and regulations

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
1. How have you gained assurance that all relevant laws and regulations have been complied with?	Legal Implications are considered in all reports presented to the Board and the Audit & Assurance Committee. Internal and External audit reviews consider legal and statutory compliance.	Legal Implications are considered in all reports presented to the Board and the Audit & Assurance Committee. Internal and External audit reviews consider legal and statutory compliance.
2. Have there been any instances of non- compliance or suspected non-compliance with relevant laws and regulations since 5 October 2017, with an ongoing impact on the financial statements for the period ended 31 March 2022?	There have been no instances of non-compliance or suspected non-compliance.	There have been no instances of non-compliance or suspected non-compliance.
3. Are there any potential litigations or claims that would affect the financial statements?	There are no known litigations or claims that would affect the financial statements.	HEIW has received details of three potential claims in relation to the payment of clinicians pension tax liabilities. HEIW is currently reviewing whether these liabilities rest with HEIW or with other NHS Wales organisations. There are no other known litigations or claims that would affect the financial statements.

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Enquiries of management – in relation to laws and regulations		
Question	**Response for the period 1 April 2020 to 31 March 2021**	**Response for the period 1 April 2021 to 31 March 2022**
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	No reports have been received from regulatory bodies that would indicate non-compliance with relevant laws and regulations.	No reports have been received from regulatory bodies that would indicate non-compliance with relevant laws and regulations.
5. Are you aware of any non-compliance with laws and regulations within the NHS Wales Shared Services Partnership (NWSSP) and Digital Health & Care Wales (DHCW) for the period ended 31 March 2022?	HEIW is not aware of any non-compliancewithin NWSSP and NWIS.	HEIW is not aware of any non-compliance within NWSSP and DHCW. HEIW has written to both organisations to confirm this position and an update will be provided with submission of this letter.

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Enquiries of those charged with governance – in relation to laws and regulations		
Question	**Response for the period 1 April 2020 to 31 March 2021**	**Response for the period 1 April 2021 to 31 March 2022**
1. How does the Audit and Assurance Committee, in its role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	The Board and its Committees receive assurance through management reports received. There are also opportunities within the Board and its Committees to discuss anyissue should there be a concern.	The Board and its Committees receive assurance through management reports received. There are also opportunities within the Board and its Committees to discuss any issue should there be a concern.
2. Are you aware of any instances of non-compliance with relevant laws and regulations?	The Audit & Assurance Committee is not aware of any instances of non-compliance.	The Audit & Assurance Committee is not aware of any instances of non-compliance.

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Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

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Enquiries of management – in relation to related parties

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
1. Confirm that you have disclosed to the auditor: – the identity of any related parties, including changes from the prior period; – the nature of the relationships with these related parties; and – details of any transactions with these related parties entered into during the period, including the type and purpose of the transactions.	Confirmed – all fully disclosed within the financial statements.	Confirmed – all fully disclosed within the financial statements.
2. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships?	A 'Standards of Behaviour Framework Incorporating Declarations of Interest, Gifts, Hospitality & Sponsorship' has been approved bythe HEIW Board to ensure that its employees andIndependent Members practice the highest standards of conduct and behaviour. The policy requires that all staff and Members declare any interest in the 'Register of Interests': • at the commencement of employment/appointment to the Board;	A 'Standards of Behaviour Framework Incorporating Declarations of Interest, Gifts, Hospitality & Sponsorship' has been approved by the HEIW Board to ensure that its employees and Independent Members practice the highest standards of conduct and behaviour. The policy requires that all staff and Members declare any interest in the 'Register of Interests': • at the commencement of employment/ appointment to the Board;

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Enquiries of management – in relation to related parties		
Question	**Response for the period 1 April 2020 to 31 March 2021**	**Response for the period 1 April 2021 to 31 March 2022**
	• whenever a new interest arises; and • if asked to do so at periodic intervals by HEIW. The policy sets out what type of interest needs to be considered along with the consequences of failing to adhere to the policy. HEIW provides a Declarations of Interest Form to be completed by each Executive Director, Independent Member, member of SLT and any employee who may influence the procurement process. The form is to be countersigned by the relevant manager/head of service as appropriate. A request to review and update the declarations ofinterest return has been issued to the members ofthe Board prior to year-end.	• whenever a new interest arises; and • if asked to do so at periodic intervals by HEIW. The policy sets out what type of interest needs to be considered along with the consequences of failing to adhere to the policy. HEIW provides a Declarations of Interest Form to be completed by each Executive Director, Independent Member, member of the Senior Leadership Team and any employee who may influence the procurement process. The form is to be countersigned by the relevant manager/head of service as appropriate. A request to review and update the declarations of interest return has been issued to the members of the Board prior to year-end.

English Catherine 04/11/2022 11:17:41

Enquiries of the those charged with governance – in relation to related parties

Question	Response for the period 1 April 2020 to 31 March 2021	Response for the period 1 April 2021 to 31 March 2022
1. How does the Audit and Assurance Committee, in its role as those charged with governance, exercise oversight of management's processes to identify,authorise, approve, account for and disclose related party transactions and relationships?	Under the 'Standards of Behaviour Framework Incorporating Declarations of Interest, Gifts, Hospitality & Sponsorship', the Board Secretary is responsible for ensuring that: • A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Members. The Register will include details of Directorships, financial and non-financial interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners. • In accordance with the requirements of the Organisation's Freedom of Information Publication Scheme, appropriate information from the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship is published on the HEIW Website.	Under the 'Standards of Behaviour Framework Incorporating Declarations of Interest, Gifts, Hospitality & Sponsorship', the Board Secretary is responsible for ensuring that: • A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Members. The Register will include details of Directorships, financial and non-financial interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners. In accordance with the requirements of the Organisation's Freedom of Information Publication Scheme, appropriate information from the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship is published on the HEIW Website.

English Catherine
04/11/2022 11:17:41

Enquiries of the those charged with governance – in relation to related parties		
Question	**Response for the period 1 April 2020 to 31 March 2021**	**Response for the period 1 April 2021 to 31 March 2022**
	Reports detailing the content of the above registers and the effectiveness of the arrangements in place, are to be provided to theAudit and Assurance committee at agreed intervals.	Reports detailing the content of the above registers and the effectiveness of the arrangements in place, are to be provided to the Audit and Assurance committee at agreed intervals.

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English Catherine
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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.3.1**
Teitl yr Adroddiad	**Adroddiad Cynnydd Archwilio Mewnol**		
Awdur yr Adroddiad	Archwilio Mewnol		
Noddwr yr Adroddiad	Pennaeth Archwilio Mewnol		
Cyflwynwyd gan	Archwilio Mewnol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Pwrpas Adroddiad Cynnydd Archwilio Mewnol yw rhoi gwybodaeth ar y sefyllfa bresennol i'r Pwyllgor Archwilio a Sicrwydd ynghylch y gwaith a wnaed gan Archwilio Mewnol ar 24 Mawrth 2022. Mae'r adroddiad yn rhoi gwybodaeth am statws cynnydd adolygiadau Archwilio Mewnol.		
Prif Faterion	• Amlinellir sefyllfa bresennol Archwilio Mewnol yn erbyn ei gynllun blynyddol yn Adroddiad Cynnydd Archwilio Mewnol. • Ers cyfarfod diwethaf y Pwyllgor Archwilio, mae Archwilio Mewnol wedi cwblhau un Adroddiad Archwilio Mewnol: o Rheoli Prosiectau a Rhaglenni		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
	✓			
Argymhellion	Gofynnir i'r Pwyllgor: • **nodi** Adroddiad Cynnydd Archwilio Mewnol er sicrwydd • **nodi** Adroddiad Archwilio Mewnol Rheoli Prosiectau a Rhaglenni (Sicrwydd Sicr		

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Atodiadau	1. Adroddiad Cynnydd Archwilio Mewnol 2. Adroddiad Archwilio Mewnol ar Reoli Prosiectau a Rhaglenni

English,Catherine
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GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Health Education and Improvement Wales

Audit & Assurance Committee Internal Audit Progress Report

March 2022

NWSSP Audit and Assurance Services

English,Catherine
04/11/2022 11:17:42

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Health Education and Improvement Wales and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

English Catherine
04/11/2022 11:17:41

1 Introduction

1.1 This progress report provides the Audit & Assurance Committee (the 'Committee') with the current position regarding the work undertaken by Internal Audit as at **24 March 2022**. This report provides information on the status of progress of our reviews.

1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

2.1 Since the January meeting of the Committee one report has been finalised, two have been issued in draft, awaiting management responses, and we have ongoing fieldwork in two areas. A summary of the reviews is provided below in Table 1.

Table 1 – Summary of reports

Assignment	Assurance rating	High	Medium	Low	Total recommendations
Project and programme management	Substantial	-	2	1	3
Strategic readiness for digital (Draft)	-	-	-	-	-
Risk management (Draft)	Substantial	-	1	2	3

3 Delivering the Plan

3.1 Our programme of work for 2021/22 nears completion. The detail of the scheduling and progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A.

3.2 Similar to last year, the pandemic has affected the delivery of our planned work. We continue to take both a pragmatic and agile approach, and will endeavour to support HEIW while meeting our commitment to provide assurance to the Chief Executive and Board.

4 Developing the plan for 2022/23

4.1 Our proposed plan is on the agenda for the Committee.

English,Catherine 04/11/2022 11:27:41

Table 2 – Plan 2021-22

Assignment	Status	Director	Assurance	Planned timing	Notes
Annual Governance Statement	Complete	-	N/A	Q1	-
IG Toolkit	Final	Dir. of Digital	Substantial	Q1	-
Recruitment	Final	Dir. of workforce and OD	Reasonable	Q1	-
Financial planning review	Final	Dir. of Finance	Substantial	Q2	-
MARS Appraisal system	Final	Medical Director	Reasonable	Q2	-
Project/ programme management	Final	Dir. Of planning, performance and corporate services	Substantial	Q3	-
Strategic readiness for digital	Draft	Dir. of Digital	N/A	Q3	Requested to start in Q4. Advisory report – Draft issued 24.03.22
Risk management	Draft	Board Secretary	Substantial	Q4	Draft issued 17.03.22
Bursary system	WIP	Director of Nursing	-	Q3	Management requested to start fieldwork in Q4 - ongoing.

English,Catherine
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Assignment	Status	Director	Assurance	Planned timing	Notes
Performance and governance arrangements	WIP	Dir. Of planning, performance and corporate services	-	Q4	Fieldwork ongoing. Has been delayed by sickness.
Training programme directors	Planned	Medical Director	-	Q4	-

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Project & Programme Management
Final Internal Audit Report

March 2022

Health Education and Improvement Wales

English,Catherine
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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

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Review reference:	HEIW-2122-05
Report status:	Final
Fieldwork commencement:	06 January 2022
Fieldwork completion:	25 February 2022
Draft report issued:	02 March 2022
Management response received:	23 March 2022
Final report issued:	24 March 2022
Auditors:	Ken Hughes, Stuart Bodman
Executive sign-off:	Nicola Johnson, Director of Planning and Performance
Distribution:	Marie-Claire Griffiths, Assistant Director of Planning and Performance Jane Powell, Planning and Performance Business Partner
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
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Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee.

Flintshire County Council 2122/17

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Executive Summary

Purpose

To determine if there are effective arrangements and processes in place to manage the risks associated with project and programme management.

Overview

We have issued substantial assurance on this area.

The matters requiring management attention are:

- The absence of a Project Initiation Documentation (PID) for one of the projects that we reviewed.
- No documented post-implementation review arrangements within Delivery Plan Programmes and Programme Management Office template PIDs.
- The Delivery Plan Programme Group Terms of Reference documents are incomplete.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	Projects and programmes directly linked to strategic aims with Executive ownership	Substantial
2	Projects and programme reporting lines and timescales	Substantial
3	Completion of Project Initiation Document (PID)	Reasonable
4	Stakeholder and user engagement	Substantial
5	Programme team skills and experience	Substantial
6	Project management methodology	Substantial
7	Monitoring of project milestones	Substantial
8	Changes to Programme plans	Substantial
9	Post-implementation review and lessons learned	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

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	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Programme Board Terms of Reference documents	3	Operation	Medium
2	Absence of Project Initiation Document (PID)	9	Operation	Medium

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1. Introduction

1.1 Our review of project and programme management arrangements was undertaken in line with the 2021/22 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation').

1.2 The review sought to ascertain whether there are effective arrangements and processes in place to manage the risks associated with project and programme management across the organisation.

1.3 Project management can be described as the process by which projects are defined, planned, monitored, controlled and delivered to help achieve pre-determined outcomes and benefits. Programme management is the control of inter-related projects that make up the work programme.

1.4 The failure to deliver projects and work programmes on time, within budget and to specification could have significant financial and reputational implications and could adversely impact on the organisation's ability to successfully deliver their strategic aims and objectives.

1.5 The relevant lead for the review is the Director of Planning and Performance.

1.6 The potential risks considered in this review were as follows:

- Projects and work programmes are not linked to the organisation's strategic aims and objectives.
- Expected benefits are not realised resulting in wasted resources.
- Lessons are not learned or shared from completed projects.

2. Detailed Audit Findings

Objective 1: Projects and programmes are directly linked to the achievement of the organisation's strategic aims and objectives and have executive or senior management ownership.

2.1 There is an overarching organisational annual IMTP Delivery Plan for 2021/22 that includes all IMTP/Annual Plan Strategic Objectives, and their respective Executive Leads and Senior Responsible Officers (SROs). The plan includes a summary of delivery progress which is monitored by the Executive Team (ET) and Board through the performance reports on a quarterly basis.

2.2 All proposed programmes and projects, apart from 'business as usual' projects that form part of everyday HEIW service provision, are subject to discussion, prioritisation and approval by the Executive Team as part of the Autumn strategic planning meetings in preparation for the next financial year, as part of the IMTP process.

2.3 'Plans on a Page' for each Strategic Objective are presented to the Executive Team for review, and potential elaboration / changes. Once satisfied, projects and programmes are included in the draft strategic plan for submission to the HEIW Board for approval. Once finalised, the strategic plan (Annual Plan/IMTP) is sent to

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Welsh Government in line with the NHS Wales Planning Framework timescales and then implemented from April.

2.4 As such, there is a demonstrable link between the strategic priorities stated within the IMTP / Annual Plan and the programmes and projects as they are developed out of the work required to underpin HEIW's strategy. A Business Case may be submitted to Welsh Government to request additional funding for larger, high priority strategic programmes or projects, or via internal funding through existing HEIW budgets.

2.5 There does not appear to be a risk that programmes or projects are undertaken that are not captured within the IMTP Delivery Plan, as all programmes or projects of any substance (e.g., those that would require financial / staff resourcing) would require ET engagement and approval for them to proceed and would therefore be factored into the IMTP development and Delivery Planning process. Additionally, many of the ET members sit on Programme Board meetings.

2.6 Additionally, a Technical Training Plan register of programmes is maintained by the Project Management Office (PMO). This provides a central resource point offering advice and professional project management guidance to project teams. An iteration of the Training Plan is held on the PMO Teams Channel which is a work-in-progress repository of information relating to projects and is accessible to HEIW staff.

Conclusion

2.7 There was evidence that projects and programmes are directly linked to the achievement of the organisation's strategic aims and objectives and have executive or senior management ownership. We have provided substantial assurance for this objective.

Objective 2: Project and programme reporting lines and timescales are set out before a Programme starts.

2.8 We reviewed a sample of five Programmes to confirm that appropriate project management structures for recording, monitoring and reporting their progress were in place. The five Programmes had a formally constituted Programme Board / Group that met regularly. The group ensures progress oversight, monitoring and reporting to the Executive Team of their respective aims and objectives in alignment with those of the organisation.

2.9 All five programmes stated their respective desired outcomes / benefits and included planned timescales for achievement. However, for two Programmes the Terms of Reference document, that outlines the constitution and working of these Programme Boards / Groups, was not fully completed or subject to version control (**Matter Arising 1)**.

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Conclusion:

2.10 Our discussions with programme managers and our review of relevant supporting documentary evidence confirmed that the overall monitoring and reporting structures within each sampled project were put into place prior to commencement and continue to work. We have provided substantial assurance for this objective.

Objective 3: Projects and work programmes are authorised through completion of a Project Initiation Document (PID) that also sets out the objectives, resource requirements, timescales, risks, benefits and project team roles & responsibilities.

2.11 We asked five Programme Managers to provide their respective PIDs to confirm that they included sufficient information to be approved. All five of the programmes had been approved by their respective programme boards and the executive team.

2.12 Our testing identified that two of the programmes did not have a PID in place. One of these programmes had started before the PMO and the organisational Project Management Framework had been set up, and it had similar supporting documentation that we would expect to be within a PID. However, the other programme that started after the PMO was set up did not have a PID in place as it was initiated in response to a national programme that was still developing. However, this had similar documentation in place that included information that would have been included in a PID (**Matter Arising 2)**.

Conclusion:

2.13 Whilst the standard PID template sets out the objectives, resource requirements, timescales, risks, benefits and project team roles and responsibilities, not all the programmes tested held a fully completed PID. We have provided reasonable assurance for this objective.

Objective 4: Relevant stakeholder and user engagement is sought.

2.14 To ensure that each programme or project is effectively implemented it is key that relevant stakeholders and users are identified during the early planning stages and continue to contribute to the work as it progresses.

2.15 We reviewed the PID and Executive Team approval documentation (such as the Strategic Outline Case, and 'Plan on a Page') for our sample of five programmes and confirmed that the relevant stakeholders had been identified in all cases.

2.16 There was also documentary evidence within each programme's review and reporting process of ongoing stakeholder engagement.

Conclusion:

2.17 There was evidence for all programmes that we reviewed of ongoing stakeholder engagement. As such, we have provided substantial assurance for this objective.

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Objective 5: Project teams have the necessary skills and experience required to deliver each project, with appropriate project management support in place to assist where necessary.

2.18 Our discussions with the programme managers for the five programmes confirmed that they have had the necessary training (e.g., Prince2, Agile, MSP) to lead the work, which we also confirmed by reviewing project management skills training records held by the PMO.

2.19 Support staff involved in the programmes are experienced in project management or are being provided with training courses and 'on the job' support by the PMO.

Conclusion:

2.20 Our testing confirmed that project teams have the necessary project management skills to deliver the organisation's projects and programmes. We have provided substantial assurance for this objective.

Objective 6: A standardised project management method has been developed and communicated to project staff.

2.21 The organisation introduced a formal Project Management Framework which was approved by the Executive Team in July 2021. This describes how projects and programmes in HEIW are established, managed and controlled in order to promote best practice and highlight tools for project management.

2.22 The project management framework is supported by project management documentation and will be underpinned by the forthcoming Verto IT project management system. This is due to be implemented in April / May 2022.

2.23 Our discussions with programme managers confirmed they, and their project teams, had access to the project management framework.

2.24 We also note that programme managers are members and regular attenders of the organisation's Project Management Steering Group, through which the development, oversight and progress of the project management framework is monitored.

Conclusion:

2.25 A standardised project management methodology has been developed and implemented through the project management framework. We have provided substantial assurance for this objective.

Objective 7: Key milestones in project lifecycles have been defined and are monitored to identify any slippage which is reported, and the ongoing viability of projects is regularly assessed.

2.26 All five projects that we tested had defined milestones / phased objectives that lead to the next phase, or were in alignment with a separate phase of progress, and were documented via Gannt Charts or workplans.

English (United Kingdom) 04/11/2021 11:17:41

2.27 Programme progress was subject to regular monitoring by respective monthly Programme Board meetings to confirm the achievement of milestones, with performance reported regularly to the Executive SLT on a quarterly basis via the Integrated Performance Reports.

Conclusion:

2.28 The progress of programmes and projects, and the achievement of key milestones, was being regularly monitored and reported. We have provided substantial assurance for this objective.

Objective 8: Changes to project plans are formally agreed.

2.29 At the time of our review none of the five programmes that we tested had undertaken any changes to their aims, objectives or workplans.

2.30 We note that the programmes that we tested were at varying stages within the early phases of activity, and as such no material changes have taken place that would warrant re-profiling of workplans.

2.31 Any changes, and the outcome of changes, to these programmes would be documented and approved within their respective Programme Board minutes, with their workplans being updated accordingly. Changes would also be reported via their quarterly Highlight Reports and to the Executive SLT via the quarterly Integrated Performance Reports. The change control process is documented within the Project Management Framework.

Conclusion:

2.32 There are satisfactory arrangements in place to formally agree proposed changes to programme plans. We have provided substantial assurance for this objective.

Objective 9: Completed projects are subject to post-implementation review with lessons learned being captured and shared so they can be applied to future projects.

2.33 Our discussions with programme managers and our review of quarterly highlight reports confirmed that lessons learned are being captured and recorded for use during the post-implementation phase of projects.

2.34 However, four of five of the projects we tested did not set out the proposed approach to the post-implementation phase of delivery within their planning documentation or PID. We also note that the PMO template PID does not provide a section in respect of post-implementation phase. It was also unclear how lessons learned were to be disseminated and shared amongst relevant staff within the organisation (**Matter Arising 3)**.

Conclusion:

2.35 Although lessons learned were being captured on an ongoing basis for the programmes that we tested, the arrangements for carrying out post implementation reviews was not in the project documentation or the PID. It was also unclear how lessons learned would be shared. As such, we have provided reasonable assurance for this objective.

English, Catherine
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Appendix A: Management Action Plan

Matter Arising 1: Programme Board Terms of Reference (Operation)	**Impact**
All five programmes that we tested had oversight, decision making, approval and reporting structures in place which were undertaken by their respective Programme Boards. However, two of the programmes did not have Programme Group Terms of Reference documents that were complete in accordance with the principles of best practice. We note: • **Delivery Plan Programme Objective 3.5: - Lead the review, improvement and re-launch of the NHS Wales Graduate training scheme** There is a Programme Group ToR in place, but it is not dated, nor does it state any version control. • **Delivery Plan Programme Objective 4.4e: Urgent and Emergency Care** There is a Programme Group ToR in place, but it is dated July 2021 and does not accurately reflect the current position of the programme in terms of its aims and objectives. Additionally, the ToR does not state the Programme Group quoracy attendance level and has no version control. Whilst we acknowledge that the programme is awaiting further expansion to its scope and objectives based upon the Welsh Government National Programme for Emergency Care, the ToR could have been revised and updated accordingly between July 2021 to the present to reflect this within its narrative.	Projects commence without proper scrutiny and approval. Projects are not subject to ongoing monitoring to ensure they remain viable. Projects fail to achieve desired outcomes resulting in wasted financial and staff resource.
Recommendations	**Priority**
Delivery Plan Programme Objective 3.5: - Lead the review, improvement and re-launch of the NHS Wales Graduate training scheme The Programme Group ToR should be revised to ensure that it is up to date and version control is added to the document to record any subsequent changes to its content.	**Low**

English,Catherine
04/11/2022 11:17:41

Delivery Plan Programme Objective 4.4e: Urgent and Emergency Care The Programme Group ToR should be updated to state its current headline aims and objectives in alignment with the information as reported to the Executive Team. It should also include version control to allow for the additional Welsh Government National Programme for Emergency Care strategic objectives as and when they are formally published and are included into the Programme's workplan. Programme Group quoracy attendance levels should also be stated, and the resultant action taken if quoracy is not achieved.		
Agreed Management Action	**Target Date**	**Responsible Officer**
Programme Managers to ensure the Programme Group ToR are updated in line with the recommendations and agreed.	30 June 2022	Claire Monks, NHS Wales Graduate Training Scheme Manager
The Programme Group ToR will be updated to state its current headline aims and objectives in alignment with the national programme. It will also include version control and Programme Group quoracy attendance levels.	30 June 2022	Lisa Bassett, Urgent and Emergency Care Programme Manager

English Catherine
04/11/2022 11:17:41

Matter Arising 2: Absence of Project Initiation Document (Operation)	**Impact**
At the time of the review no Project Initiation Document (PID) was in place for the Programme Objective 4.4e - Urgent and Emergency Care as it was awaiting the finalisation of Welsh Government National Programme for Emergency Care strategic aims and priorities. We acknowledge that the key components of the PID can be found in other planning, approval and monitoring documentation and is reflected within the programme quarterly highlight reports. However, best practice in accordance with the Project Management Framework requires the PID to be drawn up at the beginning of the programme to document, support and substantiate the known aims and objectives as approved by the Executive Team, incorporated into the Annual Plan 2021/22, and then subsequently acted upon since the first Programme Board meetings in May 2021. The PID should then have been updated accordingly to reflect any known progress updates or communications provided by the Welsh Government to the present time and upon publication of their final aims and priorities.	Key elements that are captured within the PID may not be documented.
Recommendations	**Priority**
A PID should be drawn up for the Programme Objective 4.4e - Urgent and Emergency Care project to document, support and substantiate the current Programme aims and objectives. This should then be updated to reflect any further communications and the final strategic aims and priorities provided by the Welsh Government National Programme for Emergency Care supported by appropriate document version control.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
The programme priorities will be agreed by the end of May, Programme Manager to ensure a draft PID is drawn up and agreed by the end of June, with a final	31 July 2022	Lisa Bassett, Urgent and Emergency Care Programme Manager

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document agreed by the end of July to enable incorporation of national programme priorities.		

English Catherine
04/11/2022 11:17:41

Matter Arising 3: Planning post-Implementation Review arrangements (Design)	**Impact**
At the time of our fieldwork four of the five programmes that we tested did not have formally documented post-implementation review arrangements. We acknowledge that the PMO's template PID for use by Programme Managers does not include a section for completion in respect of post-implementation review arrangements. Best practice dictates that this final part of a project's lifecycle should be documented within a PID as known at the start of a project, and then be updated as the project progresses. We note that there is an awareness to undertake post-implementation reviews by the Programme Managers, and a process is in place to identify lessons learned on an ongoing basis which should feed into the process. We also saw evidence that during the early stages of each programme lessons learned are captured and recorded within progress highlight reports when applicable, although the arrangements for sharing lessons learned with relevant staff were unclear.	Weakness or error in the project management process are not identified or addressed leading to reoccurrence in subsequent projects.
Recommendations	**Priority**
3.1 Programmes should have formally documented arrangements in place that outline the post-implementation review process to be undertaken upon completion of the Programme's lifecycle. The Programme Management Office's template PID should be amended and updated for new programmes to include a section on post-implementation review for completion at the start of a programme, and then updated, as appropriate, as the programme progresses. 3.2 Arrangements for the sharing of lessons learned with relevant staff within the organisation should be developed.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 HEIW's Project Management Framework PID template to be amended and updated in line with the recommendation.	30 June 2022	Julie Nallon, PMO Manager

English Gateway 04/11/22 11:27 Version 2

3.2 Mechanisms to support the sharing of lessons learned to support the will be incorporated into the Programme Management Steering group and the roll out of the Verto project management system.	30 Dec 2022	Julie Nallon, PMO Manager

English Catherine
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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

English,Catherine 04/11/2022 11:17:41

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Risk Management
Internal Audit Report

April 2022

Health Education and Improvement Wales

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee.

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Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the organisation in relation to risk management.

Overview

We have issued substantial assurance on this area.

The matters requiring management attention are:

- Part of the training section of the Risk Management Policy does not reflect the current arrangements.
- We identified gaps in the information contained within the departmental risk registers of the medical and dental deaneries.
- The is no explicit reference within the departmental risk registers linking the risks to the strategic and/or operational objectives of the organisation.

Report Classification

	Trend
Substantial  Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2020/21

Assurance summary[1]

Assurance objectives		Assurance
1	Guidance Documentation	Substantial
2	Departmental Risk Registers	Reasonable
3	Escalation and De-escalation of Risks	Substantial
4	Risk Mitigating Actions	Substantial
5	Departmental Risk Monitoring	Substantial
6	Board Assurance Framework (BAF)	Substantial
7	Strategic Risk Monitoring	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
Gaps in the Departmental Risk Registers (Medical and Dental Deanery)	2	Operation	Medium

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1. Introduction

1.1 Our review of risk management arrangements was undertaken in line with the 2021/22 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation').

1.2 The review sought to evaluate and determine the adequacy of the systems and controls in place within the organisation in relation to risk management. We focused on two aspects of risk management:

- The application of the Risk Management Policy at Departmental and Directorate level.
- Use of the Board Assurance Framework to monitor risks that impact strategic objectives.

1.3 Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help us understand risks and their impact.

1.4 Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice

1.5 The relevant lead for the review was the Board Secretary.

1.6 The potential risks considered in this review were as follows:

- Risk becomes an issue as risks are not managed in line with the approved policy.
- Risk becomes an issue as staff are unaware of the process for managing them.
- Risks are not escalated effectively, accurately, and promptly impacting the decision-making ability of the organisation.
- Strategic objectives are not met as risks relating to the achievement of the objectives are not effectively managed.

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2. Detailed Audit Findings

Objective 1: The Risk Management Policy is suitably detailed to provide guidance to directorates and departments on how to identify risks, capture and score risks in a standardised format.

2.1 The Board Secretary has developed the Risk Management Policy which was last presented and reviewed at the Audit Committee in October 2021 and presented to the Executive Board for overall approval in November 2021.

2.2 Our review of the Policy confirmed that it is suitably detailed and provides guidance to staff on how to comply with the risk management arrangements.

2.3 We met with the Board Secretary, the Medical Director and with the risk leads from the Medical and Dental Deanery Directorates. Our discussions confirmed a comprehensive awareness of the risk management processes and an understanding of the controls in place as set out within the Risk Management Policy, which is readily available via the intranet page.

2.4 Staff are notified of new iterations/versions of the Policy by way of informational bulletins on the intranet home page. At induction, new members of staff with risk management responsibilities must attend a 'Introduction to Risk Management' presentation. The purpose of the presentation is to provide an entry-level understanding on the core principles of risk management. We reviewed the presentation slides and confirmed that the content defines the risk management framework, defines risk and risk mitigating controls, and provides guidance on how to identify and capture risks within a risk register.

2.5 Training records are kept for staff that have attended the presentation and those which require refresher training (every three years). Our review of the training records did not identify any issues with staff having had up to date risk management training.

2.6 We note that the above training arrangements were not detailed within the 'Training' section of the Policy. Instead, it referred to a self-guide risk management study package. Through discussions with staff, we confirmed that the training section of the Policy referred to the previous training arrangements and that this had not been amended to reflect the current arrangements. (**Matter Arising 1)**.

Conclusion

2.7 The organisation has a comprehensive Risk Management Policy setting out the risk management framework and the arrangements for ensuring that there is a robust system of controls in place for managing risk. The broad content of the Policy is suitable and in line with current arrangements. Our discussions with staff confirmed that there is a consistent understanding of the principles of the Policy and of the arrangements in place. However, the 'Training' section of the policy requires updating so that it reflects the current 'risk management induction' arrangements for new staff. We have provided substantial assurance for this objective.

Objective 2: Comprehensive departmental risk registers are in place that include detailed information on inherent risk scores, mitigating actions, risk appetite and residual risk scores.

2.8 Our testing for this objective focused on the risk management arrangements in place at directorate and departmental level. We agreed with the Board Secretary that the Medical Directorate be selected for this review, being the largest Directorate within the organisation. The Medical Deanery and the Dental Deanery are departments which form part of the Medical Directorate. The risk registers for these were selected for review.

2.9 As previously stated, the Risk Management Policy provides comprehensive risk management guidance for directorates and departments. The Policy includes a Risk Register Template which can be adopted by Directorates and Departments across the organisation. The template consists of a large table with headings capturing the risk ID, risk description, risk owner title and name, the inherent risk scoring, mitigating controls, residual risk score, RAG rating and outstanding actions.

2.10 We met with the Medical Director, the Postgraduate Dental Dean, and the Postgraduate Medical Dean to discuss the arrangements in place for maintaining their risk registers. We were provided with the latest copies of risk registers, and we reviewed these to ensure that the information was comprehensive and captured all required risk related information. The following findings were made:

- The Medical Deanery Risk Register adopted the template version (annexed within the Policy), and all information was complete and up to date. We identified one minor issue whereby the risks had not been assigned with a 'Risk Owner'. Nominating a risk owner is considered best practice as it ensures consistent responsibility and accountability for the risk management arrangements **(Matter Arising 2).**
- The Dental Deanery Risk Register did not adopt the same format as the template version and was instead based on a excel spreadsheet. Our review of the register confirmed that eight risks were missing the residual scoring and had no overall RAG status, and one risk had no inherent risk scores. (**Matter Arising 2)**.
- We also note that neither of the above risk registers explicitly linked their risks to the organisation's objectives (whether strategic or operational). Effective risk management arrangements should be consistent with and support the achievement of operational and strategic objectives of the organisation. (**Matter Arising 3)**.

Conclusion:

2.11 Our review of departmental risk registers identified a small number of matters which should be addressed. The risk register's key function is to provide management, the Board, and key stakeholders with significant information on the risks faced by the organisation and give a clear view of the status of each risk, at

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any point in time. Therefore, it is important that the risk register is fully populated and kept up to date. We have provided reasonable assurance for this objective.

Objective 3: There is a clear process for the escalation of risks to the directorate risk register (and de-escalation back down from directorate to department registers).

2.12 The Risk Management Policy states that risks should be managed at the lowest most appropriate level. If the directorate feels that a risk carries substantial weighing it can be added to the Directorate Risk Register (DRR), subject to Director Lead approval. The risk can also be escalated further into the Corporate Risk Register (CRR) if the Directorate has concerns on capacity to manage the risk (resources, budgeting etc.). The Directorate Lead can then propose the escalation of this risk subject to the approval of the Executive Team. Departmental risk registers are considered at Directorate meetings every eight weeks.

2.13 We reviewed the minutes for the Medical Senior Team (MST) meetings in September, November 2021 and January 2022 and confirmed regular scrutiny and review of the departmental risk registers. There is a standing agenda item '6 Risk Register Update' where various elements of the risk register are discussed. The topics for discussion include new and emerging risks, risks for escalation onto the Directorate Risk Register, discussions to reduce/increase the score of current risks and discussions to de-escalate and archive/remove risks. Our review of the minutes confirmed that actions are routinely followed up at the next meeting.

2.14 The Risk Management Policy also states the de-escalation process. Risks should not be removed from the risk registers until such time that the risk has been eliminated and that the removal has been agreed at the MST meeting. Risks may reduce in their importance over time, and so may be de-escalated down to an appropriate level of management.

2.15 Risks can only be de-escalated from the Directorate Risk Register to the Departmental risk registers if this has been approved by the Medical Director and discussed with the Medical Senior Team.

2.16 Our testing confirmed that risks are reviewed before they are de-escalated/closed and or archived. Our review of the MST minutes confirmed that risks are de-escalated appropriately:

- November 2021 - 2 risks were considered to have been resolved and had been closed in the "Archived Risks" tab of the Dental Deanery Risk Register. Notes were provided in the risk register to confirm the reason why these risks had been closed and no issues were noted.
- January 2022 - no risks were identified for de-escalation.

Conclusion:

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2.17 There are clear processes in place for the escalation and de-escalation of risks from and to the Departmental risk registers and the Directorate risk register. We have provided substantial assurance for this objective.

Objective 4: Where the recorded mitigating actions reduce a risk score to a lower residual score, those actions are robust, and suitable evidence exists to support the decision.

2.18 Annex 2 of the Risk Management Policy includes a template for the Risk Register which includes a section 'Mitigating Action - Summary of action to date or proposed action to reduce risk impact or proximity', and this should include a deadline or timetable for completing actions.

2.19 Our review of the Medical Deanery and Dental Deanery risk registers confirmed that for each risk sufficient explanation had been included under the mitigating action to set out and explain how the risks were being mitigated.

2.20 We tested a sample of five risks from the registers to ensure that where the recorded mitigation reduced the risk score, and the actions were supported by suitable evidence. It was noted that all actions were being progressed and at the time of the audit, all risk owners were able to provide an up-to-date position for each risk.

Conclusion:

2.21 There was evidence in place and updates on the progress for all selected mitigating actions that we reviewed and tested. As such, we have provided substantial assurance for this objective.

Objective 5: Risk is actively monitored and scrutinised at an appropriate level within the directorate. Monitoring also takes place across departments and directorates to ensure consistency in scoring.

2.22 Risk is actively monitored and scrutinised at an appropriate level within the directorate. Monitoring was confirmed to take place across departments and directorates to ensure consistency in scoring.

2.23 The Dental Deanery Risk Register (Departmental) is reviewed monthly at every Dental Management Executive meeting.

2.24 For the Medical Deanery Risk Register, each unit in the Medical Deanery maintains a Risk Register, and this is a standing item in their fortnightly Senior Team meeting with formal review every 6 weeks. Timing of this is aligned to the Medical Directorate Risk Register and it is reviewed to feed in information to the Medical Director for decision regarding inclusion or change in score.

Conclusion:

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2.25 Our testing confirmed that risk is actively monitored and scrutinised at an appropriate level within the directorate. Monitoring also takes place at

departmental level to ensure consistency in scoring. We have provided substantial assurance for this objective.

Objective 6: The Board Assurance Framework (BAF) clearly sets out the risks associated with each strategic objective, the controls and assurance mechanisms currently in place, any gaps in assurance and proposed actions.

2.26 At the October 2021 Audit Committee meeting, the Board Secretary provided the Committee with an opportunity to review the Board Assurance Framework (BAF) and provided an update on its further development. We confirmed that the BAF had been operational since September 2019. The Committee considered the BAF and noted the Chair had already provided feedback to the Board Secretary. The latest version of the BAF was approved by the Board in November 2021.

2.27 We confirmed that the inclusion of the strategic risks document had been a recommendation from Audit Wales last year and that this was now included within the updated version of the BAF. HEIW's BAF sets out clearly what a BAF should do, and the processes involved.

Conclusion:

2.28 The Organisation has made progress with this objective and has reviewed and updated its Board Assurance Framework in November 2021. The document contains the Strategic Control Framework document which aligns the strategic risks to the strategic objectives of the organisation. The BAF also includes the controls and assurance mechanisms in place to mitigate the risks. We have provided substantial assurance for this objective.

Objective 7: Monitoring of strategic risks can be evidenced in line with the requirements set out in the risk management policy.

2.29 The Risk Management Policy clearly sets out the roles and responsibilities for the management of risk. Strategic risks are identified by the Board and managed by the Executive Team, whereas operational risks are identified and managed at the most appropriate level (Directorate/Department). Strategic risks are monitored as part of the Board Assurance Framework. This enables the organisation to have clear visibility on what might prevent them from delivering their Strategic Aims and Objectives.

2.30 Furthermore, section 2.1 of the Policy states that strategic risks are the highest-level risks that could threaten the organisation's ability to deliver on the strategic priorities, as laid out in the Integrated Medium-Term Plan (IMTP). Strategic Risks are identified at Board level during the annual development of the IMTP. All strategic objectives are assigned an Executive Lead within the IMTP who is responsible for reviewing their strategic risks and associated action plans on a regular basis and providing updates to both the Executive Team and the Board.

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2.31 The organisation has a Strategic Risk Control Framework, which identifies and maps the controls and key sources of assurance against HEIW's Strategic Risks.

This is contained in the Board Assurance Framework which was approved by the Board in November 2021.

2.32 A framework is in place for reporting key information to the Board and Committees. These internal assurance methods include:

- The Performance Report.
- Internal audit reports.
- Counter-fraud reports.
- Serious incident reports.
- The Annual Governance Statement.

Our review of various Board and Committee meetings in the last three months confirmed that there is regular reporting of the above information.

Conclusion:

2.33 Our testing confirmed timely monitoring and scrutiny arrangements of strategic risks which were operating in line with the Risk Management Policy. We have provided substantial assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Risk Management Policy (Operation)		Impact
The 'Training' section of the policy states that there is a risk management 'Basics' self-guide study package that is available for all risk owners (leads for managing risks). Our discussion with the Executive Assistant to the Director of Workforce and Deputy Chief Executive, and to the Medical Director confirmed that this section of the policy was out of date and did not reflect current arrangements. As part of the current process new staff which are responsible for risk management within their role, must attend a presentation on risk management.		Out of date policies and procedures can result in inconsistent practices.
Recommendations		**Priority**
The section referencing to the study package, within the Risk Management Policy, should be amended accordingly to reflect the actual processes in place.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
HEIW Risk Management Policy to be amended to reflect the actual process. The policy is due for its annual renewal at July Board.	July 2022	Board Secretary

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Matter Arising 2: Gaps in Departmental Risk Registers (Operation)	Impact
The Risk Management Policy includes a Risk Register Template which can be used by Directorates and Departments for managing their risks. The template consists of a table with different headings that captured the risk ID, risk description, risk owner title and name, the inherent risk scoring, mitigating controls, residual risk score, RAG rating and outstanding actions. The Medical Director Postgraduate Dental Dean and Postgraduate Medical Dean provided us with the latest copies of their risk registers. We reviewed these confirm that the registers included comprehensive risk information such as risk description, risk owner, risk scoring, mitigating controls, risk appetite, progress updates and outstanding actions. We note the following: • The Medical Deanery Risk Register adopted the risk register template annexed within the Risk Management Policy. The information within the risk register was complete and found to be up to date. However, there was no information on the risk owner for each risk. • The Dental Deanery Risk Register did not adopt the same format as the template in the risk management policy and was instead based on an excel spreadsheet. Our review of the register confirmed that eight risks were missing the residual scoring and had no RAG status, and one risk had no inherent risk score.	Gaps in risk registers can have a negative impact on the effective monitoring and management of risks.
Recommendations	**Priority**
A review of the Medical Deanery and the Dental Deanery Risk Registers be undertaken by the Risk Owners to ensure that all relevant fields are updated appropriately, and arrangements be put in place to ensure that risk registers are kept up to date.	**Medium**

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Agreed Management Action	Target Date	Responsible Officer
Medical Deanery and Dental Deanery to undertake a review of the Risk Registers to ensure that all relevant fields are appropriately updated. Arrangements to be put in place to ensure the Risk Registers are reviewed at least once a month. Dental Deanery to adopt the Risk Register Template within the Risk Management Policy but will continue to use an excel spreadsheet.	May 2022	Dental Dean and Medical Deanery

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Matter Arising 3: Link between Risks and Strategic and operational objectives (Operation)		Impact
Our review of both the Medical Deanery and the Dental risk registers did not identify any links from the risks to organisational objectives, whether strategic or operational. Effective risk management arrangements should be consistent with, and support, the achievement of operational and strategic objectives.		Resources could be exhausted to mitigate risks which are not aligned/linked to the strategic/operational objectives of the organisation.
Recommendations		**Priority**
A clear link should be made within the risk registers to ensure that risks are linked to strategic/operational objectives.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
HEIW Risk Management Policy to be amended to clarify that the Corporate Risk template include reference to HEIW's 6 Strategic Aims. The policy is due for its annual renewal at July Board.	July 2022	Board Secretary

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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* Unless a more appropriate timescale is identified/agreed at the assignment.

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.3.2**
Teitl yr Adroddiad	**Cynllun Blynyddol Archwilio Mewnol 2022/23**		
Awdur yr Adroddiad	Archwilio Mewnol		
Noddwr yr Adroddiad	Pennaeth Archwilio Mewnol		
Cyflwynwyd gan	Archwilio Mewnol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Nod Cynllun Blynyddol Archwilio Mewnol 2022/23 yw darparu'r rhaglen waith arfaethedig Archwilio Mewnol ar gyfer 2022/23 i'r Pwyllgor Archwilio a Sicrwydd.		
Prif Faterion	Mae'r Cynllun wedi'i ddatblygu yn unol â Safon 2010 – Cynllunio, i alluogi'r Pennaeth Archwilio Mewnol i gyflawni amcanion allweddol. Mae'r dull cynllunio ar sail risg yn cydnabod yr angen i flaenoriaethu cwmpas yr archwiliad er mwyn rhoi sicrwydd ynghylch rheoli meysydd risg allweddol. Mae'r dull sy'n seiliedig ar risg yn integreiddio â systemau sicrwydd y sefydliad. Mae'r Cynllun yn dynodi'r aseiniadau archwilio, swyddogion gweithredol arweiniol, amlinelliad o gwmpasau, ac amseriadau arfaethedig ar gyfer rhaglen 2022/23.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓
Argymhellion	Gofynnir i'r Pwyllgor **gymeradwyo** Cynllun Blynyddol Archwilio Mewnol 2022/23.		

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Annual Internal Audit Plan

Internal Audit Charter

March 2022

Health Education and Improvement Wales

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1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (HEIW's Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Assurance Committee (the 'Audit Committee'), with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from Internal Audit reviews may be used by HEIW management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate, or be linked to, a strategic or high-level statement of how the Internal Audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

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2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and operational plan, and other changes within the organisation, assurance

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needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and Risk Registers together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the organisation, namely: Public Health Wales NHS Trust; NHS Wales Shared Services Partnership (NWSSP); DHCW; Welsh Health Specialised Services Committee (WHSSC); and Emergency Ambulance Services Committee (EASC).

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6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the HEIW's systems of assurance

The risk based internal audit planning approach integrates with the organisation's systems of assurance; therefore, we have considered the following:

- a review of the HEIW's vision, values and forward priorities as outlined in the Annual Plan and Integrated Medium Term Plan (IMTP);
- an assessment of the organisation's governance and assurance arrangements and the contents of relevant risk registers;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Education, Commissioning and Quality Committee);
- key strategic risks identified within the Strategic Risk Register and assurance processes;
- our discussions with Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) where appropriate; and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

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In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the Chief Executive, the Deputy Chief Executive and Director of Workforce & OD, interim Director of Finance, Director of Planning, Performance and Corporate Services, the

Director of Nursing, the Medical Director, the Director of Digital, the Board Secretary, Chair of the Board, and the Chair of Audit and Assurance Committee to discuss current areas of risk and related assurance needs.

The draft Plan has also been discussed by the Executive Team to ensure that Internal Audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our, and the organisation's, assessment of risk and assurance requirements as defined in the Board Assurance Framework and Risk Registers.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the Corporate Risk Register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

English Gathering 04/11/2022 11:17:17

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by HEIW, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

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6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Paul Dalton
Head of Internal Audit (Health Education and Improvement Wales)
Audit & Assurance Services
NHS Wales Shared Services Partnership

English Catherine
04/11/2022 11:17:41

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing (Quarter)
Partnership working	1	SR5/SR7	To consider outcomes to partnership working. How are risks and governance arrangements considered. How is stakeholder feedback obtained and used to inform decision making.	Dir. of Finance	1
Workforce training and development	2	SR1/SR2	To consider the control process and governance arrangements for training and development.	Dir. of Workforce & OD	1
Performance management framework	3	SR3	To consider how the framework is working and bedding in. Propose to look at a sample of directorate specific delivery plans and review tracking and reporting.	Dir. of Planning, Performance and Corp Services	2
IT – Migration of systems	4	-	To provide assurance over the processes in place for moving the hosting of systems from external organisations to the HEIW controlled cloud to ensure security and stability of service.	Dir. Of Digital	2
Finance – Delegated budgetary control	5	SR6	To consider budgetary control monitoring and reporting, and forecasting.	Dir. of Finance	2
SLA arrangements	6	SR6	Consider level of engagement (right people), capacity, frequency, monitoring.	Dir. of Finance	3

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Phase 2 of strategic review of commissioning of health professional education	7	-	To provide assurance over the operation of the programme Board, project plan, progress against agreed objectives, reporting and risk management. Use of the assurance template.	Dir. of Nurse and Health Professional Education	3
IT – Software / system development	8	-	To provide assurance over the processes in place for developing software / systems to ensure they meet user needs, are secure, and operate appropriately.	Dir. Of Digital	3
Dental Professional Support Unit (DPSU)	9	-	To consider the control process and governance arrangements within DPSU.	Medical Director	4
Quality monitoring of commissioned services	10	-	To consider operational function of a commissioned service: Quality monitoring, Performance monitoring, Governance arrangements. With a focus on health professional services.	Dir of Nurse and Health Professional Education	4
Annual Governance Statement (AGS)	-	-	To Provide 'sense check' of the AGS and narrative from Internal Audit annual report to be included in AGS. No formal report.	Board Secretary	1
Internal audit tracker		-	To ensure that the tracker is operating effectively. No formal report.	Board Secretary	1-4

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Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

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Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Health Education and Improvement Wales with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Health Education and Improvement Wales. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Health Education and Improvement Wales. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

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2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisation's risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g., individual performance) and professional quality purposes (e.g., compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

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4.5 The Audit Committee approves all Internal Audit plans and may

review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between Internal Audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

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5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes, but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the Strategic or Corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

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- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales requirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

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8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The Strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

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8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the

relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

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9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to the Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable

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- Achievable
- Relevant / Realistic
- Timely.

- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

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12 Quality Assurance

12.1 The work of Internal Audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2022

English, Catherine
04/11/2022 11:17:41

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.4.1**
Teitl yr Adroddiad	**Adroddiad Cynnydd Archwilio Cymru**		
Awdur yr Adroddiad	Archwilio Cymru		
Noddwr yr Adroddiad	Archwilio Cymru		
Cyflwynwyd gan	Archwilio Cymru		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Nod Adroddiad Cynnydd Archwilio Cymru yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd ar waith presennol ac arfaethedig Archwilio Cymru. Ystyrir cyfrifon a gwaith archwilio perfformiad, a darperir gwybodaeth hefyd am raglen ehangach yr Archwilydd Cyffredinol o archwiliadau gwerth am arian cenedlaethol a gwaith ein Cyfnewidfa Arfer Dda (GPX).		
Prif Faterion	Mae'r Adroddiad Cynnydd (Atodiad 1) yn crynhoi statws gwaith archwilio a gynhaliwyd gan Archwilio Cymru ar y prif gyfrifon, y cyflwynir adroddiad arno yn 2022. Mae Adolygiad Archwilio Cymru o Drefniadau Comisiynu Blynyddol ynghlwm yn Atodiad 2 er gwybodaeth. Ar y cyfan, canfu Archwilio Cymru fod y dull comisiynu blynyddol yn dda ac wedi'i ategu gan ymgysylltiad cryf â rhanddeiliaid. Canfu Archwilio Cymru hefyd fod rheolaethau mewnol priodol yn cefnogi'r dull comisiynu blynyddol a bod AaGIC yn rheoli ei gontractau a'r modd y mae'n cyflawni'r cynllun comisiynu blynyddol yn dda. Mae'r adroddiad yn gwneud pum argymhelliad ar gyfer gwella.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
			✓	
Argymhellion	Gofynnir i'r Pwyllgor **nodi:** • Adroddiad Cynnydd Archwilio Cymru; a • Adolygiad Archwilio Cymru o'r Trefniadau Comisiynu Blynyddol.		
Atodiadau	Atodiad 1 - Adroddiad Cynnydd Archwilio Cymru Atodiad 2 – Adolygiad o Drefniadau Comisiynu Blynyddol.		

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Audit Wales

Audit and Assurance Committee Update – Health Education and Improvement Wales

Date issued: April 2022

Document reference: HEIWAACU202204

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Audit and Assurance Committee Update

About this document

1 This document provides the Audit and Assurance Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

2 We are currently undertaking our planning work for 2022 and will bring the 2022 Audit Plan to the April Audit and Assurance Committee. This is later than usual, so we will request that it is circulated to members as soon as it is complete.

Accounts audit update

3 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2022.

Exhibit 1 – Accounts audit work

Area of work	Current status
Annual Accounts	**Accounts work 2021-22** High level audit planning commenced late January 2022. Detailed planning and interim testing followed in February and March 2022. We have met with officers and discussed matters arising that will impact the accounts and audit thereof, with more significant matters included within our 2022 Audit Plan. Draft accounts are required to be produced by 29 April 2022; our final audit will commence on 3 May 2022. The audited accounts are required to be submitted to the Welsh Government by 15 June 2022. **Ongoing liaison** Quarterly meetings with the Chair, Chief Executive and Chair of the Audit and Assurance Committee have continued throughout the period.

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Performance audit update

4 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work that is currently underway (**Exhibit 2**); and
- planned work not yet started (**Exhibit 3**).

Exhibit 2 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
Taking care of the carers?	All-Wales themes, lessons and opportunities relating to NHS staff wellbeing during COVID-19. This report is the second of two publications which highlight COVID-19 related themes from our Structured Assessment work at NHS bodies, identifying future opportunities and sharing learning. The first report – Doing it differently, doing it right? - describes how NHS bodies revised their arrangements to enable them to govern in a lean, agile, and rigorous manner during the pandemic.	The report, which was presented to the Audit and Assurance Committee in February 2022, makes recommendations for Welsh Government and NHS bodies. HEIW's management response is due to be presented to Audit and Assurance Committee in April 2022.
Review of Annual Commissioning Arrangements.	Commissioning is a core function in Health Education and Improvement Wales and its biggest investment. This piece of work looks to review its annual commissioning arrangements to ensure they are effective and helping to meet the wider needs of the NHS in Wales in terms of education and training.	The draft report was issued to HEIW in February 2022 and the final report is in today's meeting papers for the committee's consideration.

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Exhibit 3 – Planned work not yet started

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
Structured Assessment 2022	Structured assessment will continue to form the basis of the work we do at Health Education and Improvement Wales to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. This will include Governance and leadership, Financial management, Strategic planning and Use of resources	We are currently planning this years Structured Assessment and will be issuing the project brief in the spring.
All-Wales and local thematic work	This work will consider the organisation's unique position and strategic role in workforce planning in Wales. The review will focus on how Health Education and Improvement Wales supports short, medium and longer-term workforce planning in NHS Wales nationally and how it supports its stakeholder NHS partners in Wales. This work will also consider risks relating to Health Education and Improvement Wales own workforce planning arrangements and how it plans for and intends to fulfil its own workforce requirements in the short and medium term.	We are currently scoping this work. We will update the Audit and Assurance Committee as work progresses.

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2021 local project	Our 2021 audit plan included provision for a local performance audit project. Covid and wider resourcing pressures have prevented us from progressing this work. In order to help "reset" our programme of performance audit work we intend to take this project out of our plans and refund the element of the 2021 fee associated with this work. The refund will be processed in the 2022-23 financial year.

Good Practice events and products

5 We continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to prompt some thinking and support the exchange of practice. As part of the project, we held a COVID-19 Learning Week in March 2022. The material from the COVID-19 Learning Week, and other related material, is available here.

NHS-related national studies and related products

6 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee at the Senedd to support its scrutiny of public expenditure.

7 We have published one NHS-related or relevant national studies reports since we last provided the Committee with an update. **Exhibit 4** provides information on this report.

Exhibit 4 – NHS-related or relevant national studies reports

Title	Publication Date
Joint working between Emergency Services report and supporting Data Tool	January 2022

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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Review of Annual Commissioning Arrangements – Health Education and Improvement Wales

Audit year: 2020-21

Date issued: February 2022

Document reference: 2754A2022

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Summary report

About this report

1 High quality care and patient safety start with ensuring there is a well-trained workforce with the right skills to meet current and future needs. The role of Health Education and Improvement Wales (HEIW) is to take the lead on education, training, and development, shaping the Welsh healthcare workforce to help drive high quality care for the people of Wales. One of the ways it fulfils this remit is by commissioning education and training for a wide range of health professional groups. It is responsible for commissioning education and training for all healthcare professionals, with the exception of undergraduate medical and dental education which is funded directly by the Welsh Government. This is HEIW's core function and its biggest investment. HEIW's overall expected spending for 2021-22 is £274.2 million; £227.9 million of which is for commissioning education and training. This is broken down as:

- £127.9 million – health professional education (nursing and allied health professionals)
- £55.2 million – postgraduate medical training
- £26.2 million – postgraduate GP training
- £9.3 million – pharmacy training
- £9.1 million – postgraduate dental training

2 When HEIW was established, the health professional education contracts were due to expire. With the agreement of the Welsh Government, HEIW extended the contracts for a three-year period. This allowed HEIW time to plan new contracts through its strategic review of health professional education. As part of this, HEIW considered the scope and configuration of education to meet the ambitions set out in A Healthier Wales. It also focused on the value for money of new contracts, that they are fit for purpose, and align with HEIW's strategic objectives. HEIW is delivering its review in two phases[1]. Following an extensive procurement exercise during the first phase, HEIW agreed ten-year contracts in August 2021 in readiness for courses staring in September 2022. Phase two is currently underway.

3 Our audit examined whether HEIW has effective arrangements for the annual commissioning of health education and training in Wales. This review does not examine the strategic review or the new contracts, but reference has been made where appropriate. Specifically, we looked at whether the annual commissioning of health education and training is well-planned, supported by robust systems and appropriate resources, and underpinned by robust performance monitoring and oversight. To test practical arrangements, our fieldwork mainly focused on the commissioning process for health professional education.

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[1] Phase one predominantly focused on pre-registration health professional education. Phase two largely focuses on post-registration education.

Key messages

4 Overall, we found that **HEIW has a good approach to the annual commissioning of health education and training. This is enabled by strong stakeholder engagement, internal controls and contract variation process. There is scope to improve the information upon which HEIW relies for commissioning and strengthen performance reporting and the quality of improvement action plans.**

5 HEIW has a clear approach for developing its annual commissioning plan. It is strengthening the approach further by aligning the planning processes for the annual commissioning plan and strategic planning. HEIW engages stakeholders well as part of the annual commissioning approach. The Education Commissioning and Quality (ECQ) Team uses a range of information to develop commissioning plans. They rely on workforce information within health board Integrated Medium Term Plans (IMTPs), but these are often of varying quality. HEIW is working to improve the accessibility of benchmarking data to better inform the commissioning process.

6 Board, executive and operational level roles and responsibilities for planning and managing education and training contracts are clear. This was further clarified through the recent strategic review of contracts. HEIW is also strengthening the Education Commissioning and Quality (ECQ) Team by taking action to build resilience within the team.

7 HEIW applies appropriate internal controls to support annual commissioning and there are clear arrangements to review and vary education and training contracts each year.

8 HEIW's framework for managing contract performance is improving and has been strengthened in the new contracts. But there is scope to improve the quality of university improvement action plans, which we found were presented in inconsistent formats and were of varying quality. There is also scope to improve the administration of contract business meetings through timely circulation of draft minutes. And an opportunity for HEIW to better triangulate the information presented in the all-Wales annual performance and annual quality reports to help understand trends and issues. HEIW is planning to strengthen the information provided in the quarterly integrated performance report, which should further support the Board's scrutiny and oversight role. However, there is scope to improve reporting to the Education, Commissioning and Quality Committee, by standardising the format of the quality assurance reports for each healthcare professional. This will strengthen scrutiny and assurance by enabling committee members to review information before the meeting.

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Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. HEIW's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Workforce information R1 Health board Integrated Medium Term Plans (IMTP) are the main source of information used to determine required student numbers and placements. However, our work has identified that the quality of data and information within IMTPs relating to workforce planning is of variable quality. **HEIW should:** **a) work with the Welsh Government to strengthen annual and/or IMTP planning guidance to ensure that workforce commissioning requirements are clearly set out in core health body plans or supporting documents; and** **b) work with health boards to identify and forecast longer-term workforce trends and needs to inform commissioning plans.**
Contract business meeting minutes R2 Minutes of the contract business meetings are not circulated in a timely manner. The minutes are circulated along with the papers of the next meeting, leaving a four-month lag. To improve the administration of contract business meetings, **HEIW should aim to circulate draft minutes within two weeks of the meeting taking place. The minutes can be formally confirmed as accurate at the next meeting.**
University improvement action plans R3 Where HEIW identifies areas of underperformance or issues, universities are required to produce an action plan, which HEIW monitors. We found the action plans submitted by the universities were of varying quality and submitted in a variety of formats. **HEIW should develop a standardised format for action plans that as a minimum ask universities to set out:** • **Identified issues** • **Mitigating/improvement actions** • **Lead for each action** • **Time scales for completion**

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Recommendations

- **Space for progress updates**

Annual performance and quality report

R4 There are two annual reports on the commissioning process, one on performance and one on quality. This is because performance and quality information are available at different times of the year and producing two reports avoids a reporting lag. However, separating the two reports means that HEIW is potentially missing key trends or issues. **HEIW should identify ways in which they can bring together key themes and issues from the annual performance and quality reports to provide a more comprehensive picture of the commissioning process and education effectiveness.**

Reporting to Education Commissioning and Quality (ECQ) Committee

R5 The ECQ Committee receive regular reports on the quality of commissioned education and training, but the format of these reports is inconsistent and presented as a mixture of verbal and written updates. To strengthen assurance and to allow committee members to review information before the meeting, **HEIW should present its quality assurance reports in a standardised, written format at each meeting.**

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Detailed report

The annual commissioning approach is good and supported by strong stakeholder engagement. However, there are opportunities to strengthen the information used to inform plans

HEIW has a clear and improving approach for developing its annual commissioning plan and engages well with stakeholders as part of this process

10 Each year, HEIW develops an Education Commissioning and Training Plan for the following year's student intake. The new planning cycle starts in January, 18 months ahead of the new intake, by collating, evaluating, and modelling workforce data. HEIW engages its stakeholders effectively on the draft recommendations, usually in May. In June, the executive signs off the plan prior to committee level scrutiny and final Board approval in July. Once the Welsh Government approves the plan and associated funding, HEIW formally writes to commissioned universities and health boards confirming student numbers and placements. This normally takes place in December.

11 The plan sets out the levels of medical and health professional education and training that need commissioning in the upcoming academic year. Specifically, HEIW provides detail on the number of proposed student places, the rationale for any changes in the number of placements and the financial investment needed. In July 2020, the Board, subject to prior scrutiny by the ECQ Committee, approved HEIW's 2021-22 Education Commissioning and Training Plan. This is the second commissioning plan that HEIW has developed since its establishment.

12 The planning process is complicated because the organisation must work both to an academic and financial year (**Exhibit 2**). A consequence of this is that the Board approved HEIW's 2021-22 Annual Plan around a year after the 2021-22 Education Commissioning and Training Plan. In this instance it has meant that the plan driving the organisation's strategic direction is approved after the plan that should support its delivery. There are also financial implications. The funding to support the commissioning plan, representing over 80% of HEIW's total budget, is approved by the Welsh Government before the strategic annual plan. The two planning cycles can also result in teams duplicating work to support both arrangements. HEIW is considering options to improve the process and reduce some of the duplication of effort when planning. Any significant process changes would need to be agreed with the Welsh Government and academic partners.

13 In the interim, the planning department is managing the development of the 2023-24 commissioning plan. That team is also responsible for developing the IMTP and this should help to better align the timing and content of plans. This is a pragmatic

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interim solution, which should build stronger links between the annual commissioning and strategic planning cycles.

Exhibit 2: HEIW's planning process timeline

Exhibit source: HEIW 2021-22 Annual Plan

14 HEIW works with a range of partners to develop and adapt its commissioning plans including:

- Regulatory and professional bodies
- The Council of Deans for Health (Wales)
- Welsh Government
- Health board and trust executive directors, deputy directors of nursing and deputy directors of therapies and healthcare science
- Various colleges and societies

15 When developing the previous 2020-21 Education Commissioning and Training Plan, HEIW staff attended peer meetings and had face to face discussions about proposals for health education and training. However, the 2021-22 planning process started at the early stages of the COVID-19 pandemic. HEIW adapted well

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and adopted a virtual planning approach. During an initial three-week virtual consultation exercise in May 2020, HEIW sent stakeholders a presentation outlining the proposals. The consultation led to HEIW refining and improving the draft commissioning plan, for example, increasing the number of student placements for some allied health professions. Due to the ongoing restrictions, HEIW adopted a similar virtual approach to stakeholder engagement for its 2022-23 Education Commissioning and Training Plan, which was approved by the Board in July 2021.

16 HEIW's commissioning plan engagement helps to inform discussions with universities and colleges. Some of these conversations take place at their contract business meetings allowing the universities and HEIW an opportunity to discuss practicalities and potential issues before commissioning and placement numbers are set. Overall, the university school managers were complimentary about their relationship with HEIW. They felt HEIW were striking the right balance between being the commissioner and supporting as an education partner.

While commissioning plans are informed by a range of information, they are heavily reliant on workforce information within health board IMTPs which are of varying quality. HEIW is however taking steps to improve the accessibility of benchmarking data

17 Understanding current and future workforce needs, challenges and trends is a key element of the annual commissioning process. Based on this intelligence, HEIW seeks to ensure that the right number of students are being recruited in the right disciplines to meet healthcare workforce needs across the NHS in Wales.

18 HEIW considers a good range of information including strategies and policies which set out national service priorities, available workforce data and an evaluation of the previous year's performance. The commissioning team also considers the capacity within the NHS bodies to effectively support student training.

19 HEIW primarily uses health board Integrated Medium Term Plans (IMTP) to determine the required student numbers and placements and assess wider workforce needs and challenges. For example, the 2021-22 commissioning plan highlights professions with resource shortfalls, such as:

- Nursing – across the board including adult, child health, mental health (including CAMHS), practice nursing
- Allied Health Professionals –including physiotherapy, dietetics, orthoptists
- Health Care Science – radiographers, sonographers, cardiac physiologists

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20 However, those we met with during our fieldwork highlighted that the workforce planning information within IMTPs is of variable quality. This is also an issue that we have highlighted in past structured assessments[2]. The concern for HEIW is that without robust, reliable workforce plans, it cannot be confident that the identified workforce need reflects true need (**Recommendation 1**).

21 The 2021-22 commissioning plan includes predicted workforce projections for some healthcare professions from 2019 to 2025. Whilst this is positive, HEIW needs to work with health bodies to forecast longer-term workforce trends and needs. HEIW has limited benchmarking data to inform the commissioning process. For example, the 2020 All Wales Annual Performance Report includes some benchmarking data, such as comparing university fill and attrition rates, but this is limited to Wales. HEIW is setting up a task group with its counterparts in England, Scotland, and Northern Ireland to improve benchmarking on a UK-wide basis. Where courses are commissioned at several universities, such as nursing, this helps to improve and enable comparison of performance through benchmarking. The strategic review has enabled the expansion of some courses to other universities, so this will also aid benchmarking in the future.

The annual commissioning process is supported by appropriate internal controls and HEIW is strengthening its capacity in the Education, Commissioning and Quality Team

Roles and responsibilities to plan and manage annual education contracts are clear, and HEIW has taken steps to strengthen resource weaknesses in the Education Commissioning and Quality Team

22 The 12 strong (10.76 WTE) Education, Quality and Commissioning (ECQ) team, sits within the Nursing and Health Professional Directorate. They are responsible for work-based learning, pre-registration education, post registration education and placement quality development. There is a head of service for each of these areas.

23 The team is becoming better resourced to deliver its core role, although the resilience of the team was a risk. Some members perform a distinct role which could result in a single point of failure if they are away from work. HEIW is starting to address this issue. This includes transferring the ECQ Team's data analyst to the Workforce Data Analytics Team, with that data analyst working as a business partner with the ECQ team. This provides peer support and enables more than one

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[2] We have not reviewed health board annual plan/IMTP workforce plans as part of this review. However, we plan to explore this topic area in future reviews.

data analyst to support the ECQ Team if needed. The ECQ Team has also adapted its contract business manager role into a recently recruited to business improvement manager position. This new remit is broader with a stronger emphasis on relationship management, working with HEIW's finance business partners, college deans and university school managers. The ECQ Team has also employed additional dedicated administrative support to bolster capacity.

24 Roles and responsibilities for planning and managing education and training contracts are clear at Board, executive and operational levels. Roles have been further clarified through the recent strategic review of contracts. HEIW is a relatively small organisation and internal processes such as workshops, cross-team working, and mid-term reviews with executives give staff the opportunity to understand each other's roles. The university school managers we spoke to said they were clear who their key HEIW contacts were and appreciated the open-door policy the ECQ team operates.

There are appropriate controls for annual commissioning and clear arrangements to review and vary education and training contracts

25 In any given academic year there are new students and existing students at various stages of progress in their training. For new student placements, HEIW writes to each university setting out the number of student places required. But each year the numbers of students in their second year or beyond will change as students may leave courses or defer their place. As such, there needs to be a process to vary the contracts on an annual basis. Contract variation ensures agreement of revision of numbers and the payments received by the universities are based on actual student numbers.

26 HEIW has a clear process to manage annual variation orders. Each year the ECQ team draws up a variation order for each course. The partners ratify variation orders at the contract business meetings with universities. These are then signed by the appropriate university personnel, such as the school dean or university's head of finance. As per its scheme of delegation, the Chief Executive signs the variation orders on behalf of HEIW, unless they are above £5 million, which the Board then approves. This was the case for the 2021-22 variation orders for the four universities providing pre-registration nursing education, where the Board approved the orders at its closed session in September 2021. The school managers we interviewed felt the contract variation process was straight forward and did not raise any issues.

27 HEIW's existing financial controls and governance processes help to support the annual commissioning process. For example, the roles and responsibilities for annual commissioning and contract variations are set out in HEIW's standing financial instructions. The limits for financial authorisation are detailed in the

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organisation's delegated financial limits. Both documents are reviewed on an annual basis.

28 HEIW uses its risk management arrangements to help anticipate the potential issues that it needs to manage or control. The corporate risk register clearly identifies several risks that could interrupt the delivery of education and training. For example, COVID-19 disrupting training and placements, lack of jobs for students opting for a bursary and the inability to capture NHS workforce data hindering workforce modelling. Operationally, the ECQ Team manages its own departmental risk register.

HEIW manages its contracts and delivery of the annual commissioning plan well. But there are opportunities to strengthen action planning and performance reporting

HEIW has a good framework for managing contract performance, which has been strengthened in the new contracts. There is scope to improve the quality of university improvement action plans and performance reporting

29 HEIW has a continuous cycle of contract performance management. The arrangements and expectations for which are stipulated in the contracts HEIW holds with universities. Annually, HEIW holds three formal contract business meetings with each university. The meetings, chaired by the Deputy Director of Education Commissioning and Quality, are an opportunity to review and hold universities to account on their performance and to discuss any issues. The contract business meetings cover finance, performance, and quality. Equivalent meetings are held at an operational level.

30 In October 2021, we observed a contract business meeting and found that HEIW and the university had a respectful relationship, with HEIW providing healthy challenge but also support. The meeting was well chaired, but the agenda was quite large, meaning the latter items were a bit rushed. The school managers we interviewed spoke positively about these meetings. They felt that HEIW balanced being a commissioner and education partner well, and they felt challenged on areas of underperformance. They also value the task and finish groups HEIW organises for all universities to tackle common issues, such as student vaccinations. They would like more opportunities to meet in such forums. However, university school managers did raise that they do not get the minutes of the previous contract business meetings in a timely manner. The minutes are

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circulated along with the papers of the next meeting, leaving a four-month lag (**Recommendation 2**).

31 Contract management arrangements require the universities to submit a range of information to HEIW. Some university school managers raised that the volume of information that HEIW requests can be burdensome, and some also felt that HEIW is duplicating a role already performed by regulators. However, as the commissioner, HEIW needs assurance that education providers are meeting their contractual obligations and improving the quality of health education.

32 HEIW sets out performance information requirements in their contracts. These have recently been strengthened with the new arrangements, starting in September 2022. The type of information HEIW currently collects from universities includes:

- the university's internal quality information;
- regulator reports, for example, reports from the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC);
- national student survey results;
- course fill rates;
- student attrition rates; and
- student demographic data.

33 HEIW also triangulates the data provided by the universities and regulators. Each year, the ECQ Team meets with a sample of trainees from every year group for every course commissioned, student bodies, health board placement mentors and practice education facilitators. This is an effective way for HEIW to get first-hand understanding of the quality of the courses they commission and listen to students' and mentors' experience. HEIW is in the early stages of strengthening its quality assurance processes for training and education. It is developing a quality framework spanning all health professions. The advantage of this approach is a standardised quality management process for medical and non-medical professions, consistent terminology, and effective information sharing.

34 Where HEIW identifies areas of underperformance or issues, universities are required to produce an action plan setting out how the issues will be addressed. The action plans are monitored by the ECQ team through routine engagement with universities. We reviewed a sample of action plans and found they were of varying quality and presented in different formats. Some did not have clear, measurable actions, identified leads or timescales. HEIW would benefit from developing an action plan template which it can issue to universities to complete (**Recommendation 3**).

35 HEIW produces an annual performance report for each university. The report summarises the university's performance against its key performance indicators (KPIs) and highlights any improvement actions. An all-Wales Annual Performance Report provides an overall summary. However, the performance reports do not include quality measures. HEIW prepares a separate Annual Quality Report which

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summarises information such as results of the national student survey, its annual meetings with students and mentors, and regulator reports. HEIW explained that performance data and quality information is available at different times of the year. The two annual reports are produced separately to avoid a reporting lag to the Board and ECQ Committee. However, HEIW is potentially missing key trends and triangulation of issues because of this. HEIW should consider how the information is triangulated from both reports to provide a more comprehensive picture of education effectiveness for board members (**Recommendation 4**).

HEIW is strengthening information provided to the Board on annual commissioning plan delivery, but there is scope to improve how performance is reported to the Education, Commissioning and Quality Committee

36 HEIW's quarterly integrated performance report provides the Board with updates on commissioning activity, such as contract and performance issues, recruitment activities and fill rates. HEIW is in the process of strengthening the integrated performance report by seeking to incorporate more commissioning indicators for health professional education, such as attrition rates and national student survey scores.

37 At each meeting, the ECQ Committee receives updates on education performance and quality. This includes a separate update for each health professional group, (medicine, dentistry, pharmacy, nursing, and health professionals). The updates inform the committee on aspects such as current student recruitment rates, quality issues and student and mentor surveys and feedback. Whilst these updates are positive, we found the format of the updates was inconsistent. The update for medical training tends to be a written report, whereas updates for the other professions are a mixture of verbal and written. Although the meetings are minuted, the committee would benefit from receiving a report in a consistent format for each health professional group, this would allow members to review the information prior to the meeting, which in turn would allow members to consider the questions they want to ask in advance and strengthen assurance. (**Recommendation 5**).

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Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Workforce information R1 Health board Integrated Medium Term Plans (IMTP) are the main source of information used to determine required student numbers and placements. However, our work has identified that the quality of data and information within IMTPs relating to workforce planning is of variable quality. **HEIW should:** **a) work with Welsh Government to strengthen annual and/or IMTP planning guidance to ensure that workforce commissioning requirements are clearly set out in core health body plans or supporting documents; and** **b) work with health boards to identify and forecast longer-term workforce trends and needs to inform commissioning plans.**	Producing an annual education and training plan is a statutory function of HEIW, given our role as the workforce and education body for NHS Wales. We consider the workforce plans from NHS Wales Health Boards and Trusts, and the views and advice from other stakeholders. It is our responsibility to produce a plan that is both challenging but deliverable and we don't just rely on IMTP information for the development of the education commissioning recommendations. We review and consider the following: • education commissioning requests from organisations. We consider trends in requesting and trends that we have contracted over the past few years. We consider students in training and training capacity and quality – we undertake modelling for Nursing and AHP which looks at student training information against workforce information. • we look at organisations' IMTP and their plans for services going forward and	September 2022	Martin Riley

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Recommendation	Management response	Completion date	Responsible officer
	consider this against WG strategy and priority areas. • we consider wider workforce information from ESR including trends and key workforce indicators such as changes to participation rates, wider workforce considerations to create the bigger picture eg population, Labour Market Intelligence and undertake horizon scanning or research: – National priorities ie Made in Wales – Availability of applicants – Placement capacity – Roles available for graduates – More recently the impact of the pandemic Closer work with Health Boards and the E&T Planning process is being continually refined and has a new focus in 22/23.		
Contract business meeting minutes R2 Minutes of the contract business meetings are not circulated in a timely manner. The minutes are circulated along with the papers of the next meeting, leaving a four-month lag. To improve the	Targets will be set for a 2 week turnaround of minutes. This will be built into the contract business meeting planning process.	April 2022	Martin Riley

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Recommendation	Management response	Completion date	Responsible officer
administration of contract business meetings **HEIW should aim to circulate draft minutes within two weeks of the meeting taking place. The minutes can be formally confirmed as accurate at the next meeting.**			
University improvement action plans R3 Where HEIW identifies areas of underperformance or issues, universities are required to produce an action plan, which HEIW monitors. We found the action plans submitted by the universities were of varying quality and submitted in a variety of formats. **HEIW should develop a standardised format for action plans that as a minimum ask universities to set out:** • **Identified issues** • **Mitigating/improvement actions** • **Lead for each action** • **Time scales for completion** • **Space for progress updates**	All action plans contain the content included in the recommendation: • Identified issues • Mitigating/improvement actions • Lead for each action • Time scales for completion • Space for progress updates The reason a standard template is not used is that individual Universities are subject to their own internal improvement plans – eg their annual performance review (APR) or Programme Improvement Plan (PIP). Rather than be prescriptive and make them produce the same information in a different way we accept their internal format. In addition – depending upon the issue – the plan can be lengthy/complex.	June 2022	Martin Riley

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Recommendation	Management response	Completion date	Responsible officer
	However, the ECQ Team will create a standard register/database to collate a summary of all the actions. This will standardise the information and the longer submitted action plans will act as backing information. There is already work underway to standardise quality reporting to the ECQ Committee and this database will provide a useful audit tool and can be used to inform and update committee of progress.		
Annual performance and quality report R4 There are two annual reports on the commissioning process, one on performance and one on quality. This is because performance and quality information are available at different times of the year and producing two reports avoids a reporting lag. However, separating the two reports means that HEIW is potentially missing key trends or issues. **HEIW should identify ways in which they can bring together key themes and issues from annual performance and quality reports to provide a more comprehensive picture of the commissioning process and education effectiveness.**	A new Performance and Quality Framework is being developed as part of the move towards the new contracts commencing in September 2022. This will incorporate both performance KPIs and Quality reporting. The updates of this will be fed into the HEIW Quarterly Performance Reports.	September 2022	Martin Riley

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Recommendation	Management response	Completion date	Responsible officer
Reporting to Education Commissioning and Quality (ECQ) Committee R5 The ECQ Committee receive regular reports on the quality of commissioned training, but the format of these reports is inconsistent and presented as a mixture of verbal and written updates. To strengthen assurance and to allow committee members to review information before the meeting, **HEIW should present its quality assurance reports in a standardised, written format at each meeting.**	This is already being actioned and the ECQ Committee have commended the move to a more integrated and consistent written approach. This will continue to be refined and the new system addressed in **Recommendation 4** will further support this move.	February 2022	Martin Riley

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Erthyglau Catherine
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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.4.2**
Teitl yr Adroddiad	**Cynllun Archwilio 2022 Archwilio Cymru a Ffi Archwilio**		
Awdur yr Adroddiad	Archwilio Cymru		
Noddwr yr Adroddiad	Archwilio Cymru		
Cyflwynwyd gan	Archwilio Cymru		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Mae Cynllun Archwilio 2022 Archwilio Cymru yn nodi'r gwaith y mae Archwilio Cymru yn bwriadu ei wneud yn ystod 2022 i gyflawni ei gyfrifoldebau statudol fel archwilydd allanol AaGIC a chyflawni ei rwymedigaethau o dan y Cod Ymarfer Archwilio. Mae hefyd yn nodi'r Ffi Archwilio ar gyfer 2022/23.		
Prif Faterion	Mae'r Cynllun yn dynodi'r aseiniadau archwilio a'r cyfnodau amser arfaethedig ar gyfer rhaglen 2022/23. Mae'r cyfraddau ffioedd ar gyfer 2022/23 wedi cynyddu 3.7% oherwydd yr angen i fuddsoddi'n barhaus mewn ansawdd archwilio ac mewn ymateb i bwysau cost gynyddol. Y Ffi Archwilio amcangyfrifedig ar gyfer 2022/23 yw £167,173.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓
Argymhellion	Gofynnir i'r Pwyllgor **gymeradwyo** Cynllun Archwilio 2022 Archwilio Cymru a'r Ffi Archwilio.		
Atodiadau	Atodiad 1 - Cynllun Archwilio 2022 Archwilio Cymru		

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Archwilio Cymru
Audit Wales

2022 Audit Plan – Health Education and Improvement Wales

Audit year: 2021-22

Date issued: March 2022

Document reference: 2867A2022

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This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on the Special Health Authority's (SHA) financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. I lay them before the Senedd together with any report that I make on them. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether other information presented with the financial statements is prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit and Assurance Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 There have been no limitations imposed on me in planning the scope of this audit.

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Audit of financial statement risks

9 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
Management Override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
Scheme Pays Initiative The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of Matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.

10 In addition to my responsibilities in respect of the audit of the body's statutory financial statements set out above, I am also required to certify a return to the Welsh Government which provides information about Health Education and Improvement Wales to support preparation of Whole of Government Accounts.

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Performance audit work

11 In addition to my Audit of Financial Statements, I must also satisfy myself that the SHA has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

12 My work programme is informed by specific issues and risks facing the SHA and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

13 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: my planned 2022 performance audit work at the Special Health Authority

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the SHA in relation to: • Governance and leadership • Financial management • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets)
All-Wales and local thematic work	As part of my 2022 plan, I intend to review workforce planning risks that NHS bodies are experiencing currently and are likely to experience in the future. For the SHA, this work will consider the organisation's unique position and strategic role in workforce planning in Wales. This will particularly focus on how the SHA supports short, medium and longer-term workforce planning in NHS Wales nationally and how it supports its stakeholder NHS partners in Wales. I will also consider risks relating to the SHA's own workforce planning arrangements and how it plans for and intends to fulfil its own workforce requirements in the short and medium term.

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Theme	Approach/key areas of focus
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

14 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

15 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

16 We will provide updates on the performance audit programme though our regular updates to the Audit and Assurance Committee.

Fee, audit team and timetable

17 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];

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[1] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

18 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures.

19 The estimated fee for 2022 is set out in **Exhibit 3**. This represents a 0.9% increase compared to your actual 2021 fee.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	84,825	85,500
Performance audit work:		
• Structured Assessment	38,285	50,285
• All-Wales thematic and local work[3]	44,063	29,850
Performance work total	82,348	80,136
Total fee	**167,173**	**165,636**

20 Planning will be ongoing, and changes to our programme of audit work, and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Interim Director of Finance.

21 Further information on my fee scales and fee setting can be found on our website.

22 Our 2021 audit plan included provision for a local performance audit project. Covid and wider resourcing pressures have prevented us from progressing this work. In order to help "reset" our programme of performance audit work i intend to take this project out of our plans and refund the element of the 2021 fee associated with this work. The refund will be processed in the 2022-23 financial year.

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[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

[3] As detailed in the respective audit plans.

Audit team

23 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director (Performance Audit)	029 2032 0604	Dave.Thomas@audit.wales
Matthew Edwards	Audit Director (Financial Audit)	029 2032 0663	Matthew.Edwards@audit.wales
Helen Goddard	Audit Manager (Financial Audit)	029 2032 0642	Helen.Goddard@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	029 2082 9342	Andrew.Doughton@audit.wales
Helen Williams	Audit Lead (Financial Audit)	029 2032 0708	Helen.Williams@audit.wales
Urvisha Perez	Audit Lead (Performance Audit)	029 2032 0610	Urvisha.Perez@audit.wales

24 We can confirm that team members are all independent of you and your officers.

Timetable

25 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

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Exhibit 5: audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	January to March 2022	March 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum	May to June 2022	June 2022 June 2022 July 2022
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.5**
Teitl yr Adroddiad	**Adroddiad ar Gydymffurfiaeth Prosesau Caffael AaGIC**		
Awdur yr Adroddiad	Rhian Sadler, Rheolwr Busnes Caffael, Partneriaeth Cydwasanaethau GIG Cymru		
Noddwr yr Adroddiad	Rhiannon Beckett, Cyfarwyddwr Cyllid		
Cyflwynwyd gan	Christine Thorne, Dirprwy Bennaeth Cyrchu Cenedlaethol TGCh a Chynnyrch Swyddfa		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Diben yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Risg am y gweithgarwch caffael yn ystod y cyfnod rhwng 18 Ionawr 2022 a 30 Mawrth 2022; ac yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 i'r Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheirianneg) yn y Cyfarwyddiadau Ariannol Sefydlog.		
Materion Allweddol	Dyma brif bwyntiau'r papur hwn: • Cadarnhau bod y cam gweithredu sydd heb ei gwblhau ac sy'n deillio o'r*Adolygiad o Systemau a Phrosesau Caffael AaGIC*' wedi cael ei gyflawni, a rhoi'r wybodaeth ddiweddaraf am gyflwyno Model Gweithredu Cenedlaethol Gwasanaethau Caffael Partneriaeth Cydwasanaethau GIG Cymru (NWSSP). Mae'r gweithgaredd hwn yn ymwneud â chyflawni: *Nod Strategol 2* AaGIC, sef: *Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau ei fod yn diwallu anghenion y dyfodol.* Nid oes dim risgiau allweddol i roi gwybod amdanynt.		
Cam Penodol i'w Gymryd ***(✓un yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
			√	
Argymhellion	Gofynnir i'r Aelodau **nodi'r** adroddiad er sicrwydd		

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ADRODDIAD AR GYDYMFFURFIAETH PROSESAU CAFFAEL AaGIC

1. CYFLWYNIAD

Un o ofynion Cyfarwyddiadau Ariannol Sefydlog AaGIC yw bod y Pwyllgor Archwilio a Sicrwydd yn cael gwybod am bob cais am Weithredu Un Dyfynbris (SQA), Gweithredu Tendr Sengl (STA), Tendrau Sengl yn dilyn galwad am Gystadleuaeth FTS, Estyniadau i Gontractau a Dyfarnu cyllid ychwanegol y tu allan i delerau'r contract gwreiddiol (a weithredir drwy Nodyn Newid Contract (CCN) neu Amrywio Telerau).

2. CEFNDIR

Pwrpas yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd am weithgarwch caffael yn ystod y cyfnod rhwng 18 Ionawr 2022 a 30 Mawrth 2022, ac yn unol â'r Cyfarwyddiadau Ariannol Sefydlog.

2.1 Cynllun Gwella'r Broses Gaffael

Mae cydweithwyr yn y Gwasanaeth Caffael ac AaGIC yn parhau i gwrdd yn rheolaidd ers mis Hydref 2021, gan gynnal yr amserlen o gyfarfodydd bob deufis ac adolygiadau chwarterol, a gan sicrhau bod meysydd sy'n peri pryder yn cael eu hadolygu a'u trafod mewn partneriaeth i sicrhau canlyniad priodol.

Mae sesiynau galw heibio ym maes caffael yn cael eu cyflwyno a byddant yn dechrau yn Ebrill-22 ar ddiwrnod wedi'i drefnu bob wythnos i roi rhagor o gymorth i gydweithwyr yn AaGIC i reoli ymchwiliadau ynghylch gweithgarwch caffael presennol/yn y dyfodol neu i reoli contractau sydd wedi'u dyfarnu.

Yn y Pwyllgor Archwilio a Sicrwydd diwethaf, daeth Cyfarwyddwr Gwasanaethau Caffael Partneriaeth Cydwasanaethau GIG Cymru i ddisgrifio'r Model Gweithredu Cenedlaethol newydd a'r strategaethau, ynghyd â'r gwelliannau a fydd yn cael eu sicrhau. Dechreuodd y cyfnod pontio ar 7 Mawrth; mae cynlluniau gwaith a phrosesau'n cael eu hadolygu, ac mae argymhellion a gwelliannau'n cael eu gwneud.

3. Y CYNNIG

3.1 Gweithgareddau Caffael

Mae'r tabl canlynol yn crynhoi'r eitemau sydd i'w dwyn i sylw'r Pwyllgor Archwilio a Sicrwydd ar gyfer y cyfnod adrodd. Mae eglurhad o'r rhesymau a'r amgylchiadau, a manylion ynghylch unrhyw gamau pellach a gymerwyd hefyd wedi eu cynnwys yn yr atodiadau i'r adroddiad hwn.

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Cyfeirnod SFI	Disgrifiad	Eitemau

3.5	Gweithredoedd Un Dyfynbris	1
4.2	Gweithredoedd Tendr Sengl	1
5.3	Tendrau Sengl er ystyriaeth yn dilyn cais am Gystadleuaeth OJEU	0
10.8	Estyniadau i Gontractau	4
14.2	Dyfarnu cyllid ychwanegol y tu allan i delerau'r contract (a weithredir drwy Nodyn Newid Contract (CCN) neu Amrywio Telerau)	5

4. MATERION LLYWODRAETHU A RISG

Nid oes dim materion llywodraethu a risg eraill wedi'u nodi y tu hwnt i'r rhai sydd wedi'u cynnwys uchod ac yn atodiadau'r adroddiad hwn.

5. GOBLYGIADAU ARIANNOL

Dylai'r Pwyllgor Archwilio a Sicrwydd nodi manylion yr Atodiadau sydd ynghlwm a monitro faint o fusnes, a gwerth y busnes, sy'n cael ei gyflwyno er cymeradwyaeth ar gyfer Tendr Sengl neu Ddyfynbris Sengl. Yn ôl y canllawiau cyffredinol ar wario arian cyhoeddus, dylid cyflawni hyn mewn ffordd deg, tryloyw ac agored, gan sicrhau y ceisir cystadleuaeth lle bynnag y bo modd. Felly, dylid cael cyn lleied â phosib o geisiadau am weithredoedd sengl.

6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor **nodi'r** adroddiad er sicrwydd

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig *(nodwch ✓)*	**Nod Strategol 1:** Arwain y broses o gynllunio a datblygu gweithlu cymwys, cynaliadwy a hyblyg, a sicrhau ei lesiant, er mwyn helpu i gyflawni *'Cymru Iachach'*	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd er mwyn gwella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol yn GIG Cymru drwy feithrin gallu arwain tosturiol ac ar y cyd ar bob lefel
	√		
	Nod Strategol 4: Datblygu atebion cenedlaethol i'r gweithlu i gefnogi'r gwaith o ddarparu blaenoriaethau gwasanaeth cenedlaethol a gofal o ansawdd uchel i gleifion.	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio ynddo	**Nod Strategol 6:** Cael ein cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
Ansawdd, Diogelwch a Phrofiad Cleifion			
Nid oes dim goblygiadau pendant o ran ansawdd a diogelwch yn gysylltiedig â'r gweithgareddau a nodwyd yn yr adroddiad hwn.			
Goblygiadau Ariannol			
Cyfarwyddiadau Ariannol, Rheolau Sefydlog, Mesurau Rheoli Ariannol a systemau a phrosesau cyfrifyddu yw'r sail ar gyfer nifer o fesurau rheoli sefydliadol, sy'n rhan o'r gwaith o gyflawni targedau ariannol a llywodraethu da. Yn ôl y canllawiau cyffredinol ar wario arian cyhoeddus, dylid cyflawni hyn mewn ffordd deg, tryloyw ac agored, gan			

English Translation 04/11/20 11:12:41

sicrhau y ceisir cystadleuaeth lle bynnag y bo modd. Felly, dylid cael cyn lleied â phosib o geisiadau am weithredoedd sengl.	
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)	
Does dim goblygiadau cyfreithiol penodol yn gysylltiedig â'r gweithgarwch a nodir yn yr adroddiad hwn.	
Goblygiadau Staffio	
Nid oes dim goblygiadau staffio penodol yn gysylltiedig â'r gweithgareddau a nodwyd yn yr adroddiad hwn.	
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)	
Ddim yn berthnasol i'r adroddiad hwn.	
Hanes yr Adroddiad	Cyflwyniad safonol fel rhan o'r eitem sefydlog ar yr agenda.
Atodiadau	Atodiad 1 a 2 Manylion yr Adroddiad ar Gydymffurfiaeth Prosesau Caffael Atodiad 3 Cynllun Gwella'r Broses Gaffael

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Health Education Improvement Wales - Audit Committee Report – April 2022

Appendix 1 – Summary Information

Trust	Division	Procurement Ref No	Period of Agreement/Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
HEIW	Medical	HEIW-SQA-610	01.03.2022 – 31.03.2022	Single Quotation Action	O&G Simulators Obstetrics and Gynaecology	Medge Platforms, Inc	£25,000	Official simulator for all courses organized by ISUOG (International Society of Ultrasound in Obstetrics & Gynaecology). Market engagement conducted (framework analysis, NHS Supply Chain & Sourcing). No other supplier identified.	Endorsed	No further action required.	First Submission
HEIW	Pharmacy	HEIW-STA-604	01.02.2022 – 31.12.2026	Single Tender Action	Critical access to British Pharmacological Society Material	British Pharmacological Society	£53,750	Provider only representative body in the UK for psychologists and psychology.	Endorsed	No further action required.	First Submission

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HEIW	Workforce	CCN-HEIW-050	January 2022	Change Control Notice	EDI Enhancements within Gwella Portal	CDSM Interactive Solutions	£14,350	Additional requirements to fulfil enhancements within Gwella portal	Endorsed	No further action required	First Submission
HEIW	Estates	CCN-HEIW-051	January 2022	Change Control Notice	Additional air-conditioning units	Whitehead Building Services	£9,259	Additional need of air conditioning units to support server rooms at Ty Dysgu. Not possible to compete as would introduce risk of an additional supplier in a high risk area.	Endorsed	No further action required	First Submission
HEIW	Corporate	CCN-HEIW-052	January 2022	Change Control Notice	Welsh Translation	Cymen	£20,000	Due to continued increase in demand of Welsh Translation, increase in contract value required.	Endorsed	Ensure data is reviewed to capture all demand.	First Submission
HEIW	Pharmacy	CCN-HEIW-053	February 2022	Change Control Notice	Enhancement to Overt System within Pharmacy	Overt	£7,500	Critical enhancement to current provisions to support system.	Endorsed	No further action required as Learning Management System will	First Submission

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										deliver future need.	
HEIW	Medical	CCN-HEIW-054	March 2022	Change Control Notice	Provision of Professional Support for Medical Trainees and Professionals	Hammet Street Consultants	£290,000	Critical increase in contract value to support medical trainees and professionals	Endorsed	Ensure increase in demand is captured in new procurement process	First Submission
HEIW	Workforce	HEIW-STA-552EXT	17.04.2022 – 16.07.2022	Contract Extension	Behavioural Science Training	Kate Malcomess Consultancy Ltd	Original value £58,988 (no additional fee for extension)	Extension for completion of work	Endorsed	Service confirmed no future requirement after current contract	First Submission
HEIW	Digital	HEIW-STA-520EXT	01.04.2022 – 31.05.2022	Contract Extension	Provision of dedicated server environments for two separate servers	Iomart	£3,720	Ensure continuity of service whilst need being delivered internally	Endorsed	No further action required	First Submission
HEIW	Dental	HEIW-ITT-41416EXT	01.05.2022 – 01.11.2022	Contract Extension	CPR Training for Dental Practices - Adult and Paediatric Life Support and Management of Common Medical Emergencies	Lubas Medical	£18,000	Continue in delivery of training whilst new tender exercise undertaken	Endorsed	Progressing with renewal tender exercise	First Submission

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HEIW	Workforce	HEIW-MQ-308830EXT	01.05.2022 – 30.09.2022	Contract Extension	Transfer & Implementation of the Essential Children and Adolescent Mental Health Service (CAMHS) within HEIW	Dr David Coyle	Original value £9,800 (no additional fee for extension)	Finalise delivery of work.	Endorsed	No further action required as no future need.	First Submission

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Health Education Improvement Wales - Audit Committee Report – April 2022

Appendix 2 – Summary Further Matters

Trust	Division	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
HEIW	Workforce	HEIW-FN-094	01.02.2022 – 31.03.2022	File Note	Development and Provision of accredited compassionate leadership Programme	Wrexham Glyndwr University	£30,000	Co-developed Programme to enable the embedding of health & social care compassionate leadership principles.	Endorsed	Meeting scheduled in April to fully understand requirements to eliminate future use of file notes.	First Submission
HEIW	Digital	HEIW-FN-096	02.03.2022 – 31.03.2023	File Note	Training for Articulate 360 and Instructional Design	Omniplex	£8,000	Current agreement expired and there was an urgent requirement to maintain training of core skills for digital staff ensuring project deliverables are achieved.	Endorsed	Meetings implemented with digital team to ensure all training is captured in appropriate time.	First Submission

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Appendix 2

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Report Title	**Procurement Improvement Plan – Action Plan**
Report Author	Christine Thorne Deputy Head of National Sourcing ICT & Office Products

NB: Actions shaded in grey are complete.

No.	Action	Original Proposed Deadline	New Proposed Deadline	Responsible Area
2	Increase site presence at Ty Dysgu	Complete		NWSSP Procurement
3	Understanding of HEIW colleague's actual expectations from procurement services and senior management engagement.	Complete		NWSSP Procurement & HEIW Finance
5	Share Performance Data from Procurement Process Presentation	Complete		NWSSP Procurement
6	Reinstate highlight report, format to be agreed HEIW to ensure relevant detail covered	Complete		NWSSP Procurement
7	List of Finance Business Partners required along with their designated areas.	Complete		HEIW Finance
8	Procurement Dashboard to be presented within P2P meetings	Complete		NWSSP Procurement
10	Share performance data and undertake quarterly reviews - to include performance data, key pressures, delivery against IMTP.	Complete		NWSSP Procurement
12	Procurement Manual Seminar	Complete		NWSSP Procurement
14	Share data of single tenders and file notes per department within HEIW.	Complete		NWSSP Procurement
17	NWSSP Procurement services to provide a full level of service and will continue to do so.	Complete		NWSSP Procurement

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1	Internal Procurement Department refresher training for purchase order processing.	16.08.2021	29.10.2021	NWSSP Procurement
9	Analysis of data to be completed to understand orders raised and where catalogues can be established. However, noted and agreed due to HEIW being a Special Health Authority and due to the requirements, it will be difficult to achieve a high volume of items onto a catalogue. Information will feed into bi-monthly meetings for action and quarterly reviews for performance.	17.09.2021	20.10.2021	NWSSP Procurement
11	Review of approval mechanism to ensure correct approvals in place before proceeding with tender activity. To be discussed at first bi-monthly meeting.	Reopened.	18/10/2021	NWSSP Procurement & HEIW Finance and Strategic Planning
13	Engagement required before submission of single tender requirements and before detail submitted to service desk. Agreed the service desk focus on completion of transactional process and not the provision of professional procurement advice.	16.08.2021	20.10.2021	HEIW Finance
15	Create Procurement awareness sessions for HEIW colleagues	31.08.2021	20.10.2021	NWSSP Procurement
18	Introduction of advice shop where member of HEIW can 'drop in' and speak with Procurement Team	16.08.2021, deferred 02.11.21	31.03.22	NWSSP Procurement

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.6**
Teitl yr Adroddiad	**Adroddiad Cynnydd Gwrth-Dwyll**		
Awdur yr Adroddiad	Nigel Price – AATLI		
Noddwr yr Adroddiad	Rhiannon Beckett, Cyfarwyddwr Dros Dro Cyllid		
Cyflwynwyd gan	Nigel Price - AATLI		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Pwrpas yr Adroddiad Cynnydd Gwrth-Dwyll yw rhoi diweddariad i'r Pwyllgor Archwilio a Sicrwydd ar waith Gwrth-Dwyll y GIG a gwblhawyd rhwng 31 Rhagfyr 2021 a 31 Mawrth 2022.		
Prif Faterion	• Nid oes unrhyw ymchwiliadau sy'n gysylltiedig ag AaGIC. • O 1 Ebrill 2022 mae gan y Gwasanaeth Gwrth-Dwyll adnoddau llawn. • Cyflwynwyd dau gyflwyniad gwrth-dwyll i staff AaGIC • Mae ymarfer asesu risg ar y gwiriadau diwydrwydd dyladwy a gynhaliwyd gan asiantaethau cyflogaeth wedi'i gwblhau ac mae'r canfyddiadau wedi'u cynnwys yn yr adroddiad cynnydd hwn.		

Camau Penodol Gofynnol (✓ticiwch un yn unig)	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
			✓	
Argymhellion	Gofynnir i'r Pwyllgor: • **Derbyn** a **Thrafod** yr Adroddiad Cynnydd Gwrth-Dwyll • **Nodi'r** cynnydd a wnaed hyd yma			

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ADRODDIAD CYNNYDD GWRTH-DWYLL

1. RHAGARWEINIAD

Pwrpas yr Adroddiad Cynnydd Gwrth-Dwyll yw darparu'r Pwyllgor Archwilio a Sicrwydd â'r adroddiad diweddaraf ar holl waith Gwrth-dwyll y GIG a gyflawnwyd, ar gyfer y cyfnod a ddaeth i ben 31 Mawrth 2022.

Mae arddull yr adroddiad wedi ei fabwysiadu, mewn ymgynghoriad â'r Cyfarwyddwr Cyllid, gyda'r nod o hysbysu a diweddaru aelodau'r Pwyllgor Archwilio a Sicrwydd o fanylion amlinellol y newidiadau sylweddol mewn achosion y gweithiwyd arnynt yn ystod y cyfnod, yn ogystal ag unrhyw faterion gweithredol cyfredol.

2. CEFNDIR

Yn unol â Chyfarwyddiadau'r Ysgrifennydd Gwladol dros Iechyd ar Gwrth-Dwyll yn y GIG, mae angen cyflwyno adroddiadau diweddariad ar gynnydd yn rheolaidd i Bwyllgor Archwilio a Sicrwydd y Corff Iechyd, a ddylai amlinellu sefyllfa bresennol unrhyw waith Gwrth-dwyll a Llygredd a'u cynnal o fewn y Corff Iechyd ar ddyddiad cyfarfod y Pwyllgor Archwilio a Sicrwydd.

Yr AATLl i gynllunio a chytuno, gyda'r Cyfarwyddwr Cyllid, ar Gynllun Gwaith Blynyddol sy'n cynnwys nifer awgrymedig o ddiwrnodau sy'n fframwaith ar gyfer adeiladu a datblygu trefniadau Gwrth-dwyll cadarn ac sy'n argymell, i Bwyllgor Archwilio a Sicrwydd y Cyrff Iechyd, yr adnoddau angenrheidiol i wneud y gwaith yn effeithiol.

3. CYNNIG

Y cynnig yw bod yr adroddiad yn cael ei nodi er sicrwydd.

4. MATERION LLYWODRAETHU A RISG

Drwy fabwysiadu strwythur llywodraethu cryf, dylai ffocws y Corff Iechyd fod ar brosesau effeithiol ar gyfer asesu risg o dwyll, y mae'n rhaid iddynt, yn eu tro, ganolbwyntio ar atal twyll, canfod twyll ac ymchwilio i dwyll. Rhaid ystyried asesiadau risg twyll, a'r tair elfen allweddol yw:

- dynodi risg twyll cynhenid (y risg o dwyll)
- asesu tebygolrwydd ac arwyddocâd pob risg twyll cynhenid
- ymateb i risgiau cynhenid tebygol a/neu arwyddocaol

Er mwyn asesu'r materion risg, rhaid i staff AaGIC ddeall bod y mwyafrif yn ymwneud â dogfennau ffug, llofnodion ffug, adrodd twyllodrus, cam-berchnogi neu lygredd.

Wrth edrych ar feysydd o'r fath, dylid ystyried y canlynol:

- Cymhellion, pwysau a chyfleoedd oherwydd gwendidau yn y system
- Y risg na fydd Uwch Reolwyr yn cadw at bolisi neu'n diystyru rheolaethau

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- Technoleg Gwybodaeth
- Risgiau o dwyll rheoleiddiol, cyfreithiol neu i enw da

Wrth asesu tebygolrwydd ac arwyddocâd unrhyw risgiau o dwyll, dylai unrhyw asesiad ystyried y canlynol:

- Hanes twyll yn y sefydliad yn y gorffennol
- Nifer yr achosion o dwyll o fewn y GIG gydag unrhyw achosion tebyg
- Cymhlethdod y risg
- Y risgiau i unigolion neu adrannau penodol
- Nifer y bobl neu'r trafodion dan sylw

Wrth amcangyfrif arwyddocâd, dylid ystyried gweithrediadau, enw da ac atebolrwydd cyfreithiol (troseddol, sifil a rheoleiddiol) y sefydliad.

Dylid dogfennu asesiad risg twyll y Corff Iechyd hefyd gan ddefnyddio fframwaith strwythuredig, a dylid adrodd ar unrhyw ganfyddiadau i'r Pwyllgor Archwilio a Sicrwydd.

Dylai'r broses gyfan fod yn ddogfen "fyw" a pharhaus, gyda'r prif ffocws ar welliant parhaus. Gellir bwrw ymlaen â hyn drwy sicrhau, drwy'r sesiynau ymwybyddiaeth o dwyll amrywiol, digwyddiadau a chyhoeddiadau, bod pob lefel o reolwyr a staff o fewn AaGIC yn cael gwybod am y canlynol a bod ganddynt y canlynol:

- darllen a deall eu cyfrifoldebau, fel y'u hamlinellir ym mholisi a gweithdrefn Gwrth-Dwyll y Cyrff Iechyd
- deall twyll a dynodi unrhyw feysydd sy'n peri pryder
- deall eu rolau a'u cyfrifoldebau unigol yn y fframwaith rheolaeth fewnol ac yn enwedig o ran unrhyw wendidau posibl yn y system
- creu diwylliant gwrth-dwyll drwy sicrhau amgylchedd rheoli cryf
- adrodd am unrhyw amheuon neu achosion honedig o dwyll
- cydweithrediad llawn mewn unrhyw ymchwiliad yn ymwneud â thwyll

5. GOBLYGIADAU ARIANNOL

Mae twyll a gyflawnir yn erbyn y GIG yn cael arwain at oblygiadau ariannol, gan y byddai'r Corff Iechyd wedi dioddef colled ariannol gychwynnol o ganlyniad i weithredoedd y gwrthrych. Mae gwaith staff Gwrth-Dwyll y Corff Iechyd yn cael ei gwblhau er mwyn lleihau'r lefel o dwyll neu lygredd o fewn AaGIC i'r lefel isaf posibl.

6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor:

- **Derbyn** a **Thrafod** yr Adroddiad Cynnydd Gwrth-Dwyll
- **Nodi'r** cynnydd a wnaed hyd yma

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Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓	✓	✓

Ansawdd, Diogelwch a Phrofiad Cleifion
Dim wedi'u nodi
Goblygiadau Ariannol
Mae twyll a gyflawnwyd yn erbyn y GIG yn cael effaith ariannol gan y byddai'r Corff Iechyd wedi dioddef colled ariannol gychwynnol o ganlyniad i weithredoedd y gwrthrych. Mae staff Gwrth-Dwyll y Corff Iechyd yn cyflawni gwaith er mwyn ceisio lleihau lefel y twyll neu'r llygredd o fewn AaGIC i'r lefel isaf posibl a'i gadw ar y lefel honno er mwyn rhyddhau adnoddau ar gyfer gofal cleifion.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Lle mae unrhyw dystiolaeth o dwyll ar yr olwg gyntaf wedi'i ddynodi, yna gofynnir am gyngor ar y ffordd orau i symud ymlaen ac a oes digon o dystiolaeth i gefnogi erlyniad troseddol gan Adran Twyll Arbenigol y CPS.
Goblygiadau o ran Staff
Dim
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Dim

Hanes yr Adroddiad	Mae'r papur diweddaraf ar Wrth-Dwyll yn eitem safonol ar yr agenda a'r Pwyllgor Archwilio a Sicrwydd.
Atodiadau	Atodiad 1 – Adroddiad Cynnydd Gwrth-Dwyll Gan gynnwys: • Crynodeb o ddiwrnodau gwrth-dwyll a gwblhawyd; a • Adroddiad Asesu Risg Cyn Cyflogaeth Asiantaeth Recriwtio

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NHS WALES
Health Education & Improvement Wales

Audit & Assurance Committee 12th April 2022
Counter Fraud Update

Nigel Price
Local Counter Fraud Investigator
Cardiff and Vale University Health Board

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AUDIT COMMITTEE 12th April 2022

COUNTER FRAUD UPDATE

1. **Introduction**
2. **Case Update**
3. **Progress and General Issues**
4. **Appendix 1 – Plan Summary**
5. **Appendix 2 - Recruiting Agency Pre-Employment Risk Assessment**

Mission Statement

To provide the HEIW with a high-quality NHS Counter Fraud Service, which ensures that any report of fraud is investigated in accordance with the Directions for Countering Fraud in the NHS and all such investigations are carried out in a professional, transparent and cost-effective manner.

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1. INTRODUCTION

1.1 In compliance with the Directions on Countering Fraud in the NHS, Counter Fraud is required to provide updates to the Audit and Assurance Committee on the work that has been completed against the agreed work-plan. This report provides the Audit Committee with an update for the period 31st December 2021 to the 31st March 2022.

2. CURRENT CASE UPDATE

2.1 There are no investigations linked to HEIW.

3. PROGRESS AND GENERAL ISSUES

During this reporting period 13 days have been spent on counter fraud work. Those days complete the allocated 50 days for HEIW which are detailed in Appendix 1. The days have been spent preparing, delivering and analysing the feedback from the fraud awareness presentations; reviewing HEIW policies; preparing reports for, and attending the organisation's audit committees and conducting risk assessment enquires on pre-employment checks carried out by employment agencies that supply staff to HEIW.

As required under the Government Functional Standard GovS 013: Counter Fraud HEIW has nominated a Fraud Champion during 2021/22. The role of the Fraud Champion is to support and promote the fight against fraud at a strategic level and with other colleagues within their own organisation. The champion will also support the Local Counter Fraud Specialists. Monthly meetings have been held between the manager of counter fraud and HEIW's Fraud Champion to discuss and plan the development of the role within HEIW.

3.1 Fraud Awareness Presentations

Face-to-face fraud awareness sessions for HEIW staff have been cancelled due to COVID-19 restrictions. However, 2 awareness sessions have been delivered during this reporting period.

Feedback from previous presentations shows that 95.5% of the delegates "agreed" they feel more comfortable discussing any concerns with counter fraud. The session also improved their knowledge of how a counter-fraud referral is investigated, the potential outcomes of committing fraud, and how to report any concerns they may have.

3.2 System Weaknesses and Lessons Learnt

Nothing to report for this period.

3.4 Risk Assessments

On the 9th September 2021 a meeting was held with the Director of Finance and the Head of Financial Accounting to discuss potential risk assessment exercises on behalf of HEIW. It was agreed that it would be beneficial to review the due diligence checks that employment agencies use before supplying staff to HEIW.

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The exercise has been completed and a report of the findings is attached at appendix 2. The recommendations will be discussed with the Director of Finance and Head of the People team for their consideration.

3.5 Counter Fraud Resources Update

The full complement for the Cardiff & Vale UHB team is three accredited Local Counter Fraud Specialists, one of whom was the team manager, and one admin support. The days allocated to HEIW for counter fraud work is calculated on the on the four whole-time equivalents.

Due to a number of staff changes in the service there was a reduction in available resources during 2021/22, although HEIW received its full allocation of 50 days.

The two posts that became vacant during the year have now been filled. The substantive team manager took up post on the 1st April 2022. A meeting between the new manager, the fraud champion, the Director of Finance and the manager of HEIW'S risk register will be arranged at the earliest opportunity.

3.6 Counter Fraud Annual Plan 2022/23

The Local Counter Fraud manager, in consultation with the Director of Finance, will usually prepare an annual workplan for consideration and approval at the Audit and Assurance Committee in April each year. Due to the new manager starting in April it is proposed that the agreement of the 2022/23 annual plan is deferred to the next committee meeting on 5th May 2022. This will allow the manager and the Director of Finance to review the priorities and requirements of the service for the forthcoming year.

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APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2021/22

AREA OF WORK	Planned Days	Days to Date
General Requirements		
LCFS Attendance at All Wales Meetings	1	2
Planning/Preparation of Annual Report and Work Programme	1	5
Production of Reports and attendance at Audit & Assurance	4	9
Liaison with the DoF, NHS CFA, Welsh Government	0	4
Self Review Tool (SRT) and QA Assessment	1	4
Annual Activity		
Create an Anti-Fraud Culture	2	2
Presentations, Briefings, Newsletters etc.	15	15
Fraud Awareness Events	0	0
Deterrence		
Review/develop Policies/Strategies	2	2
Prevention		
The reduction of opportunities for Fraud and Corruption to occur.	0	0
Detection		
National Pro-Active Exercises (e.g. Procurement)	2	2
National Fraud Initiative 2020/21	4	5
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	15	0
Ensure that Sanctions are applied to cases as appropriate	1	0
Seek redress, where fraud has been proven to have taken place	2	0
TOTAL HEALTH EDUCATION IMPROVEMENT WALES	**50**	**50**

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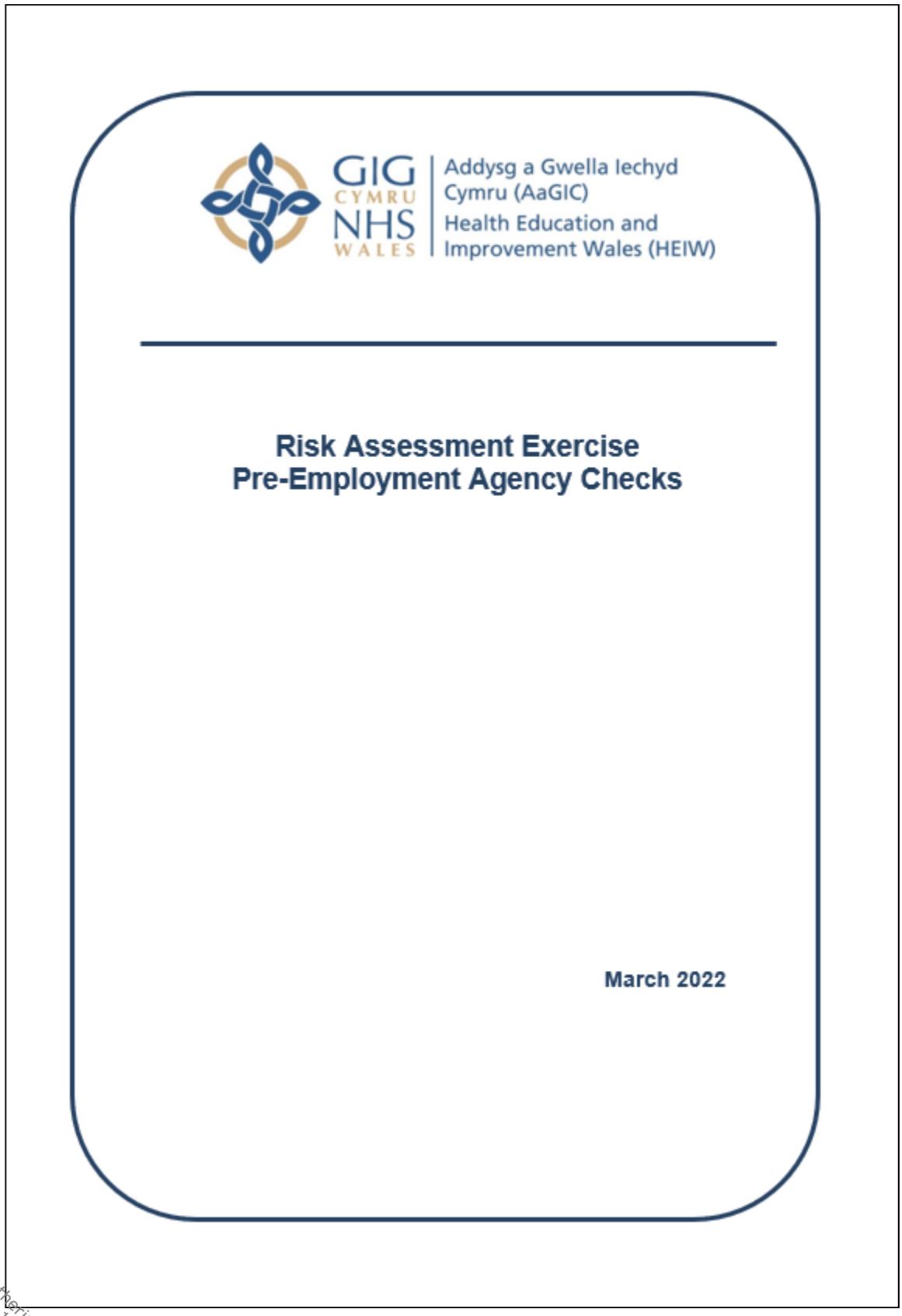
APPENDIX 2



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Executive Summary

An incident occurred in which a recruiting agency provided a person whose stated qualifications and experiences were false. An investigation by the Local Counter Fraud Services revealed a weakness in the recruiting process. Based on that an exercise to confirm that the agencies apply robust checks on the claims made by potential employees was carried out. Agencies contracted to supply staff to the NHS must comply with requirements to complete pre-employment checks as set out in the NHS Employment Check Standards 2016.

The risks of employing unqualified and appropriately trained staff within an organisation can have a considerable negative impact on;

1. Patient Safety,
2. Staff Safety
3. Health and safety within the workplace.
4. Financial Management.
5. the professional reputation of the organisation.

It should be noted that due to impact of COVID-19, restrictions have changed in the way in which pre-employment checks are being completed. Specifically, in relation to the viewing of original documents.

This exercise has been completed fully across three Health Boards/Special Health Authorities covered by our LCFS service with potential for further exercises. Across all of the Agencies whose practices were reviewed only one agency was found not have completed satisfactory checks. There was a disconnect in understanding between the Special Health Authority and the agency. The Agency stated they believed the Special Health Authority to be conducting the relevant checks regarding experience where the Special Health Authority believed them to have been completed by the Agency. Full details of this are contained within the report. Recommendations to mitigate the risk of the organisation have been made as detailed at the end of this report.

Introduction and Background

This exercise, led by Local Counter Fraud Services, has focused on pre-employment checks completed by suppliers which provide agency workers to Health Education and Improvement Wales (HEIW).

As part of an on-going risk assessment, identified risks to the organisation involved patient safety, staff safety, health and safety in the work place and potential risks to the financial management of the organisation. A proactive approach to reviewing and reducing these identified risks has been developed, with a specific remit looking at the pre-employment checks completed by suppliers and whether these checks are compliant or non-compliant with shared policies already in place.

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Under the Crown Commercial Services agreements RM6160 (Non-Clinical Staff) and RM6161 (Clinical Staff) there is a Framework Specification in place for the supply of registered agency personnel to the health boards, trusts and Special Health Authorities in Wales. Both frameworks contain sections regarding pre-employment checks contained within their specifications, the wording is almost identical for both, relevant sections are detailed below:

5. Temporary Worker Compliance Requirements - Pre-Employment Check Standards (RM6160)

5.1. The Supplier shall undertake employment checking which seeks to verify that all Temporary Workers meet the preconditions of the role they are applying for. All Temporary Workers must be fully compliant prior to the commencement of the role.
5.2. The Supplier shall have a dedicated compliance manager who will ensure that all checks have been undertaken correctly prior to the appointment of a Temporary Worker.
5.3. For NHS Contracting Authorities, the Supplier shall ensure that Temporary Workers supplied are compliant with the requirements specified in NHS Employers Check Standards:
- 5.3.1. Identity checks;
- 5.3.2. Professional Registration and Qualification checks;
- 5.3.3. Employment History and Reference checks;
- 5.3.4. Right to Work checks;
- 5.3.5. Work health assessments; and
- 5.3.6. Criminal Record checks.

5.4. For full details of pre-employment check checks for NHS Contracting Authorities, the Supplier shall refer to NHS Employers Check Standards: https://www.nhsemployers.org/your-workforce/recruit/employment-checks
5.8. All Contracting Authorities may specify additional, or tailored employment or security check requirements at Call-Off stage. All additional Employment or security checks shall be conducted by the Supplier at no additional cost to the Contracting Authority. As part of this contract the following requirements are detailed within the Service Specification.

8. Temporary Worker Compliance Requirements - Employment Check Standards (RM6161)

8.1. The Supplier shall undertake employment checking which seeks to verify that all Temporary Workers meet the preconditions of the role they are applying for. All Temporary Workers must be fully compliant prior to the commencement of the role.
8.2. The Supplier shall have a dedicated compliance manager who will ensure that all checks have been undertaken correctly prior to the appointment of a Temporary Worker.
8.3. For NHS Contracting Authorities, the Supplier shall ensure that Temporary Workers supplied are compliant with the requirements specified in NHS Employers Check Standards:
- 8.3.1. Identity checks;
- 8.3.2. Professional Registration and Qualification checks;
- 8.3.3. Employment History and Reference checks;
- 8.3.4. Right to Work checks;
- 8.3.5. Work health assessments;
- 8.3.6. Criminal Record checks; and
- 8.3.7. Appraisal and Revalidation checks.

English Catherine 04/11/2022 11:17:41

8.4. For full details of pre-employment check checks for NHS Contracting Authorities, the Supplier shall refer to NHS Employers Check Standards: https://www.nhsemployers.org/your-workforce/recruit/employment-checks
8.8. All Contracting Authorities may specify additional, or tailored employment or security check requirements at Call-Off stage. All additional Employment or security checks shall be conducted by the Supplier at no additional cost to the Contracting Authority.

Scope of Exercise

The exercise looked at relevant pre-employment data for the financial year 2020/21 relating pre-employment checks carried out by relevant suppliers. For the purposes of this exercise, pre-employments checks data was requested direct from Suppliers (namely Agencies) in relation to registered and unregistered agency nurses, health care assistance and administrative staff.

Method

A random selection approach was chosen by Local Counter Fraud Services in requesting the required data in order to run the exercise.

Agency Supplier Data

A list of agencies that are used by HEIW was obtained showing that there were 7 Agencies that are utilised by the Special Health Authority.

From this list, 4 agencies were chosen at random;

1. 'Agency 1'
2. 'Agency 2'
3. 'Agency 3'
4. 'Agency 4'

A Local Counter Fraud Specialist requested lists of all agency staff provided by the companies to HEIW in the relevant time period which was 1st April 2020 to 31st March 2021. This shows that a total of 13 agency workers were provided. From this list all of the workers were chosen to be part of the exercise. The following information was requested from the Agency:

- Proof of Photographic ID (i.e. Passport)
- Birth Certificate (if driving license used instead of passport)
- Evidence of right to work in UK
- DBS check (if required for role)
- Proof of qualifications (if applicable)
- Professional Registration (if applicable)
- Visa Details (if applicable)

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As part of the framework, agencies are required to respond to requests for such information of 14 days.

The supplied information was then cross checked against the required standards and recorded in a spreadsheet. Dependant on the role filled or the individuals circumstances not all of the requested information is applicable. Should a required element not be provided or be unsatisfactory the spreadsheet would result in a 'Red' result highlighting the specified worker in red to show the deficiency.

Findings

From the data collated by Local Counter Fraud Services the results are summarised below:

'Agency 1'

- Counter Fraud Services requested data relating to all 6 Agency Workers.
- 'Agency 1' were compliant in returning the data within the specified 14-day time frame.
- 'Agency 1' were compliant in providing qualifications, DBS checks and professional registration where required.
- 'Agency 1' were fully compliant across all requested information.

'Agency 2'

- Counter Fraud Services requested data relating to all 4 Agency Workers.
- 'Agency 2' were compliant in returning the data within the specified 14-day time frame.
- 'Agency 2' were compliant in providing the identification and DBS checks for the workers.
- 'Agency 2' were not compliant in providing qualification checks for one of the workers. They were unable to provide qualification or equivalence evidence for this worker.
- Further enquiries conducted identified that the agency were not fully aware of the requirement for this stating it was not fully made out in the request. The identified issue in the system is making clear what is a "requirement" for a role as opposed to "preferred".

'Agency 3'

- Counter Fraud Services requested data relating to the 2 Agency Workers.
- 'Agency 3' were compliant in returning the data within the specified 14-day time frame.
- Both workers were for administrative roles and did not require DBS checks or registration, they had satisfactory ID and right to work checks.
- 'Agency 3' were fully compliant across all requested information.

'Agency 4'

- Counter Fraud Services requested data relating to the 1 Agency Worker.
- 'Agency 4' were compliant in returning the data within the specified 14-day time frame.

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- The worker was for an administrative role and did not require DBS checks or registration, they had satisfactory ID and right to work checks.
- 'Agency 4' were fully compliant across all requested information.

Recommendations

The Local Counter Fraud Services recommends the following:

1. When placing a requisition/'request' include a note that highlights that it is the Agencies responsibility to complete pre-employment checks as per the framework.

2. Conduct 'mini local audits' at regular intervals. At periodic intervals (3/4/6 Months) randomly choose a worker who is being supplied, request the agency to provide all of the pre-employment/due diligence check information. This will ensure regular random checks are completed to ensure standards are kept high.

3. Include in the requisition/'request' document any information regarding restrictions on working hours/visas. The agencies hold this information and should not allow working over these restrictions but it is important to know this as the end 'employer' to avoid any inadvertent breaches to these restrictions.

4. When recruiting for a role that requires specific qualifications or registration ensure that it is clearly set out in the requisition/'request' that they are required and that it is expected that the Agency will ensure that these are held by the worker prior to their commencing work.

5. In relation to Agency Suppliers, they should be informing the Special Health Authority of any changes to agency workers situation or who are no longer working for them in order to provide a more effective service. This could be a quarterly or bi-annual process in order to keep Special Health Authority records current and to reduce the risk of financial loss to the organisation.

Conclusion

This exercise has shown that the agencies supplying staff have completed the majority of the required checks effectively and accurately, one shortcoming was identified which gave rise to potential risks to the organisation. However, the above recommendations will mitigate this risk in the future.

Recruiting through agencies and relying on an outside agency to complete checks will always carry some level of risk to the Special Health Authority in relation to patient safety, staff safety and the financial management within our Special Health Authority. However, this risk can be limited by setting out clearly and precisely what is required and expected from the agencies and conducting regular checks that it is being completed, as detailed above in the recommendations.

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Key Contacts

Name	Job Title	Contact
Nigel Price	Local Counter Fraud Specialist	Nigel.Price@wales.nhs.uk 02921 836481
Emily Thompson	Local Counter Fraud Specialist	Emily.Thompson@wales.nhs.uk 029218 36262
Henry Bales	Local Counter Fraud Specialist	Henry.Bales@wales.nhs.uk 029218 36265

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.7**
Teitl yr Adroddiad	**Datganiad Llywodraethu 2021/22**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Gofyn i'r Pwyllgor ystyried y Datganiad Llywodraethu drafft a rhoi adborth.		
Materion Allweddol	Mae Datganiad Llywodraethu drafft AaGIC, sy'n ymdrin â llywodraethiant y sefydliad yn ystod y cyfnod hyd at 31 Mawrth 2022, ar gael yn Atodiad 1.		
Cam Penodol i'w Gymryd ***(Rhowch ✓wrth un yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
		✓		
Argymhellion	Gofynnir i'r Pwyllgor wneud y canlynol: • **Trafod** cynnwys y Datganiad Llywodraethu drafft; a • **Darparu adborth** er mwyn rhoi sicrwydd i'r Bwrdd fod proses lywodraethu gadarn wedi bod ar waith yn ystod y cyfnod hyd at 31 Mawrth 2022.		

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DATGANIAD LLYWODRAETHU 2021/22

1. CYFLWYNIAD

Pwrpas y papur hwn yw gofyn i'r Pwyllgor Archwilio a Sicrwydd ystyried y Datganiad Llywodraethu drafft a rhoi adborth.

2. CEFNDIR

Mae'n ofynnol i gyrff y GIG gyhoeddi Adroddiad a Chyfrifon Blynyddol mewn tair rhan, fel un ddogfen, sy'n cynnwys:

1. Yr Adroddiad Perfformiad;
2. Yr Adroddiad Atebolrwydd - sy'n cynnwys y Datganiad Llywodraethu; a'r
3. Datganiadau Ariannol.

3. Y CYNNIG

Mae Datganiad Llywodraethu drafft AaGIC, sy'n ymdrin â llywodraethiant y sefydliad yn ystod y cyfnod hyd at 31 Mawrth 2022, ar gael yn Atodiad 1.

Gofynnwyd i Aelodau'r Pwyllgor ystyried cynnwys y Datganiad Llywodraethu drafft a rhoi adborth arno.

4. MATERION LLYWODRAETHU A RISG

Yn unol â'r Llawlyfr Cyfrifon, rhaid i'r Adroddiad Blynyddol (sy'n cynnwys y Datganiad Llywodraethu) a'r cyfrifon drwyddynt draw fod yn deg, yn gytbwys ac yn ddealladwy ac mae'r swyddog atebol yn cymryd cyfrifoldeb personol amdano ac am y dyfarniadau sy'n ofynnol er mwyn penderfynu ei fod yn deg, yn gytbwys ac yn ddealladwy.

5. GOBLYGIADAU ARIANNOL

Nid oes unrhyw oblygiadau ariannol. Ystyrir bod llunio'r Adroddiad Blynyddol yn fater craidd i AaGIC.

6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor wneud y canlynol:

- **Trafod** cynnwys y Datganiad Llywodraethu drafft; a
- **Darparu adborth** er mwyn rhoi sicrwydd i'r Bwrdd fod proses lywodraethu gadarn wedi bod ar waith yn ystod y cyfnod hyd at 31 Mawrth 2022.

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Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig ***(nodwch ✓)***	**Nod Strategol 1:** Arwain y broses o gynllunio, datblygu a gofalu am les gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni '*Cymru Iachach*'	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd er mwyn gwella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol yn GIG Cymru drwy feithrin gallu arwain tosturiol ac ar y cyd ar bob lefel
	✓	✓	✓
	Nod Strategol 4: Datblygu atebion cenedlaethol i'r gweithlu i gefnogi'r gwaith o ddarparu blaenoriaethau gwasanaeth cenedlaethol a gofal o ansawdd uchel i gleifion.	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio ynddo	**Nod Strategol 6:** Cael ein cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓	✓	✓
Ansawdd, Diogelwch a Phrofiad Cleifion			
Sicrhau bod gan AaGIC broses lywodraethu gadarn ar waith a fydd yn helpu AaGIC i gyflawni'i amcanion ac yn y pen draw i gynnal ansawdd a diogelwch profiad cleifion.			
Goblygiadau Ariannol			
Nid oes unrhyw oblygiadau ariannol.			
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)			
Mae cwblhau'r Adroddiad Blynyddol yn ddyletswydd statudol ar AaGIC.			
Goblygiadau Staffio			
Nid oes unrhyw oblygiadau staffio.			
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)			
D/B			
Hanes yr Adroddiad			
Atodiadau	Atodiad 1 – Datganiad Llywodraethu Drafft 2021/22		

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Governance Statement for the Period Ended 31 March 2022

1. Scope of Responsibility

The Board of Health Education Improvement Wales (HEIW) is accountable for Governance, Risk Management, and Internal Control. The Chief Executive Officer (CEO) has responsibility for maintaining appropriate governance structures and procedures, as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which the CEO is personally responsible. These are carried out in accordance with the responsibilities assigned to the CEO as Accountable Officer by the Chief Executive of NHS Wales.

The Annual Report outlines the different ways the organisation has worked both internally and with partners in response to the unprecedented pressure in planning and providing services arising from supporting the NHS workforce response to the pandemic. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement , however, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

The background to HEIW, its functions and the Annual Plan 2021/22 is set out in the Performance Report. On 27 July 2022, the Health and Education and Improvement Wales (No. 2) Directions 2018 were amended extending HEIW's functions to include the Office of Chief Digital Officer (OCDO) for Health and Care. The position in respect of HEIW hosting the OCDO is considered on page [] of the Performance Report.

This Governance Statement explains the composition and organisation of HEIW's governance structures and how they support the achievement of our objectives.

During 2021/22 we have continued to further develop our system of governance and assurance. Our Board Assurance Framework (BAF) is reviewed by the Board on an annual basis. The BAF was approved by the Board in November and [HEIW's Strategic Risks were reviewed and approved at the March Board]. We will continue to evolve our BAF in 2022/23.

The Board sits at the top of our governance and assurance system. It sets strategic objectives, monitors progress, agrees actions to achieve these objectives and ensures appropriate controls are in place and working properly. The Board also takes assurance from its committees, assessments, against professional standards and regulatory frameworks.

Impact of COVID on governance

The main impact on HEIW's governance process during this crisis period has been the suspension of open Board and committee meetings being held in public. These meetings have continued to be held in accordance with our original timetable but held virtually through video conferencing technology. There have been no other material changes to HEIW's normal decision-making process.

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Where relevant HEIW's actions taken in response to COVID-19 have been explained within this Governance Statement.

Suspension of Board and committee meetings being held in public due to COVID-19

It is acknowledged that in these unprecedented times, there are limitations on Boards and committees being able to physically meet where this is not necessary and can be achieved by other means. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings, and it has not therefore been possible to allow the public to attend meetings of our Board and committees from 26 March 2020. To ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

- A committee briefing placed on HEIW's website within 72 hours of a meeting;
- Unconfirmed draft minutes of Board and committee meetings placed on HEIW's website within 14 days of the meeting;
- Since July 2020 HEIW Board meetings have been streamed live via a videoconference platform;
- Since July 2021, HEIW committee meetings have been streamed live via a videoconference platform;

The decision not to hold open Board and committee meetings in public has been regularly reviewed by the Board during 2021/22 and on 31 March 2022 a phased return to in-person meetings commenced with an in-person meeting of the March Board. While the public have not been able to attend Board meetings in person at this time, they continue to be able to access the meetings virtually.

Reporting period

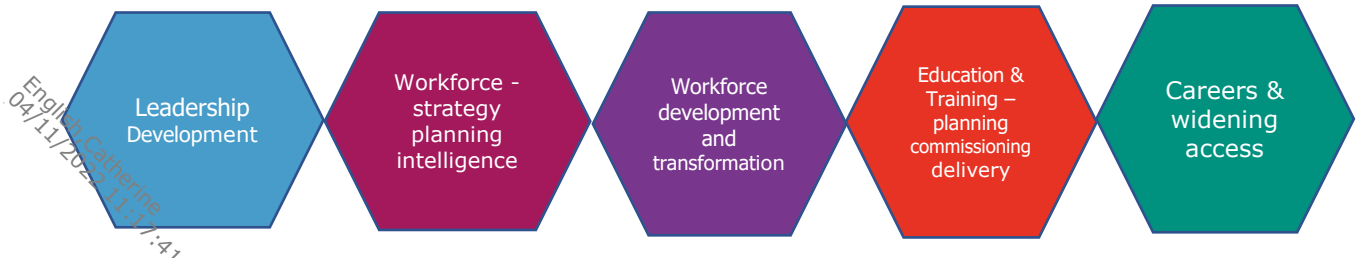
The reporting period for this Governance Statement is primarily focussed on the financial year from 1 April 2021 to 31 March 2022. However, it also includes reporting on material issues that have taken place between 31 March 2022 and the date that the Governance Statement is approved by the HEIW Board on [13 June 2022].

1.1 Our System of Governance and Assurance

Our vision is "Transforming the workforce for a healthier Wales" which was developed through extensive engagement with our staff, stakeholders and partners.

Our purpose is To develop a workforce that delivers excellent care to patients/service users and excellent population health
As a Special Health Authority our unique contribution or "added value" is to:

- address strategic and specialist workforce issues that individual NHS organisations cannot address on their own;
- make Wales a great place to train and work for our health and care staff;
- maximise the contribution of all professions and occupations through our statutory functions.



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With our staff we also developed and agreed our values which are:

- **Respect for all:** in every contact we have with others;
- **Together as a Team:** we will work with colleagues across NHS Wales and with partner organisations; and
- **Ideas that Improve:** harnessing creativity, and continuously innovating and evaluating.

These values are supported by a Values and Behaviours Framework and together these set out clearly the expectations on all staff and the way we work.

HEIW, in line with all Health Boards and Trusts in Wales, has agreed standing orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the HEIW (Establishment and Constitution) Order 2017 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved to the Board; a scheme of delegation to officers and others; and standing financial instructions, they provide the regulatory framework for the business conduct of HEIW and define its 'ways of working'. These documents, together with the range of corporate policies set by the Board, make up the Governance and Assurance Framework.

HEIW's Declarations of Interest and Standards of Behaviour Policy was rolled out across the organisation in 2018/19. Work has continued during 2021/22 in respect of communication and to ensure that declarations are up to date to proactively manage any conflicts of interest that might arise for our Board members and staff.

1.2 The Role of the Board

The Board has been constituted to comply with the *Health Education and Improvement Wales Regulations 2017*. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Independent Members also fulfil a number of Champion roles where they act as ambassadors (see Table 1).

In December HEIW concluded a successful public recruitment process for two new Independent Members. On 4 January 2022, Jonathan Morgan was appointed as an Independent Member for a term of four years. John Gammon will join the Board in August 2022 also for a term of four years. On 31 January 2022, John Hill-Tout retired as an Independent Member at the end of his second term.

The Board is made up of Independent Members and Executive Directors. Lisa Llewelyn took up post as the Director of Nurse and Health Professional Education on 1 June 2021, taking over from the Interim Director of Nursing Angela Parry. Julie Rogers was permanently appointed as the Director of Workforce and Organisational Development/Deputy Chief Executive on 1 March 2022. Julie Rogers had previously undertaken the role on secondment from Welsh Government. Eifion Williams retired as the Director of Finance on 31 December 2021 and Rhiannon Beckett commenced as Interim Director of Finance on 1 January 2022.

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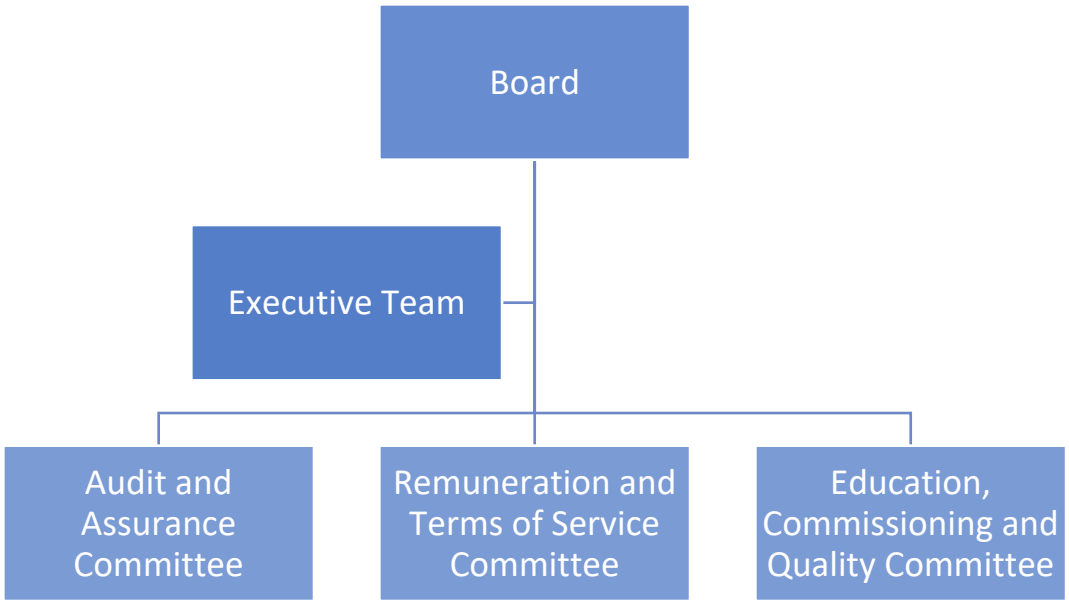
In addition to the Executive Directors , HEIW has had two seconded director positions; the Director of Planning, Performance and Corporate Services and Director of Digital Development. Nicola Johnson, Director of Planning, Performance and Corporate Services, returned to her host organisation Swansea Bay University on 1 April 2022. We have determined that the Director of Digital Development

Role will be converted into a substantive post in 2022/23. Both Directors, together with the Executive Directors and the Board Secretary, have been members of the Executive Team, with a standing invitation to Board meetings where they can contribute to discussions, but without voting rights as they are not Executive Directors.

During 2021/22 several board development sessions were undertaken which included a focus on the following elements of governance:

- Developing a Quality Framework;
- Risk Appetite and Risk Tolerance;
- Strategic Risks;
- Nurse Staffing Levels Act
- Governance Leadership and Accountability Standard
- Corporate Governance Code of Good Practice
- Board Assurance Framework;
- Board's self-assessment of its own effectiveness.
- Equality, Diversity and Inclusion

The full membership of the Board, their lead roles and committee responsibilities are outlined in Table 1. Below is a summary of the Board and committee structure:



The Board provides leadership and direction to the organisation and has a key role in ensuring the organisation has sound governance arrangements in place. The Board also seeks to ensure the organisation has an open culture and high standards when conducting its work. Together, Board members share corporate responsibility for all decisions and play a key role in monitoring the performance of the organisation. All the meetings of the Board during 2021/22 were appropriately constituted with a quorum. The key business and risk matters considered by the Board during 2021/22 are outlined in this statement and further information can be obtained from meeting papers available on our website: https://heiw.nhs.wales/about-us/board-meetings-agendas-and-standing-orders/

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1.3 Committees of the Board

The Board has established three committees, the Audit and Assurance Committee, Remuneration and Terms of Service Committee, and the Education Commissioning and Quality Committee. These committees are chaired by the Chair or Independent Members of the Board and have key roles in relation to the system of governance and assurance, decision making, scrutiny and in assessing current risks. The committees provide assurance and key issue reports to each Board meeting to contribute to the Board's assessment of assurance and to provide scrutiny on the delivery of objectives.

The Board is responsible for keeping the committee structure under review and reviews its standing orders on an annual basis. The Board will consider whether any changes are needed during 2022/23 in line with the Board's governance framework and priorities of the Integrated Medium Term Plan 2022/25.

HEIW is committed to openness and transparency with regard to the way in which it conducts its committee business. The HEIW Board and its committees aim to undertake the minimum of its business in closed sessions and ensure business wherever possible is considered in public with open session papers published on HEIW's website. **https://heiw.nhs.wales/corporate/board-meetings-agendas-and-papers/**

The closed session elements of Board and committee meetings are undertaken because of the confidential nature of the business. Such confidential issues may include commercially sensitive issues, matters relating to personal issues or discussing plans in their formative stages.

An important committee of the Board in relation to this Governance Statement is the Audit and Assurance Committee. The Committee keeps under review the design and adequacy of HEIW's governance and assurance arrangements and its system of internal control. During 2021/22, key issues considered by the Audit and Assurance Committee relating to the overall governance of the organisation included:

- Revisiting its terms of reference, which will be kept under regular review;
- Approving the Internal Audit Plan for 2021/22 and keeping under review the resulting Internal Audit Reports. Noting key areas of risk and tracking the management responses made to improve systems and organisational policies;
- Ensuring effective financial systems and controls procedures are in place;
- Further developing the Board's risk management systems and processes and monitoring the same;
- Developing arrangements to work with Audit Wales (AW), and considering, the 2021 Structured Assessment and AW's 2022 Audit Plan;
- Providing assurance to the Board in respect of Information Management and Information Governance.

[The Committee provides an Annual Report of its work to the Board and undertook a self-assessment for 2021/22 in April 2021. A questionnaire based on the National Audit Office Audit and Risk Committee Checklist has been developed and circulated to Committee members and attendees. Respondents included representatives from AW and Internal Audit. An action plan in response to the self-assessment was agreed in June 2021 and the improvements identified were implemented during the year.

The Remuneration and Terms of Service Committee considers and recommends to the Board salaries, pay awards and terms and conditions of employment for the Executive Team and other staff. During 2021/22 key issues considered by the Remuneration and Terms of Service Committee included:

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- Performance of Executive Directors against individual objectives
- National pay awards for members of staff
- Retire and return of senior staff
- Secondment agreements

The Education, Commissioning and Quality Committee enables the Board to undertake greater scrutiny in respect of commissioning, monitoring and quality assessing of education and training. Greater scrutiny will enable HEIW to manage and mitigate risk. The Committee considered the following key matters in 2021/22:

- Reviewed its own terms of reference;
- Reviewed the impact of COVID-19 on education and training for students and trainees and considered the lessons learnt;
- Reviewed the draft NHS Wales Education, Commissioning and Training Plan for [2021/22] and recommended the Plan for approval at the HEIW Board in July 2021;
- Received assurance reports on the tender process for Phase 1 of Health Professional Education Contracts;
- Considered the Strategic Review of Health Care Education - Phase 2;
- Ensured the effective management and improvement of the quality of HEIW's education and related research activities;
- Ensured the effective performance, monitoring, management and value of education and training programmes and contracts;
- Monitored compliance of education and training activities with education providers.

The Committee provides an Annual Report of its work to the Board and undertook a self-assessment for 2021/22 in June 2021. A questionnaire based on the National Audit Office Audit and Risk Committee Checklist has been developed and circulated to Committee members and attendees. A number of areas of focus were identified by the Committee and progressed during the year.

As part of the refresh of our communications and engagement activities post COVID, a new Stakeholder Reference Group supporting the Board with advice and discussion across the range of its functions was established in November 2021. The Stakeholder Reference Group replaced the Education Advisory Group which existed as an external advisory sub-committee to the Education Quality and Commissioning Committee.

In response to the standing down of the Education Advisory Group, the Education, Commissioning and Quality Committee in February commissioned a review of its internal advisory sub-committee, the Multi-Professional Quality and Education Group. That review will report back to the Committee in June.

1.4 Membership of the Board and its Committees

In Table 1 the membership of the Board and its committees is outlined for the period ended 31 March 2022, along with attendance at Board and committee meetings for this period Members are involved in a range of other activities on behalf of the Board, such as regular board development and briefing meetings, and a range of other internal and external meetings.

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Any proposed changes to the structure and membership of Board committees requires Board approval. The Audit and Assurance Committee, together with the Education Commissioning and

Quality Committee, has considered its own terms of reference and recommended changes to the Board. The Board will ensure that terms of reference for each committee are reviewed annually to ensure the work of committees clearly reflects any governance requirements, changes to delegation arrangements or areas of responsibility. The Audit and Assurance Committee and the Education Commissioning and Quality Committee are also required to develop annual reports of their business and activities.

Table 1 - Board and committee membership and attendance since 1 April 2021 to 31 March 2022:

Name	***Position***	***Area of Expertise/ Representation Role***	***Board/ Committee Membership***	***Meeting Attendance 2020/21***	***Champion Roles***
Chris Jones	*Chair*	• *Primary Care* • *Widening Access* • *Prevention*	• *Board (Chair)* • *RATS Committee (Chair)*	*8/8* *9/9*	• *Welsh Language*
*John Hill-Tout**	*Vice Chair*	• *Performance* • *Governance* • *Finance*	• *Board* • *Audit and Assurance Committee* • *RATS Committee*	*6/7* *5/5* *7/8*	• *Primary Care* • *Mental Health*
Tina Donnelly	*Independent Member*	• *Leadership* • *Students* • *Workforce* • *Education/ Training*	• *Board* • *Education, Commissioning and Quality Committee* • *RATS Committee*	*8/8* *4/4* *7/9*	• *Student/ Trainee* • *Equality and Diversity*
Ruth Hall	*Independent Member*	• *Rural Education* • *Quality and Improvement*	• *Board* • *Audit and Assurance Committee* • *Education, Commissioning and Quality Committee* • *RATS Committee*	*6/8* *6/6* *4/4* *8/9*	• *Rural Champion*
Gill Lewis	*Independent Member*	• *Health & Social Care Workforce*	• *Board* • *Audit and Assurance Committee* • *Education, Commissioning and Quality Committee*** • *RATS Committee*	*7/8* *6/6* *1/1* *7/9*	• *Health & Social Care Integration*

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Heidi Phillips	*Independent Member*	• *Integrated Care* • *Improvement* • *Widening Access* • *Education/ Training*	• *Board* • *Audit and Assurance Committee RATS Committee*	*6/8* *4/6* *9/9*	• *Quality Improvement* • *Widening Access* • *Digital*
*Jonathan Morgan****	*Independent Member*	• *Health and Social Services* • *Audit* • *Public accounts* • *Future Generations* • *Law*	• *Board* • *RATS Committee*	*2/2* *1/1*	•
Alex Howells	*Chief Executive*	• *n/a*	• *Board*	*8/8*	• *n/a*
Julie Rogers	*Deputy Chief Executive/ Director of Workforce and OD*	• *n/a*	• *Board*	*8/8*	• *n/a*
Angela Parry (****)	*Interim Director of Nursing*	• *n/a*	• *Board*	*2/2*	• *n/a*
Lisa Llewelyn (*****)	*Director of Nurse and Health Professional Education*	• *n/a*	• *Board*	*6/7*	• *n/a*
Pushpinder Mangat	*Medical Director*	• *n/a*	• *Board*	*7/8*	• *n/a*
Eifion Williams (******)	*Director of Finance*	• *n/a*	• *Board*	*6/6*	• *n/a*
Rhiannon Beckett (*******)	*Interim Director of Finance*	• *n/a*	• *Board*	*2/2*	• *n/a*

Please note the Director of Finance is the lead officer for the Audit and Assurance Committee. The Director of Workforce & Organisational Development is the lead officer for the Remuneration and Terms of Service Committee. The Medical Director and the Director of Nurse and Health Professional Education are the lead officers for the Education Commissioning and Quality Committee.

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(*) – John Hill Tout's term as an Independent Member ended on 31 January 2022. Attendance reflects the number of Board and Committee meetings up to the end of the term.

(**) – Gill Lewis was appointed a full member of the Education, Commissioning and Quality Committee in February 2022. Attendance reflects the number of Committee meetings since appointment.

(***) – Jonathan Morgan was appointed as an Independent Member on 4 January 2022. Attendance reflects the number of Board and Committee meetings since appointment.

(****) – Angela Parry's appointment as Interim Director of Nursing ended on 30 June 2021. Attendance reflects the number of Board meetings up to the end of her appointment.

(*****) – Lisa Llewelyn commenced as Director of Nurse and Health Professional Education on the 1 June 2021. Attendance reflects the number of Board and Committee meetings since appointment.

(******) – Eifion Williams retired on 31 December 2021. Attendance reflects the number of Board meetings up to the end of his appointment.

(*******) – Rhiannon Beckett was appointed Interim Director of Finance on 1 January 2022. Attendance reflects the number of Board and Committee meetings since appointment.

Table 2 - Dates of board and committee meetings held during the period 1 April 2021 to 31 March 2022.

The Board and its committees are fully established and (other than in respect of the suspension of holding Board and committee meetings in public due to COVID 19 as outlined above) operated in line with the Board's standing orders. The following table outlines dates of Board, Board development and committee meetings held during the period 1 April 2020 – 31 March 2021.

Board/ Committee	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sept 2021
Board	n/a	27/05/21	10/06/21	29/07/21	n/a	30/09/21
Board Development	29/04/21	n/a	17/06/21	n/a	19/08/21	n/a
Audit and Assurance Committee	07/04/21	06/05/21	09/06/21	21/07/21	n/a	n/a
Education Commissioning & Quality Committee	n/a	n/a	25/06/21	n/a	n/a	02/09/21
Remuneration and Terms of Service Committee	29/04/21	27/05/21	17/06/21	29/07/21	n/a	30/09/21

Board/Committee	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022

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Board	28/10/21	25/11/21	n/a	27/01/22	n/a	31/03/22
Board Development	28/10/21	n/a	16/12/21	n/a	24/02/22	n/a
Audit and Assurance Committee	21/10/21	n/a	n/a	n/a	07/02/22	n/a
Education Commissioning and Quality Committee	n/a	n/a	n/a	18/01/22	n/a	03/03/22
Remuneration and Terms of Services Committee	n/a	25/11/21	16/12/21	27/01/22	n/a	31/03/22

Local Partnership Forum

The HEIW Local Partnership Forum (LPF) provides the formal mechanism for social partnership within HEIW as well as providing a vehicle for engagement, consultation, negotiation, and communication between trade unions and HEIW management. During 2021-22 the LPF has met bi-monthly and focussed on both strategic and practical issues including culture and organisational development, employment policies, equality and diversity, staff wellbeing, and welfare. During the COVID-19 pandemic it provided a key method of communicating and discussing changes to the HEIW operating model.

2. The Purpose of The System of Internal Control

HEIW's Board system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks. It can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of HEIW policies, aims and objectives. It also evaluates the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control has been in place for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts. Our Board Assurance Framework (BAF) was reviewed and approved by the Board in November 2021. We use the BAF system and process to monitor, seek assurance and ensure that shortfalls are addressed through the scrutiny of the Board and its committees. Oversight of our Corporate Risk Register system is provided through the scrutiny and monitoring of the Board and its committees.

Key controls are defined as those controls and systems in place to assist in securing the delivery of the Board's strategic objective. The effectiveness of the system of internal control is assessed by our internal and external auditors.

A diagram of the Board Control Framework is set out overleaf.

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Levels of Assurance

First Line Operational

- Organisational structures – evidence of delegation of responsibility through line Management arrangements.
- Compliance with appraisal process
- Compliance with Policies and Procedures
- Incident reporting and thematic reviews
- Compliance with Risk Management processes and systems
- Performance Reports, Complaints and Trainee Experience Reports, Finance Reports

Second Line

Risk and Compliance

Reports to Assurance and Oversight Committees

- Audit and Assurance Committee
- Education Commissioning and Quality Committee
- Remuneration Committee
- Health and Safety Groups etc

Findings and/or reports from inspections, Annual Reporting, Performance report through to committees

Third Line Independent

- Internal Audit Plan
- Audit Wales
- External Audits (e.g. Annual Accounts and Annual Report)
- HIW Inspections
- Regulators
- Reviews and Reports by Royal Colleges

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- External visits and accreditations
- Independent Reviews

3. *Capacity to Handle Risk*

We have continued to develop and embed our approaches to risk management and emergency preparedness throughout 2021/22. Our Risk Management Policy is reviewed on an annual basis and was reviewed and approved by the Board in November 2021.

HEIW's risk appetite statement set out below describes the risks it is prepared to accept or tolerate in the pursuit of its strategic goals:

> *HEIW recognises that, as an improvement based organisation, it is impossible for it to deliver its services and achieve positive outcomes for its stakeholders without a high appetite for risk. Indeed, only by taking risks can HEIW realise its aims.*
>
> *HEIW nevertheless recognises that its appetite for risk will differ depending on the activity undertaken. Its acceptance of risk will be based on ensuring that potential benefits and risks are fully understood before decisions on funding are made, and that appropriate actions are taken.*
>
> *HEIW's risk appetite takes into account its capacity for risk, which is the amount of risk it is able to bear (or loss we can endure) having regard to its financial and other resources, before a breach in statutory obligations and duties occurs.*

HEIW's risk tolerance in respect of each of its statutory function is incorporated within the Corporate Risk Register. This will ensure a consistent, integrated approach whereby all risks are clearly linked to organisational objectives with a line of sight to the BAF.

As a part of the development of our BAF, which included full engagement with the Board, seven strategic risks were identified. [In March 2021 the Board considered the strategic risks which faced the organisation in 2021/22]. Table 3 outlines the key strategic risks for HEIW.

Table 3 HEIW current Strategic Risks

1	**Workforce skills and expertise given specialist nature of organisation.** There is a risk that HEIW may find itself without the workforce with the requisite skills it requires to deliver on its Strategic Objectives. This could be caused by a lack of staff with relevant skills in the external market or education system or internally due to a lack of staff skills, career mobility, succession planning and skills management, or due to undesirable employee attrition and sickness absence of key individuals. The continued impact on staff wellbeing due to the COVID pandemic renders this risk to be particularly serious.
2	**Capacity to deliver a growing range of functions and responsibilities.** The risk of lack of capacity may be caused by a lack of sufficient workforce capacity to deliver the growing functions of the organisation, which could be a result of insufficient planning and an over reliance on existing ways of working, not embracing innovation, new ways of working and not investing in appropriate technology.

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3	**Cultural change required to deliver an integrated, multi professional approach.** There is a risk that HEIW could fail to maintain and continue to develop a positive organisational culture which enables, encourages and develops staff engagement in embracing the multi professional approach. This could be caused by an over reliance on existing ways of working or a lack of time and attention focused on Organisational Development and a failure to embed Compassionate Leadership principles.
4	**Effective engagement to ensure that we are influencing and shaping the agenda as system leader and can deliver our plans.** Acting as a system leader will require effective horizon scanning and insight into the NHS system and workforce trends and clear communication and engagement for coalition building to encourage system change. The risk of failing to influence the agenda as system leader could be caused by a failure to communicate and engage effectively with stakeholders within health and social care including our newly established Stakeholder Reference Group.
5	**Effective engagement with our partners to ensure the delivery of shared objectives and aims.** The successful implementation of HEIW's aims and objectives in several areas will rely on engagement and co-operation with our partners in health, social care and education. The risk of failing to deliver in these areas could be caused by insufficient capacity, not effectively maintaining engagement with partners or a failure to achieve buy in from our partners.
6	**Volatility of HEIW's financial position including the reliance on commissioning plans, student choices and associated budgets.** This could be exacerbated by the increasing financial challenges faced by government and our education providers particularly post COVID-19, leading to a reduction in our flexibility to respond to developments.
7	**Workforce intelligence and Data.** The risk that the quality of workforce intelligence captured and reported within the NHS does not support accurate decision making and planning for the NHS's future workforce requirements. This could lead to both overcapacity and undercapacity within the workforce.

Risk Management

The Board sees active and integrated risk management as key elements of all aspects of our functions and responsibilities, especially in order to support the successful delivery of our business.

The Chief Executive / Accountable Officer has overall responsibility for the management of risk for HEIW. The Board and its committees identify and monitor risks within the organisation. Specifically, executive team meetings present an opportunity for the executive function to consider and address risk, and actively engage with and report to the Board and its committees on the organisation's risk profile. The Corporate Risk Register is reviewed monthly by the Executive Team, and quarterly by the Audit and Assurance Committee. Since [November] the Board receives a copy of the Corporate Risk Register for noting at every meeting and undertakes a review of the Corporate Risk Register twice a year. Risks are escalated to the Board as appropriate.

At an operational level Executive Directors are responsible for regularly reviewing their Directorate Risk Registers and for ensuring that effective controls and action plans are in place and monitoring progress.

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[In March we received a substantial assurance report from Internal Audit following an audit of the risk management system which focussed in particular on the processes for the Medical Directorate].

HEIW's Risks

The Corporate Risk Register is continuously updated to capture HEIW's risks as they are identified. The key risks that have been managed during 2021/22 are outlined below:

- Cybersecurity remained a high priority risk and work focused on reducing HEIW's cyber security risk profile while improving cyber security resilience. The Cybersecurity threat was also felt to be heightened as a result of the pandemic due to fraudsters increasingly targeting health organisations. To mitigate this risk HEIW continued to roll out the Cyber Security Implementation Plan.

- The commissioning of post-registration and post-graduate education from Higher Education Institutions without the security of formal contractual arrangements. Phase 2 of the Strategic Review of Education has been developed to include the commissioning of this education provision.

  Difficulties in implementing the Single Lead Employer Model process and the associated impact on trainee experience. To mitigate the risks, roll out was paused and a tripartite review was undertaken to identify areas for support and improvement.
- Difficulties in obtaining Visa sponsorship for newly qualified GPs who are unable to apply for Indefinite Leave to Remain. To mitigate the risk we are working with NHS Wales Shared Services Partnership to provide them with information for their case to extend sponsorship with the Home Office and highlighting the matter to Welsh Government.

- Difficulties in obtaining references for international medical graduates to support their application onto the Medical Performers List. We are raising awareness of the matter with the All Wales Associate Medical Directors of Primary Care and working with Medical Directors to develop a common approach and solution.

- The cost of the increased recruitment of GPs continuing to increase in excess of the forecasted budget. A deep dive has been undertaken by the Medical Deanery and Finance Team to ascertain the causes of the underspend and the over-recruitment is to be carefully managed in future to reduce the overall financial risk.

Further information can be found in the Board papers on our website: **Board meetings, agendas and standing orders - HEIW (nhs.wales)**

The Board is also committed to ensuring staff throughout the organisation are trained and equipped to appropriately assess, manage, escalate and report risk. HEIW managers have continued to receive internal training on risk during 2021-22.

Crisis Management

HEIW has a Crisis Management and Business Continuity Policy and plan.

The HEIW Crisis Management and Business Continuity Policy and plan has been in operation throughout 2021/22 and was deployed as required in response to the COVID-19 situation during 2021/22.

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In line with the Crisis Management and Business Continuity Policy and plan during the COVID-19 crisis, the Crisis Management Team (CMT) in HEIW, has had the role of monitoring the impact and co-ordinating the management of the risks arising. The CMT has also ensured the Executive Team and Board are regularly briefed and assessed if any risks should be escalated and included within the corporate risk register.

The CMT has met as required throughout 2021-22 to manage the impact of the pandemic. It met regularly from March 2021 to June 2021 when it was stood down. A lessons learned exercise was undertaken in September which will inform a review of our Business Continuity Plan in early 2022/23. The CMT was reactivated in late December 2021 alongside the submission of weekly summary updates to Welsh Government on the System response to the Omicron wave. This ended in early March 2022 as the impact of the pandemic lessened and the organisation returned to a more business as usual footing.

The need to plan and respond to the COVID-19 pandemic presented several challenges to the organisation and a number of new and emerging risks were identified. Significant action has been taken by HEIW to support NHS Wales' response to the pandemic. This has also involved working as members of the Health and Social Services Group (HSSG) COVID Planning group which has representatives from the NHS, Local Government and Welsh Government.

While COVID-19 moves towards becoming endemic, there remains a level of uncertainty about the overall impact the pandemic will have on the longer-term delivery of services by the organisation, but appropriate action is being taken to mitigate risk.

HEIW continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response, and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust risk management arrangements and the ability to identify, assess, and mitigate risks which may impact on the ability of the organisation to achieve their strategic objectives.

HEIW has continued to contribute to the national response through the Deputy CEO's role as joint chair of the Workforce Deployment and Wellbeing Planning and Response Group (Workforce Cell).

Our operating model has responded to the pandemic in line with Government Guidelines and to safeguard the health of staff. This has included periods where our headquarters, Ty Dysgu, has been closed where the organisation transitioned successfully to near 100% homeworking. Where permitted by public health guidance, Ty Dysgu has been open to staff who need to come to the office for business or wellbeing reasons. Ty Dysgu reopened to staff on the 17 March 2022 where HEIW moved to our agile 3:2 working model The 3:2 model is based on full time office-based staff working from Ty Dysgu three days a week and from home two days week. Following two years of lockdown it was recognised that returning to the office would be difficult for some members of staff. Given this, we set up a small steering group to facilitate the gradual transition to return to the office and have actively put in place measure to support staff wellbeing.

4. The Control Framework

NHS Wales organisations are not required to comply with all elements of the corporate governance code for central government departments. However, an assessment was undertaken against the main principles as they relate to NHS public sector organisations in Wales and of the Governance, Leadership and Accountability Standard. In response to last year's assessment the Board has focussed on the following areas: the Board's self-assessment process to ensure it better reflects HEIW's role

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in education and training and further development of the induction processes for Independent Members.

The information provided in this governance statement also provides an assessment of how we comply with the main principles of the Code as they relate to HEIW as an NHS public sector organisation. The Board recognises that not all reporting elements of the Code are outlined in this governance statement but are reported more fully in the organisation's wider Annual Report. The Board is satisfied that it is complying with the main principles of, and is conducting its business in, an open and transparent manner in line with the code. There have been no reported departures from the Corporate Governance Code.

The corporate governance code for central government departments can be found at: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220645/corporate_governance_good_practice_july2011.pdf**

HEIW's risk management framework complies materially with the Orange Book, the public sector guide outlining the major principles on the Management of Risk, taking into account the organisation's size, structure and needs.

There have been no reported departures from the Orange Book.

The Orange Book can be accessed at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815635/Orange_Book_Management_of_Risk.pdf

The Health and Care Standards set out the requirement for the delivery of health care in Wales. As an education and training body with no direct contact to patients our focus in respect of the Health and Care Standards relate to staff and resources. Improvements to these areas are captured in our Performance Report.

HEIW has a structure in place for quality governance. In line with Standing Orders, the Board has established a committee to cover the quality of the education and training provided by HEIW – the Education Commissioning and Quality Committee. This Committee holds Executive Directors to account and seeks assurance, on behalf of the Board, that it is meeting its responsibilities in respect of the quality of education and training services. Quality and Quality Improvement is further considered below.

4.1 Other Control Framework Elements

Control measures are in place to ensure compliance with all of the organisation's obligations under equality, diversity and human rights legislation.

HEIW's aspiration is to be an excellent employer and a great place to work. As such we are fully committed to meeting the general and specific duties set out in the Public Sector Equality Duties Act (2011). It is also essential that these duties are reflected in the functions of the organisation, which affect students, trainees and staff across the wider NHS.

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At HEIW we are committed to eliminating discrimination and promoting diversity and inclusion through equality of opportunity and through everything that we do. We have continued to embed our diversity, quality and inclusion agenda which is informed by strong leadership co production, collaboration and direct engagement with those who are affected by the decisions we make.

HEIW ensures equality of opportunity and access for all by building upon the foundation of Equality and Human Rights Legislation and strive not only to comply with legal requirements, but also to use these to ensure that the organisation exemplifies best practice. HEIW acknowledges that our ability to recruit and retain the best people depends upon creating a positive, compassionate and inclusive culture.

In October 2020, we published our first Strategic Equality Plan which sets out our direction of travel for the next four years, explaining how we will work to promote equality, eliminate discrimination and foster good relations between those who share a protected characteristic and those who do not.

In recent months we have strengthened our governance of this area and established an EDI steering group to support the executive leads for EDI and Race Equality in the discharge of their responsibilities, as well as a network to share and highlight best practice, learning and delivery. Two of our independent board members have observer status at the network meetings.

Our Inclusion Network continues to champion equity and equality within the organisation and hosts a number of both virtual and in person events that raise the profile of and celebrate diversity.

In this last year, we have published our second Annual Equality Report (for 2020-2021) and our Gender Pay Gap Reports for 2020 and 2021.

Pension Scheme - As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Welsh Risk Pool - The Welsh Risk Pool Services (WRPS) is a risk sharing mechanism, akin to an insurance arrangement which provides indemnity to NHS Wales's organisations against negligence claims and losses. Individual NHS organisations must meet the first £25,000 of a claim or loss which is similar to an insurance policy excess charge.

The HEIW Board along with its internal sources of assurance, which includes its internal audit function provided by NHS Shared Services, also uses sources of external assurance and reviews from auditors, regulators and inspectors to inform and guide our development. The outcomes of these assessments are being used by the Board to further inform our planning and the embedding of good governance across a range of the organisation's responsibilities.

Quality and Quality Improvement. - During 2021/22 HEIW has implemented or continued to implement the measures detailed below to secure quality and quality improvement in relation to its functions:

- The Education Commissioning and Quality Committee's (ECQC) remit includes; assuring the Board on whether effective arrangements are in place to quality manage education systems and; to make recommendations in respect of the quality of education and monitoring education quality.
- There has been significant progress in developing a HEIW Multi-professional Quality Framework with reporting to ECQC across the Medical and Nursing Directorates aligned to the principles of the framework. The Quality Framework provides a system for ensuring high-quality education

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and training by means of quality planning, quality management and quality assurance and quality improvement.

- The mid and end-of-year service reviews with each sub-directorate team focuses on quality and quality improvement. In addition, cross directorate working on quality activities has been encouraged and facilitated by the adoption of the Quality Framework.
- Quality Activity continues to be undertaken in collaboration with training programme structures as well as local education providers responsible for the education and training delivered within a supportive learning environment. HEIW works closely with regulators to ensure high quality training environments.
- HEIW gathers information on student and trainee experiences. This information is used to inform improvements within the education and training provision.
- HEIW has clearly identified roles within the organisation which support the quality agenda.
- Quality Improvement is embedded in the functions of HEIW, both in terms of internal sharing of good practice as well as through learning from NHS and other healthcare partners. We deliver Quality Improvement training to ensure that staff are equipped with the skills to deliver improvement. We also provide these skills to trainees and their trainers to utilise within the clinical arena.

Welsh Language- As HEIW was established in 2018 it has not been named as an organisation that comes under the Welsh Language Measure 2011. Given this the Welsh Language Commissioner's Office asked HEIW to prepare a Statutory Language Plan as prescribed under the original (1993) Welsh Language Act.
Our draft Welsh Language Scheme, based on the Welsh Language Standards, was subject to a public consultation and approved by the Welsh Language Commissioner in October, and the Board approved the publication of our Scheme at its November 2021 meeting.

Stakeholders and Partners

As an All-Wales organisation, with several strategic functions, the importance of communicating and engaging with our partners and stakeholders cannot be over emphasised. This includes trainees and students, NHS Wales, Social Care Wales, Education providers, Regulators, Private sector (business, suppliers), Professional bodies and Welsh Government.

For much of 2021 – 2022, our communication and engagement activities and resources continued to support the response to the pandemic, with some core activities such as our roadshows and national stakeholder events being postponed. However, recognising the importance of communications and engagement to our work, we continued as many of our core activities as possible online; building and strengthening relationships and helping to shape our ongoing work and services.

This approach included:

- Supporting Covid 19 response by sharing and promoting public health messages; encouraging students and trainees to have their Covid 19 and flu vaccinations, and keeping students, trainees, educators and learning partners up to date on education and training developments via email, newsletters and our dedicated online Covid information pages.
- Creating all-Wales recruitment webpages signposting volunteers and professional returners to information on how they could support mass vaccination in their local area. At the height of the mass vaccination response the website was trending on Google.

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- Engaging and consulting virtually on key work programmes including the Mental Health Workforce Plan, Consultant Clinical Scientists and Medical Administration Unit, the Education and Training Plan for Wales and our IMTP.
- Launching key pieces of work such as the General Practice Nurse Framework, Compassionate Leadership Principles, and our new HEIW website.
- Virtual events enabling promotion, engagement, participation and feedback including the Foundation Pharmacist Fair, Arts Therapies, National Strategy for Consultant Pharmacists
- Restarting healthcare student forum conferences.
- Establishing a Stakeholder Reference Group to facilitate engagement, dialogue and advice from stakeholders to inform our strategic planning and decision making.
- Recognising developments in and future planning of education and training with the conclusion of the healthcare professions pre-registration education tender, and hosting of profession specific webinars.
- Introducing our workforce of the future and promoting careers in NHS Wales through profession specific blogs, promotion and awareness raising of the Graduate Programme and Clinical Fellowship group, plus the launch of Careersville - our virtual careers village which is available in Welsh and English.
- Holding bilingual public Board and Committee meetings as well as our AGM and showcase event spotlighting achievements and developments of interest to our audience.
- Introducing virtual bilingual briefing sessions with MSs and MPs enabling discussion with political representatives from across Wales
- Regular bilingual news and social media posts plus newsletters including our Primary Care Newsletter, Stakeholder Bulletin, Mental Health Newsletter
- Highlighting achievement and recognition through news articles and social media promotion of award wins
- Supporting and awareness raising through sponsorship including the Advancing Healthcare Awards, UK HPMA awards and Womenspire awards.

Looking ahead, we need to balance communication and engagement activities in physical and virtual environments acknowledging our commitments to bio-diversity, accessibility and understanding the time constraints on busy departments, services and the workforce.

In light of this, we have reviewed our communication and engagement proposals and plans for 2022 – 2023. These bring together the above points and the importance of effectively engaging, listening and learning, as well as providing accurate, open and transparent information via a number of channels.

Our plans for 2022-2023 include:

- Review of our stakeholder list to ensure it is representative of our partners and stakeholders
- Re-establish bilingual HEIW face-to-face roadshows for trainees, students, trainers, supervisors and educators at hospital sites
- Hold two national bilingual stakeholder engagement events in person showcasing HEIW work, current and future plans and opportunities to engage and inform our programmes of work. (In 2022 – 2023 we hope to increase the number of national stakeholder events).
- Establish online trainee representative events

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In addition, we have specific objectives in our IMTP which include:

- Commissioning research to understand our reach and impact
- Refreshing and relaunching our Communications and Engagement Strategy
- Developing effective and beneficial relationships with seldom heard from groups
- Introducing new digital engagement channels to enhance our engagement offer
- Put in place a relationship management approach to ensure ongoing engagement and communication
- Develop effective strategic relationships with education partners

Carbon Reduction - HEIW has a Board-approved Biodiversity and Decarbonisation Strategy 2021-24 intended to help reduce the impact of climate change and improve biodiversity. The strategy sets out the organisation's high-level aspirations and intentions to meet requirements, to call its staff, stakeholders, partners and suppliers to action, and to make positive changes now to achieve longer-term goals for Wales. It focuses on four key areas for action. These are:

1. Engaging and supporting our staff
2. Sustainable procurement
3. Developing our office, Ty Dysgu, and supporting our local communities
4. Environmental sustainability

To date we have taken the following actions to reduce our impact on change:

- Installed LED lighting and motion sensors indoors and out
- Implemented a recycling scheme to deal with our most commonly used recyclables, including food, plastics, batteries, and toner cartridges
- Monitored waste and how much is recycled via reports from our disposal partners
- Started using 100% green energy
- Increased the allowance via the Cycle to Work scheme to £2500 to support staff to make more sustainable transport choices
- Undertaken groundworks at Ty Dysgu to promote biodiversity.

HEIW is named as responsible for a key action in one of the Education initiatives in the NHS Wales Decarbonisation Strategic Delivery Plan (March 2021) which relates to the education of the workforce. As well our efforts to reduce our impact on climate change, we have an external role to play in promoting sustainable healthcare through education, training and leadership.

This is considered further within the sustainability section within the Performance Report part of the Annual Report (pages [ ]).

Ministerial Directions

Whilst Ministerial Directions are received by NHS Wales organisations, these are not always applicable to HEIW. Ministerial Directions issued throughout the year are listed on the Welsh Government website Health and social care | Topic | GOV.WALES .

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The following ministerial direction received as at year end 31 March 2022 was applicable to HEIW.

Ministerial Direction/ Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
Amendment to Health and Education and Improvement Wales (No. 2) Directions 2018	**27 July 2021**	HEIW's functions updated to include the Office of Chief Digital Officer (OCDO) for Health and Care.
WHC 2021 (010) – Amendments to Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions	29 July 2021	Standing Orders amended and approved by Board
[WHC (2021) 31 – NHS Wales Planning Framework 2022-25	March 2022	IMTP 2022-25 approved by Board
WHC 2021/024 - NHS Wales' contribution towards a net-zero Public Sector by 2030: NHS Wales Decarbonisation Strategic Delivery Plan	March 2022	An action plan has been developed and committed to within the IMTP 2022-25 approved by Board]

Data Breaches

Incidents resulting in a data breach are reported in accordance with HEIW's statutory requirements and documented confidentiality breach protocol. Under the Data Protection Act 2018 (DPA) personal data breaches (as defined by the act) are considered a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

Personal data breaches (as defined in the DPA) are required to be risk assessed to determine the risk to ? living individuals and the risks to the rights and freedoms of living individuals. Personal data breaches resulting in likely risk to living individuals and a high risk to individuals rights and freedoms must be reported to the Information Commissioners Office (ICO), and to data subjects where the breach is likely to result in a high risk to the rights and freedoms of individuals.

All data breaches are appropriately investigated and are reported to the Audit and Assurance Committee. Where appropriate or mandated, data breaches are reported to Welsh Government.

During 2021/22, HEIW reported no data breaches which were notifiable to Welsh Government or the Information Commissioner. Lower-level data breaches were recorded appropriately with the Data Protection Officer informed. Initial mitigations were implemented, and the incidents were discussed at meetings of the Information Governance and Information Management Group so lessons learned can be shared.

4.2 Planning

Due to the Covid pandemic, and in common with all other NHS Wales organisations, HEIW developed and agreed an Annual Plan for 2021/22. On [31st March 2022] we submitted a Board-approved IMTP (2022-25) to Welsh Government in accordance with the NHS Planning Framework and our statutory duty to produce a financially balanced three-year integrated plan. The Board is responsible for setting the organisation's strategy and as such has played a central role in developing the IMTP (2022-25). The six Strategic Aims and the identified strategic objectives are central to the

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planning and performance practices in place to give the Board assurance on our ability to deliver as an organisation.

As the strategic workforce body for NHS Wales our plan is shaped heavily by the Workforce Strategy for Health and Care https://heiw.nhs.wales/files/workforce-strategy/, alongside a focus on supporting and addressing the significant workforce challenges linked with service and Ministerial Priorities. The plan was developed through engagement with our Board, NHS Wales and Welsh Government colleagues, our wider stakeholders and our staff. This year we are pleased that we have been able to have conversations with all NHS organisations on our emerging IMTP 2022-25. Through the establishment of our Stakeholder Reference Group, we have also engaged with over 40 different organisations on the draft Plan, as well as having a dedicated session to discuss our plans with Welsh Government Policy Leads.

In January 2020, the Board approved our Performance Framework which describes the organisation's system for making continuous improvements to achieve our Strategic Aims and Objectives and to deliver our 'Business As Usual' activities. During 2021/22 the Board has regularly assured and scrutinised our progress with the delivery of the Annual Plan 2021/22. Going forward the Board will continue to receive quarterly Integrated Performance Reports which outline the progress against delivery of the IMTP highlighting the achievements, areas we have experienced challenges and the mitigating actions in place.

Throughout this year we have continued to embed our service review process in which the Executive Team holds biannual service review meetings with senior leaders and their teams to review the progress of key projects or programmes of work. Following each round of service reviews the planning and performance team ensure the learning is shared within HEIW and the themes and learning is presented to the Board to provide further assurance on the performance of the organisation.

5. Review of Effectiveness

As Accountable Officer, the CEO has responsibility for reviewing the effectiveness of the system of internal control. The review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board and its committees rely on several sources of internal and external assurances which demonstrate the effectiveness of the Special Health Authority's system of internal control and advise where there are areas of improvement. These elements are detailed above in the diagram of the HEIW Board Control Framework at [page 11] of this Governance Statement.

The processes in place to maintain and review the effectiveness of the system of internal control include:

- Board and committee oversight of internal and external sources of assurance and holding to account Executive Directors and Senior Managers;
- Executive Directors and Senior Managers who have responsibility for development, implementation and maintenance of the internal control framework and the continuing improvement in effectiveness within the organisation;

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- The review and oversight of the principal risks on the Corporate Risk Register and the Board Assurance Framework by the Board and committees;
- The oversight of operational risk through the Board and its committees;
- Oversight of fraud risk through the Counter Fraud team;
- The monitoring of the implementation of recommendations through the audit tracker overseen by the Audit and Assurance Committee and
- Audit and Assurance Committee oversight of audit, risk management and assurance arrangements.

[HEIW's May 2022 Board received the Audit and Assurance Committee's Annual Report. The Committee Chair's reflections within the Committee's Annual Report were as follows: from AAC Annual report – to be inserted here from the 2021/22 AAC annual report.]

5.1 Internal Audit

Internal Audit provides the CEO, as Accountable Officer and the Board through the Audit and Assurance Committee, with a flow of assurance on the system of internal control. The CEO commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit and Assurance Committee.

The overall opinion by the Head of Internal Audit (HoIA) on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

5.2 The Head of Internal Audit Conclusion:

The scope of the opinion of the HOIA is confined to those areas examined in the risk based audit plan, which has been agreed with senior management and approved, by the Audit and Assurance Committee. The HOIA assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and should be seen as an internal driver for continuous improvement. The HOIA opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Assurance rating

 - + Yellow	The Board can take [**tbc by HOIA]** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

The audit work undertaken during 2021/22, has been reported to the Audit and Assurance Committee.

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The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from the work undertaken in respect of the individual risk-based audit reports contained within the Internal Audit plan which have been reported to the Audit and Assurance Committee throughout 2021/22. This assessment has taken account of the relative materiality of these areas.
- Other assurance reviews, which impact on the Head of Internal Audit Opinion including audit work performed at other organisations.

Internal audit report assurance ratings

A summary of the reviews and associated assurance ratings in each of the domains is set out below:

Corporate governance, risk management and regulatory compliance

- **Risk Management** - Overall Internal Audit issued a [**substantial]** assurance report for our review of risk management.

Strategic planning, performance management & reporting

- **Project/Programme Management** – Overall Internal Audit issued a **substantial** assurance report for our review of Project/Programme Management.
- **Performance and Governance Arrangements** - Overall Internal Audit issued a [tbc] assurance report for our review of Project/Programme Management.

Financial governance and management

- **Financial Planning Process** - Overall Internal Audit issued **substantial** assurance for this review.

Information governance & security

- **Information Governance Toolkit** – Overall Internal Audit issued **substantial** assurance for this review.
- **Strategic Readiness for Digital** – Overall Internal Audit issued [tbc] assurance for this review.

Operational service and functional management

- **Medical Appraisal Revalidation System (MARS)** - Overall Internal Audit issued **reasonable** assurance for this review.
- **Bursary System** – Overall Internal Audit issued [tbc] assurance for this review.

Workforce management

- **Recruitment –** Overall Internal Audit issued **reasonable** assurance for this review.
- **Training Programme Directors –** Overall Internal Audit issued **[tbc]** assurance for this review.

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5.3 External Audit – Audit Wales (AW)

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. The AW undertakes the external auditor role for HEIW on behalf of the Auditor General.

AW's structured assessment for 2021 was designed in the context of the ongoing response to the pandemic and was delivered in two phases, Phase 1 and Phase 2. The Phase 1 structured assessment report considered HEIW's operational planning arrangements and how these were helping to lay the foundations for effective recovery Phase 2 of the structured assessment considered how corporate governance and financial management arrangements had adapted over the period and focused on how these arrangements ensured resources were used efficiently and effectively.
The assessment found that HEIW is well governed with clear, effective arrangements to manage its finances, has good systems of assurance and continues to balance supporting NHS-wide recovery with delivering education and training.

Audit Wales did not make any recommendations based on the 2021 Structured Assessment work.

5.4 Data Quality

The quality and effectiveness of the information and data provided to the Board is continually reviewed at each meeting of the Board and some revisions have been made during the year to provide further clarity for the Board.

5.5 Regulators

HEIW works with all professional regulators in the development of our education and training programmes. Over the past year, we have continued to work closely with regulators when adjusting our courses to respond to the workforce demands created by the pandemic. We have a specific role supporting the GMC in relation to quality of postgraduate medical education.

6. Conclusion – Corporate Governance Report

As indicated throughout this statement, the need to plan and respond to the COVID-19 pandemic has continued to have a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition to the risks. The need to respond and recover from the pandemic will be with the organisation and wider NHS throughout 2022/23 and beyond. I will ensure our Governance Framework considers and responds to this need.

During the period 1 April 2021 –31 March 2022 there have been no significant internal control or governance issues identified. This is due to the establishment of sound systems of internal control in place to ensure HEIW met its objectives. It is recognised that further work will be necessary in 2022/23 to further develop these arrangements. It will be important to communicate widely with staff to further embed these arrangements.

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Signed by
Chief Executive:

Date: 13 June 2022

Statement of the Chief Executive's Responsibilities as Accountable Officer

The Welsh ministers have directed that the Chief Executive should be the Accountable Officer to the Special Health Authority.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issues by Welsh Government.

The Accountable Officer is required to confirm that, as far as she is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accountable Officer has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

The Accountable Officer is required to confirm that that the Annual Report and accounts as a whole is fair, balanced and understandable and that they take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accountable Officer is responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Chief Executive:
Date: 13 June 2022

Directors' Report

The information required for this report can be found in the tables and pages of the Annual Report detailed below.

Composition of Board: Table 1 [pages [7 and 8] of the Governance Statement] – detailed information in relation to the composition of the Board including executive directors and independent members, who have authority or responsibility for directing or controlling the major activities of HEIW during the financial year 2021–2022. This includes the names of the Chair and Chief Executive. Table 1 also includes the names of the directors forming the Audit and Assurance Committee.

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Board and board level committee meeting dates for the period ending 31 March 2022: Table 2 [page 9 of the Governance Statement]

Declaration of interest: details of company directorships and other significant interests held by members of the Board which may conflict with the responsibilities as Board members [page 9 of the Performance Report].

HEIW confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

Information Governance. During 2021/22, no data breaches met the assessment criteria for reporting to the ICO. [(page 20 of the Governance Statement)]. Environmental, social and community issues: HEIW is cognisant of the impact it has on the environment and takes steps to minimise this, where possible. Details of the Board approved HEIW Decarbonisation Strategy and approach to sustainability are outlined in page [19] of the Governance Statement.

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the special health authority and of the income and expenditure of the special health authority for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts. The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with the requirements outlined in the above mentioned direction by Welsh ministers. By order of the board, signed:

Chair

Date: 13 June 2022

Chief Executive

Date: 13 June 2022

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.8.1**
Teitl yr Adroddiad	**Adroddiad ar Faterion Allweddol – cyfarfod Grŵp Llywodraethu Gwybodaeth a Rheoli Gwybodaeth (IGIMG) a gynhaliwyd ar 18 Mawrth 2022**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Pwrpas yr Adroddiad	Agored		
Prif Faterion	Pwrpas yr adroddiad yw amlinellu'r trafodaethau a gynhaliwyd gan yr IGIMG.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	Mae'r adroddiad hwn yn canolbwyntio ar y materion allweddol a godwyd yng nghyfarfod IGIMG a gynhaliwyd ar 18 Mawrth 2022.		
	Gwybodaeth	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
			✓	
Argymhellion	Gofynnir i Aelodau'r Pwyllgor: • **Nodi** cynnwys yr adroddiad **er sicrwydd**.			

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ADRODDIAD AR FATERION ALLWEDDOL – CYFARFOD GRŴP LLYWODRAETHU GWYBODAETH A RHEOLI GWYBODAETH (IGIMG) A GYNHALIWYD AR 18 MAWRTH 2022

1. RHAGARWEINIAD

Pwrpas yr adroddiad yw rhoi diweddariad ar faterion a ystyriwyd gan y Grŵp Llywodraethu Gwybodaeth a Rheoli Gwybodaeth (IGIMG). Gofynnir i'r Pwyllgor Archwilio a Sicrwydd (Pwyllgor) nodi'r adroddiad cryno gan y Cadeirydd.

2. CEFNDIR

Mae'r IGIMG yn rhoi sicrwydd i'r Pwyllgor Archwilio a Sicrwydd fel is-grŵp. Ei ddiben yw cefnogi a llywio'r agenda Llywodraethu Gwybodaeth ehangach a rhoi sicrwydd i'r Pwyllgor Archwilio a Sicrwydd bod mecanweithiau arfer gorau Llywodraethu Gwybodaeth effeithiol ar waith yn y sefydliad.

3. CYNNIG

Cyfarfu'r IGIMG ar 18 Mawrth 2022, ac mae Atodiad 1 yn rhoi crynodeb i'r Pwyllgor o'r meysydd a ystyriwyd yn y cyfarfod. Cofnod ffurfiol y cyfarfod yw'r cofnodion a gymeradwywyd.

4. MATERION LLYWODRAETHU A RISG

Nid oes unrhyw oblygiadau llywodraethu a risg i'r Pwyllgor eu hystyried.

5. GOBLYGIADAU ARIANNOL

Nid oes unrhyw oblygiadau ariannol i'r Pwyllgor eu hystyried/cymeradwyo.

6. ARGYMHELLIAD

Gofynnir i Aelodau'r Pwyllgor **nodi** cynnwys yr adroddiad **er sicrwydd**.

Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru lachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	

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	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	Nod Strategol 5: Bod yn gyflogwr da ac yn le gwych i weithio	Nod Strategol 6: Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✔	✔	✔

Ansawdd, Diogelwch a Phrofiad Cleifion	
Mae sicrhau bod y Pwyllgor yn cyflawni ei fusnes yn briodol ac yn gyson â'i reolau sefydlog yn ffactor allweddol yn ansawdd, diogelwch a phrofiad cleifion sy'n cael gofal.	
Goblygiadau Ariannol	
Dim	
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)	
Mae'n hanfodol bod y Pwyllgor yn cydymffurfio â'i reolau sefydlog, sy'n cynnwys cael diweddariadau gan ei is-grwpiau.	
Goblygiadau o ran Staff	
Dim	
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)	
Ddim yn berthnasol	
Hanes yr Adroddiad	Mae'r adroddiad hwn yn eitem sefydlog ar agenda'r Pwyllgor.
Atodiadau	Atodiad 1 – IGIMG, Crynodeb y Cadeirydd

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ATODIAD 1

Dyddiad y cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.8.1**
Rhyddid Gwybodaeth	Agored		
Is-grŵp Adrodd	Grŵp Llywodraethu Gwybodaeth a Rheoli Gwybodaeth		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Cadeirir gan	Dafydd Bebb, Ysgrifennydd y Bwrdd ac Uwch Swyddog Risg Gwybodaeth		
Cyfarwyddwr Gweithredol Arweiniol	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Dyddiad y Cyfarfod Diwethaf	18 Mawrth 2022		

Crynodeb o'r materion allweddol a ystyriwyd gan yr is-grŵp ac unrhyw benderfyniadau cysylltiedig a wnaed:

Derbyniodd y Grŵp y **System Tracio Argymhellion Archwiliad** yn ymwneud â Llywodraethu Gwybodaeth a Rheoli Gwybodaeth ac ystyriodd y cynnydd yn erbyn gweithredu argymhellion archwilio a ddeilliodd o'r System Adolygu TG ac Adolygu Arfarnu Meddygol (MARS).

Derbyniodd y Grŵp **Ddiweddariad Chwarter 4 ar y Cynllun Cyflawni a Gweithredu Llywodraethu Gwybodaeth 2021/22** a nododd y cynnydd a wnaed o ran y gweithgareddau a amlinellwyd yn y cynllun ar gyfer chwarteri tri a phedwar.

Derbyniodd a nododd y Grŵp ddiweddariad ar Gynllun **Gweithredu'r Gofrestr Asedau Gwybodaeth.**

Derbyniodd y Grŵp y wybodaeth ddiweddaraf am y **Cyflwyniad Pecyn Cymorth IG** a nododd y bwriad i wella cydymffurfiaeth yn erbyn y Pecyn Cymorth Llywodraethu Gwybodaeth pan fydd datganiad gorfodol yn cael ei gyflwyno ym mis Mawrth 2022. Amlygwyd, yn dilyn sgôr cydymffurfio lefel isel yn y cyflwyniad gwirfoddol ym mis Mawrth 2021, rhagwelwyd y byddai ail gyflwyniad y pecyn cymorth Llywodraethu Gwybodaeth yn cyflawni sgôr cydymffurfio lefel 2. Roedd hyn yn gyflawniad arwyddocaol i'r sefydliad.

Derbyniodd a nododd y grŵp y wybodaeth ddiweddaraf am **Brosesau Cyfrifon TG Pobl sy'n ymuno, yn newid swydd, yn Gadael a Chyfrifon wedi'u Hatal**. Hefyd cymeradwyodd y Grŵp **Hysbysiad Preifatrwydd Cwci** i'w ddefnyddio ar systemau AaGIC.

Derbyniodd y Grŵp ddiweddariad ar y **Cynllun Gwaith Seiberddiogelwch**. Nodwyd nad oedd dau o'r gweithgareddau allweddol wedi'u cyflawni oherwydd blaenoriaethu'r mudo Azure. Cadarnhawyd bod yr ymarfer ymateb i ddigwyddiadau seiber wedi'i drefnu ar gyfer 28 Mawrth 2022 ac y bydd prawf treiddiad allanol a mewnol llawn yn cael ei gwblhau yn ystod 22/23. Cadarnhawyd bod y risg seiberddiogelwch ar y Gofrestr Risg Gorfforaethol yn debygol o aros yn goch yn ystod 2022/23 oherwydd y risg uwch o ymosodiadau seiber o ganlyniad i ffactorau allanol parhaus.

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Derbyniodd a nododd y Grŵp y **Diweddariad ar Reoliadau NIS.**

Derbyniodd y Grŵp y wybodaeth ddiweddaraf am **Ddigwyddiadau Seiber a Gwybodaeth** ac roedd yn fodlon gyda'r camau a gymerwyd hyd yma.

Derbyniodd y Grŵp yr **Adroddiad Llywodraethu Gwybodaeth a Rheoli Gwybodaeth drafft**. Cadarnhawyd bod 4 cais Rhyddid Gwybodaeth (FOI) wedi dod i law yn ystod y cyfnod adrodd, ac ymatebwyd i bob un o fewn amser. Y gyfradd gydymffurfio (ymateb o fewn yr 20 diwrnod gwaith) o'r ceisiadau a dderbyniwyd oedd 100%. Cadarnhawyd ein bod wedi derbyn cais am wybodaeth gan Swyddfa'r Comisiynydd Gwybodaeth ym mis Ionawr 2022 yn ymwneud â chwyn yr oeddent wedi'i dderbyn. Gwnaethom ymateb i'r cais ar 15 Chwefror a darparu rhagor o wybodaeth ar 3 Mawrth. Disgwylir penderfyniad ar ganlyniad y gŵyn yn fuan. Nododd y grŵp yr adroddiad.

Risgiau a materion allweddol/materion sy'n peri pryder y mae angen i'r Bwrdd fod yn ymwybodol ohonynt:

Ddim yn berthnasol

Argymhellion i'r Pwyllgor Archwilio a Sicrwydd eu hystyried:

Ddim yn berthnasol

Camau a ddirprwywyd gan y Pwyllgor:

Ddim yn berthnasol

Prif ffynonellau gwybodaeth a dderbyniwyd:

- Adroddiad Diweddariad Cyffredinol ar Lywodraethu Gwybodaeth
- Adroddiad Diweddariad ar y Gofrestr Asedau Gwybodaeth
- Diweddariad ar Gyflwyniad y Pecyn Cymorth
- Diweddariad ar Gynllun Gwaith Llywodraethu Gwybodaeth
- System Tracio Argymhellion Archwiliad
- Adroddiad FOI a DPA
- Adroddiad Rheoli Ased
- Adroddiad ar y rhai sy'n Ymuno, yn newid swydd ac yn Gadael
- Hysbysiad Cwci
- Cynllun Gwaith Seiberddiogelwch
- Diweddariad ar Reoliadau NIS
- Diweddariad ar Ddigwyddiad Seiber
- Diweddariad ar Ddigwyddiadau Gwybodaeth

Uchafbwyntiau'r is-grwpiau sy'n adrodd i'r Pwyllgor hwn:

Ddim yn berthnasol

Materion a gyfeiriwyd at Bwyllgorau eraill:

Dim wedi'u dynodi

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Dyddiad y Cyfarfod	**12 Mawrth 2022**	**Eitem ar yr Agenda**	**2.9**
Teitl yr Adroddiad	**Adolygiad Effeithiolrwydd y Pwyllgor 2021/22**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Pwrpas yr Adroddiad	Agored		
Prif Faterion	Cyflwyno Dogfen drafft ar Adolygiad Effeithiolrwydd y Pwyllgor i'r Pwyllgor Archwilio a Sicrwydd (Pwyllgor) ac amlinellu'r dull o gynnal y broses adolygu.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	Cynhelir hunanasesiad o'r Pwyllgor Archwilio a Sicrwydd yn flynyddol i roi sicrwydd i'r Bwrdd bod y Pwyllgor yn cyflawni ei ddyletswyddau'n effeithiol. Gwahoddir aelodau i ystyried a chymeradwyo'r Ddogfen Adolygu Effeithiolrwydd Pwyllgor drafft (Atodiad 1).		
	Gwybodaeth	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
Argymhellion				✓
	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd: • **Cymeradwyo** cynnwys y Ddogfen Adolygu Effeithiolrwydd Pwyllgor (Atodiad 1).			

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ADOLYGIAD EFFEITHIOLRWYDD Y PWYLLGOR 2021/22

1. RHAGARWEINIAD A CHEFNDIR

Bydd aelodau'r Pwyllgor Archwilio a Sicrwydd (Pwyllgor) yn ymwybodol bod y Pwyllgor yn cynnal hunanasesiad o'i effeithiolrwydd a'i effaith bob blwyddyn trwy gwblhau rhestr wirio effeithiolrwydd.

Eleni, bwriedir dosbarthu'r Rhestr Wirio i'r aelodau, a'r swyddogion hynny sy'n gweithio gyda'r Pwyllgor, i'w chwblhau yn unigol.

2. MATERION LLYWODRAETHU A RISG

Mae cynnal hunanasesiad blynyddol yn rhoi sicrwydd i'r Bwrdd bod y Pwyllgor yn cyflawni ei ddyletswyddau'n effeithiol. Er mwyn llywio'r gwerthusiad o effeithiolrwydd y Pwyllgor a dynodi'r themâu allweddol i'w trafod yn y Pwyllgor ar 5 Mai 2022, gofynnir i aelodau'r Pwyllgor ac ymatebwyr ehangach gwblhau'r rhestr wirio hunanasesu a dynnwyd o Rhestr Wirio Risg a Swyddfa Archwilio Genedlaethol y Swyddfa Archwilio Genedlaethol. Gofynnir iddynt hefyd ymateb i nifer o gwestiynau gwerthuso a amlinellwyd ar ddechrau'r ddogfen Adolygu Effeithiolrwydd (Atodiad 1) erbyn dydd Mawrth, 19 Ebrill 2022. Cyflwynir gwerthusiad o'r Adolygiad yn y Pwyllgor Archwilio a Sicrwydd ar 5 Mai 2022.

3. GOBLYGIADAU ARIANNOL

Nid oes unrhyw oblygiadau ariannol yn gysylltiedig â'r Adolygiad o Effeithiolrwydd y Pwyllgor.

4. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd:

- **Cymeradwyo** cynnwys y Ddogfen Adolygu Effeithiolrwydd y Pwyllgor (Atodiad 1).

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Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓	✓	✓

Ansawdd, Diogelwch a Phrofiad Cleifion
Mae cynnal hunanasesiad blynyddol yn rhoi sicrwydd i'r Bwrdd bod y Pwyllgor yn cyflawni ei ddyletswyddau'n effeithiol.
Goblygiadau Ariannol
Nid oes unrhyw oblygiadau ariannol.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Nid oes unrhyw oblygiadau cyfreithiol.
Goblygiadau o ran Staff
Nid oes unrhyw oblygiadau o ran staff.
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Bydd yr adolygiad o effeithiolrwydd yn cael ei gwblhau'n rheolaidd a'i gefnogi gan raglen dreigl o wella ac asesu. Mae'r adolygiad o effeithiolrwydd yn asesu a yw'r Pwyllgor yn cyflawni ei ddyletswyddau'n unol â Chylch Gorchwyl y Pwyllgor Mae'r adolygiad yn rhan annatod o'r adroddiad Llywodraethu sydd wedi'i gynnwys yn adroddiad blynyddol y sefydliad.

Hanes yr Adroddiad	
Atodiadau	• Atodiad 1 – Dogfen Adolygu Effeithiolrwydd y Pwyllgor Archwilio a Sicrwydd.

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AUDIT AND ASSURANCE COMMITTEE EFFECTIVENESS REVIEW 2021/22

The members of the Audit and Assurance Committee and those officers who work with the Committee, will be aware that annually the Committee undertakes a self-assessment of its effectiveness and impact. This has historically been drawn from the National Audit Office Audit and Risk Committee Checklist.

It is intended to undertake a similar exercise this year with an evaluation of the Review being presented at the Audit and Assurance Committee on 5 May 2021. In order to inform the evaluation and the key themes for discussion, and also to allow everyone to prepare their thoughts prior to the meeting, a number of key questions and also the self-assessment checklist are provided below.

It would be helpful if you would be able to complete this document **by Tuesday, 19 April 2022** and return your contributions to Catherine.English@wales.nhs.uk

The checklist has been partially completed for the procedural questions, however, if you wish to comment on these please do so.

Committee Overview Questions

	Strongly Agree	Agree	Disagree	Strongly Disagree
The Audit and Assurance Committee has a positive impact on the good governance of HEIW's affairs				
The Audit and Assurance Committee contributes effectively to improving HEIW's overall performance				
The Audit and Assurance Committee's role is well understood within the overall governance framework				
The Audit and Assurance Committee's relationship with other committees is productive				

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Committee Evaluation Questions

1. **What aspects of the work of the Audit and Assurance Committee do you think have improved over the last year and why (please give examples)?**
2. **What are the continuing challenges for the way we work and what are your suggestions for improvement?**
3. **What other areas of HEIW's business should the Committee consider adding value to organisational delivery of the IMTP?**
4. **Have you any other suggestions which would improve the ways in which the Audit and Assurance Committee works and engages with the wider organisation?**

Please include any comments you wish to make about the evaluation questions in the box below.

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AUDIT AND ASSURANCE COMMITTEE: SELF ASSESSMENT CHECKLIST

Question/Checklist		Yes	No	N/A	Comments
Principle 1 – Membership, Independence, Objectivity and Understanding					
1	Do we have a minimum of three members, all Independent Members, at least two of whom, including the Audit and Assurance Committee Chair, are Independent Members of the organisation's Board?	✓			
2	Does the Director of Finance, the Head of Internal Audit and the External Auditor routinely attend Audit and Assurance Committee meetings?	✓			
3	Are we satisfied with the range, frequency and number of Executives and other participants attending the Audit and Assurance Committee meetings? (Numbers of attendees should be sufficient to deal adequately with the agenda, but not so many as to blur the issues).				
4	Is our relationship and communication with the wider organisation effective in support of the Annual Governance Statement?				
5	Are conflicts recorded and declared at the start of every meeting, and is appropriate action taken when relevant matters are discussed?	✓			

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6	Do we have a clear understanding of our terms of appointment, including what is expected of us, how our individual performance will be appraised, the duration of our appointment, training required and how this will be provided?				

Conclusion	
Are we performing effectively in this area?	
Are there any actions we want to take to build our effectiveness?	

Question/Checklist		**Yes**	**No**	**N/A**	**Comments**
Principle 2 – Skills					
7	Are we satisfied that, collectively, we have the range of skills we need to ensure that the Accountable Officer and the Board gain the assurance they need to governance, risk management, the control environment and on the integrity of all elements of the Annual Report and Accounts?				
8	Do we possess the wider skills necessary to be fully effective (e.g. in relation to the core business of the organisation, change management, the wider political landscape, and other strategically relevant issues)?				

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9	Does at least one member have recent and relevant financial experience sufficient to allow them to competently analyse the financial statements and understand good financial management discipline?	✓			
10	Where we need additional skills, are we empowered to co-opt additional members or procure specialist advice?				
11	Do we have effective induction and training arrangements for new members and does the Audit and Assurance Committee Chair ensure that all members have an appropriate programme of engagement with the organisation to help build sufficient understanding?				

Conclusion	
Are we performing effectively in this area?	
Are there any actions we want to take to build our effectiveness?	

Question/Checklist		**Yes**	**No**	**N/A**	**Comments**
Principle 3 and 4 – The Role and Scope of the Committee					
12	Do we have a clear understanding of the role and responsibilities of the Audit and Assurance Committee?	✓			

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13	Does our work programme cover the assurance needs of the Board and Accountable Officer through a balance of agenda items?				
14	Do we provide insight and strong, constructive challenge to the organisation where required?				
15	Do we have sufficient understanding of the organisation's overall control environment, including its governance and any outsourcing arrangements, and review its effectiveness regularly to provide assurance that arrangements are responding to risks within the organisation?				
16	Do we use assurance mapping to target the areas of greatest risk in our organisation?				
17	Do we critically review the comprehensiveness and reliability of assurances that we receive from across the organisation?				
18	Are we proactive in commissioning additional assurance work where we have identified a risk or control issues which is not subject to sufficient review?				
19	Do we draw the Accountable Officer and the Board's attention to the results of our work on risk?	✓			Key Issue Reports from Committee Chair at each Board meeting.

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20	Do we lead on the assessment of the Annual Governance Statement for the Accountable Officer and Board, including the provision of advice on its preparation and scope?				.
21	Do we give sufficient and timely attention to financial management and reporting issues, including consideration of key accounting policies, estimates and judgements and the quality of the year-end financial statements?				
22	Do we sufficiently consider and challenge the work of internal audit and external audit?				
23	Do we track all audit recommendations (internal and external) and hold the organisation to account for their implementation?				
24	Do we regularly review anti-fraud and corruption arrangements?				
25	Do we regularly review the organisation's cyber risk management and consider the appropriateness of the organisation's risk mitigation strategies?				
26	Do we ensure that a senior Board member has overall responsibility for whistleblowing arrangements within the organisation?				

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27	Do we regularly review our Terms of Reference?	✓			

Conclusion	
Are we performing effectively in this area?	
Are there any actions we want to take to build our effectiveness?	

Question/Checklist		Yes	No	N/A	Comments
Principle 5 – Communication and Reporting					
28	Is our work effectively and promptly reported to the Board and Accountable Officer?				
29	Are our relationships and communications sufficiently well developed with those we seek briefings from and those we provide assurance to, including where risks cross organisational boundaries?				
30	Do we provide an Annual Report to the Board, timed to support the Governance Statement; is our report open and honest in presenting our views and opinions from the work we have done during the year; and is its content consistent with good practice?				

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31	Does the Audit and Assurance Committee Chair have regular bilaterals with the key attendees (e.g. Accountable Officer, Director of Finance, the Head of Internal Audit, and the External Auditor)?				
32	Where appropriate, do we communicate our work across the organisation?				

Conclusion	
Are we performing effectively in this area?	
Are there any actions we want to take to build our effectiveness?	

Question/Checklist		**Yes**	**No**	**N/A**	**Comments**
Principle 6 – Meetings					
33	Has the Committee established a plan of matters to be dealt with across the year?	✓			
34	Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussions?				
35	Does the Committee's calendar meet the Board's requirements and financial and governance calendar?				

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36	Are Committee papers distributed in sufficient time for members to give them due consideration?				
37	Are Committee meetings scheduled prior to important decisions being made?				
38	Is the timing of Committee meetings discussed with all the parties involved?				

Conclusion	
Are we performing effectively in this area?	
Are there any actions we want to take to build our effectiveness?	

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.10**
Teitl yr Adroddiad	**Adroddiad Blynyddol drafft y Pwyllgor Archwilio a Sicrwydd 2020/21**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Pwrpas yr Adroddiad	Agored		
Prif Faterion	Prif ddiben Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd yw sicrhau'r Bwrdd bod y system sicrwydd yn addas i'r diben ac yn gweithredu'n effeithiol. Mae'r adroddiad yn crynhoi'r meysydd allweddol o weithgarwch busnes a gyflawnwyd gan y Pwyllgor yn ystod 2021/22.		
Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	Mae'r adroddiad hwn yn crynhoi'r meysydd allweddol o weithgarwch busnes a gyflawnwyd gan y Pwyllgor yn ystod 2021/22 ac yn amlygu rhai o'r materion allweddol y mae'r Pwyllgor yn bwriadu rhoi ystyriaeth bellach iddynt dros y 12 mis nesaf.		
	Gwybodaeth	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓
Argymhellion	Gofynnir i'r Pwyllgor **gymeradwyo** Adroddiad Blynyddol 2021/22 i'w gyflwyno i'r Bwrdd er sicrwydd.		

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ADRODDIAD BLYNYDDOL DRAFFT Y PWYLLGOR ARCHWILIO A SICRWYDD 2020/21

1. RHAGARWEINIAD

Prif ddiben Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd (y 'Pwyllgor') yw sicrhau'r Bwrdd bod y system sicrwydd a ddarperir gan y Pwyllgor yn addas i'r diben ac yn gweithredu'n effeithiol. Mae'r adroddiad hefyd yn cadarnhau bod y Pwyllgor wedi cyflawni ei Gylch Gorchwyl yn effeithiol.

2. CEFNDIR

Mae'r Pwyllgor, drwy ei adroddiadau yn ystod y flwyddyn, wedi hysbysu'r Bwrdd yn rheolaidd am ganlyniadau ei adolygiadau o sicrwydd, ynghyd ag unrhyw faterion eithriadol a gododd. Yn unol â llawlyfr Pwyllgor Archwilio GIG Cymru a safonau arfer da a dderbynnir yn gyffredinol, mae'n ofynnol i Gadeirydd y Pwyllgor gyhoeddi Adroddiad Blynyddol ar y materion a ystyriwyd gan y Pwyllgor yn ystod y flwyddyn ariannol.

Mae'r adroddiad yn rhoi sicrwydd i'r Bwrdd a'r Swyddog Atebol o ran digonolrwydd ac effeithiolrwydd gweithdrefnau a systemau AaGIC o ran cynnal system gadarn o reolaeth fewnol a'r casgliadau y daethpwyd iddynt ar gyfer blwyddyn ariannol 2021/22. Mae hyn i gynnwys sicrwydd ynghylch trylwyredd y prosesau ac ansawdd y data sydd wrth wraidd y datganiadau a rhoi ei sicrwydd ei hun ynghylch dibynadwyedd y datgeliadau pan gânt eu cyflwyno wedyn i'r Bwrdd i'w cymeradwyo.

Mae'r adroddiad pwyllgor blynyddol hwn wedi'i ddatblygu yn dilyn adolygiad o gofnodion a phapurau cymeradwy'r pwyllgor, gan roi ystyriaeth ddyledus i gylch gwaith y Pwyllgor fel y nodir yn ei Gylch Gorchwyl.

3. ASESIAD

Mae'r adroddiad hwn yn crynhoi'r meysydd allweddol o weithgarwch busnes a gyflawnwyd gan y Pwyllgor yn ystod 2021/22 ac yn amlygu rhai o'r materion allweddol y mae'r Pwyllgor yn bwriadu rhoi ystyriaeth bellach iddynt dros y 12 mis nesaf.

4. MATERION LLYWODRAETHU A RISG

Rheolir unrhyw risgiau a materion llywodraethu trwy gyfarfodydd y pwyllgor a bydd adroddiadau eithrio yn cael eu darparu i'r Bwrdd gan y cadeiryddion priodol.

5. GOBLYGIADAU ARIANNOL

Nid oes goblygiadau ariannol i'r Bwrdd eu hystyried/cymeradwyo.

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6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor **gymeradwyo** Adroddiad Blynyddol 2021/22 i'w gyflwyno i'r Bwrdd er sicrwydd.

Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓		✓

Ansawdd, Diogelwch a Phrofiad Cleifion
Mae sicrhau bod y Bwrdd yn cyflawni ei fusnes yn briodol drwy ei bwyllgorau ac yn gyson â'i reolau sefydlog yn ffactor allweddol yn ansawdd, diogelwch a phrofiad cleifion sy'n cael gofal.
Goblygiadau Ariannol
Dim
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Mae'n hanfodol bod y Bwrdd yn cydymffurfio â'i reolau sefydlog, sy'n cynnwys cael diweddariadau gan ei bwyllgorau.
Goblygiadau o ran Staff
Dim
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Mae'r adroddiad yn amlinellu'r gwaith a wnaed gan y Pwyllgor i adolygu perfformiad a chyllid tymor byr AaGIC yn ogystal â chanolbwyntio ar gynaliadwyedd tymor hwy. Nod y strwythur llywodraethu yw dynodi materion yn gynnar er mwyn eu hatal rhag gwaethygu ac mae'r Pwyllgor yn integreiddio i drefniadau cyffredinol y Bwrdd.

Hanes yr Adroddiad	
Atodiadau	Atodiad 1 – Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd 2021/22

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AUDIT AND ASSURANCE COMMITTEE
ANNUAL REPORT 2020/21

Committee Chair's Reflection

[Gill to insert comments after the content of the report is finalised]

1. Introduction

The Audit and Assurance Committee was established under Board delegation with approved Terms of Reference and Operating Arrangements that are aligned to the NHS Wales Audit Committee Handbook, published by the Welsh Government. The Committee is an Independent Committee of the Board and has no Executive powers other than those specifically delegated in the Terms of Reference.

The Committee, through its in-year reporting, has regularly kept the Board informed regarding the results of its reviews of assurances, together with any exceptional issues that arose. In accordance with the NHS Wales Audit Committee Handbook guidance and generally accepted standards of good practice, the Committee is required to issue an Annual Report, constituting a formal report of the matters that it has considered during the year. The purpose of this report is to provide the Board and the Accountable Officer with assurance in respect of the adequacy and effectiveness of HEIW's procedures and systems in maintaining a sound system of internal control, and the conclusions drawn for the 2021/22 financial year.

This report supports the compilation of the Accountability Report and sets out how the Committee has met its Terms of Reference.

2. Role and Purpose

The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. The primary role of the Committee is therefore to ensure the system of assurance is valid and suitable for the Board's requirements; as such it will review whether:

- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;

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- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

The Committee provides a key source of assurance to the Board, ensuring that the organisation has effective controls in place to manage the significant risks to achieving its objectives and that controls are operating effectively. The Committee's principal duties have consistently included reviewing the adequacy of HEIW's strategic governance and assurance framework, systems, and processes for the maintenance of an effective system of governance, internal control, and risk management across the whole organisation's activities. These are designed to support the public disclosure statements that flow from the assurance processes, including the Accountability Report before it is submitted to the Board for approval. Integral to this is the Committee's focus upon seeking assurance that the organisation has an effective framework of internal control to address principal risks and that the effectiveness of the framework is regularly reviewed.

During the year, the Committee has supported the Board by seeking and providing assurance that controls are in place and are working as designed and by challenging poor sources of assurance. Therefore, the Committee has a relatively broad role encompassing scrutiny of, and comment upon, the adequacy and effectiveness of HEIW's overall governance, risk management and internal control. This includes the organisations' ability to achieve its objectives; compliance with relevant regulatory requirements and other directions and requirements set by the Welsh Government and others; reliability, integrity, safety, and security of the information collected and used by the organisation; the efficiency, effectiveness, and economic use of resources and the extent to which the organisation safeguards and protects all its assets, including its people.

The Committee discharges this duty by fulfilling its responsibilities as outlined in its Terms of Reference. In performing its duties, the Committee works to an approved work plan, based on scheduled agenda topics together with a range of specific issues which are subject to review. It is supported by the activities of Audit Wales as the External Auditor; NHS Wales Shared Services Partnership (NWSSP): Audit and Assurance – Internal Audit and Specialist Services Unit, and Local Counter Fraud Specialists.

In discharging these responsibilities, the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- Adequacy of disclosure statements, (Annual Governance Statement, Accountability Report, Annual Quality Statement, Annual Report) which are supported by the Head of Internal Audit Opinion, the Audit Wales Annual Audit Report and other opinions;
- The adequacy of relevant policies, legality issues and the Codes of Conduct;
- The policies and procedures relating to fraud and corruption;
- That the system for risk management is robust in identifying and mitigating risks, enabling the Audit and Assurance Committee to provide the Board with assurance that the risks impacting on the delivery of HEIW's objectives are being appropriately managed.

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3. Governance and Assurance Development

3.1 Improvements to the Governance Framework

During the year, the Committee has continued to evolve the governance arrangements across the organisation and to further strengthen the governance framework for the organisation and test its robustness. This included the following main areas:

- Review of the Standing Orders;
- Scheme of Delegation;
- Development of the Board Assurance Framework;
- Review of the Board Committee Terms of Reference.

The Committee has focused on a number of key areas to drive forward improvements during the year and has sought to increase its visibility and promote even greater transparency during the year. This included:

- Risk Management;
- Board Assurance Framework;
- Performance Management Framework;
- Information Management and Information Governance, particularly cyber security and digital agenda;
- Asset and Contract Management.

3.2 Impact of COVID-19 on Governance Arrangements

On the 17 March 2020, the National Assembly for Wales approved The Health Protection (Coronavirus) (Wales) Regulations 2020. The Act provided additional powers to enforce the compliance of those who were instructed to isolate (in the context of reducing the spread of an infectious disease). The regulations also required HEIW to comply with social distancing measures in the workplace, the requirements of which HEIW continued to comply with throughout 2021/22.

During 2021/22, HEIW continued to be actively involved in the emergency planning response to the COVID-19 crisis and the reset and recovery agenda. The priority during this time has been to support the NHS Wales frontline services in light of the increasing demands from the pandemic, and to maintain the safety and wellbeing of its staff and learners across Wales.

As a result of the Board approval to temporarily change its governance arrangements, members of the public were unable to attend or observe the Committee during the first part of 2021/22. To facilitate as much transparency and openness as possible , the Committee has published a synopsis of the meetings within 72 hours and the unconfirmed minutes within two weeks of a meeting. In July 2021, the Committee started live streaming its meetings , which enabled members of the public to observe meetings virtually and in real-time.

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Throughout the course of the year the Audit and Assurance Committee has also made recommendations and undertaken the following actions, which have in turn led to improvements in the HEIW's governance and assurance systems:

- Recommendation by the Committee of HEIW's Annual Report 2021/22 to the Board for approval;

- Recommendation by the Committee that the Board approve the updated Standing Orders to reflect changes to the Model Standing Orders issued by Welsh Government in 2021/22.

- Recommendation by the Committee for the HEIW Board to approve the Revisions to the Delegated Financial Limits which form a part of HEIW's Standing Orders. The revisions increased the limit for the approval of payments relating to the Single Lead Employer and introduced the need to separately identify 'Capital' expenditure and individual limits for this expenditure.

- The Committee also reviewed the Declarations of Interest Register and Gifts, Hospitality and Sponsorship Register.

3.3 Policies, Procedures and Plans

The Committee received and supported:

- Revisions to the Risk Management Policy;

- Annual Reports for:
  - Audit Wales;
  - Internal Audit;
  - Counter Fraud;
  - HEIW Procurement Compliance;
  - Senior Information Risk Owner.

- Annual Work Plans for:
  - Internal Audit;
  - External Audit; and
  - Counter Fraud

- Revised Financial Control Procedures for the following areas:
  - FCP1 Budgetary Control
  - FCP2 Management of Non-Current/Fixed Assets & Maintenance of Asset Register
  - FCP3 Month-End Closedown
  - FCP4 Recovery of Payroll Overpayments
  - FCP5 Construction Industry Scheme
  - FCP6 Purchasing Card
  - FCP7 Value Added Tax
  - FCP8 General Ledger
  - FCP9 Petty Cash

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- FCP10 Accounts Receivable
- FCP11 Accounts Payable
- FCP12 Banking
- FCP13 Counter Fraud

The Committee noted the Memorandum of Understanding between HEIW and the Ministry of Defence for the provision of General Medical Council approved training programmes within NHS Wales. The Memorandum of Understanding sets out the basis upon which HEIW and the Ministry of Defence will work together and exchange information to assist each party in reaching common goals.

4. Committee Structure and Meetings

A key element of the Committee is that it solely comprises of Independent Members, providing a basis for it to operate independently of any decision-making process and to apply an objective approach in the conduct of its business.

The membership of the Committee during 2021/22 was as follows:

Chair:	Gill Lewis, Independent Member
Vice Chair:	John Hill-Tout*, Independent Member
Independent Member	Dr Ruth Hall**, Independent Member
	Heidi Phillips, Independent Member
	Jonathan Morgan***, Independent Member

* John Hill-Tout's term as an Independent Member came to an end on 31 January 2022.

** Ruth Hall stepped down as a member of the Committee on 31 March 2022
*** Jonathan Morgan was appointed a member of the Committee on 31 March 2022

During the financial year 2021/22, 6 scheduled meetings of the Audit and Assurance Committee were convened. A high level of commitment from Committee Members has been demonstrated throughout the year, as recorded in the attendance of meetings held. Although invited to attend certain meetings to provide assurances and explanations to the Committee on specific issues, neither the Chair, Chief Executive Officer, nor any other Executive Director of HEIW, are members of the Committee. The Chief Executive Officer is invited annually. Having a key role to play in establishing and maintaining a sound system of internal financial control, the Director of Finance and/or the Head of Financial Control (being a designated deputy) has attended all meetings. The Committee has also been supported on key matters at all meetings from attendance by the Board Secretary who is the Lead Officer for the Committee and has been present at all meetings.

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The Committee also has regular attendance from representatives of:

- The Auditor General/Audit Wales;
- NWSSP Audit and Assurance Services;
- NWSSP Procurement Services

- NHS Counter Fraud Services.

5. Committee Work Programme 2021/22

The Committee reviewed and approved the audit strategies and plans for the auditors as listed below, and received audit reports produced in support of them during 2021/22:

- External Auditors, Audit Wales;
- NWSSP Audit and Assurance Services Internal Auditors.

Acting upon the outcomes of effectiveness reviews is as important as undertaking them, and it is essential that outcomes and associated actions are reported appropriately. At the time of writing this report, all audit ratings from Internal Audit had received at least a reasonable assurance assessment. The Committee continues to receive progress updates directly as and when requested.

The Audit and Assurance Committee is responsible for overseeing risk management processes across the organisation and has a particular focus on seeking assurance that effective systems are in place to manage risk, and that HEIW has an effective framework of internal controls that addresses principal risks. Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed and that appropriate controls are in place. The Committee is responsible for monitoring the assurance environment and challenging the build-up of assurance on the management of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied on, and reviewing the internal audit plan in year as the risk profiles change.

6. External Audit – Audit Wales

External Audit is provided by Audit Wales with its work divided into the two broad headings of:

- Audit of the financial statements and to provide an opinion thereon;
- Forming an assessment of HEIW's use of resources and performance work.

The Audit and Assurance Committee considered the Audit Wales Structured Assessment for 2021 which was undertaken in two phases. .

Phase 1 of the assessment concluded that overall, HEIWs arrangements for preparing operational plans and monitoring their delivery were robust and that HEIW had responded positively to the Welsh Government Operating Framework by converting it to fit HEIW's remit and strategic objectives. It also concluded that HEIW's planning arrangements were robust, and there were effective arrangements in place to oversee the delivery of operational plans, which were embedded in the Performance Framework.

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Phase 2 of the assessment concluded that HEIW is well-governed, has clear, effective arrangements to manage its finances, met its financial duties at the end of 2020-21, and has a clear financial plan for 2021-22.

No new recommendations were received based on Audit Wales' 2021 Structured Assessment work.

The Committee also received the Audit Wales Annual Report 2021/22, which confirmed HEIW's accounts were properly prepared and materially accurate. It also confirmed no material weaknesses in HEIW's internal controls had been identified and that HEIW had achieved financial balance for the year ending 31 March 2021.

7. NWSSP - Internal Audit

At the direction of the Minister for Health and Social Services, Internal Audit is provided by the NHS Wales Shared Services Partnership (NWSSP). The service provision is in accordance with a Service Level Agreement agreed by the Shared Services Partnership Committee, which HEIW attends.

Internal Audit provides an independent and objective opinion to the Accountable Officer, the Board and the Audit and Assurance Committee, on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives. The Committee reviewed and approved the content of the Internal Audit Plan based on HEIW's risk profile and its detailed programme of work for 2021/22. During the year, this plan was flexed and adapted as necessary in order to respond to the impact of COVID-19 and any key risks.

The Committee has received progress reports against delivery of the plan at each meeting, with individual assignment reports also being received. The outcome of each audit, providing an overall conclusion on the adequacy and application on internal controls for each area under review, was considered by the Committee. The assessment on adequacy and application of internal control measures can range from "No Assurance" through to "Substantial Assurance".

The scope of the Head of Internal Audit Opinion is confined to those areas examined in the risk-based audit plan, which has been agreed with senior management and approved, by the Audit and Assurance Committee. The assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and seen as an internal driver for continuous improvement. The opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

The Committee was pleased to receive several internal audit reports that had received an overall assessment of substantial assurance. These included:

- Risk Management
- Communications and Engagement
- Performance Management
- Financial Planning
- Information Governance Toolkit

The Committee also received the following audit reports that had received an overall assessment of reasonable assurance:

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- Recruitment
- Pre-Registration Pharmacy
- Governance Arrangements
- Medical Appraisal Revalidation System (MARS)

- Workplace Culture

The recommendations from both Internal Audit and Wales Audit together with management's response, are recorded within the Audit Recommendations Tracker report. This is monitored and regularly reviewed by the Audit and Assurance Committee.

[A rounding off statement from the Head of Internal Audit position will be added after the April meeting]

8. Managing Risk

Managing risk is fundamental to running a successful and high performing organisation. It should be at the heart of decision-making processes and resource allocation at both an operational and strategic level. It should seek to identify opportunities to innovate and invest, alongside the need to mitigate risks.

The Committee has continued to develop and strengthen HEIW's risk management arrangements at both a strategic and operational level. Work continues to be undertaken to embed risk management at all levels of the organisation, which includes the ongoing training of all Senior Managers. This has enabled the organisation to measure key strategic risk performance, establish its risk profile and instigate thematic analysis using the Corporate Risk Register and local risk registers.

The Committee reviewed and approved the Board Assurance Framework, which included amendments to incorporate the Strategic Risks Control Framework, how HEIW identifies and maps the controls and key sources of assurance against its strategic risks, and HEIW's Strategic Objectives.

The Committee reviewed the Corporate Risk Register at each quarterly meeting and received regular updates concerning the 'red' status risks relating to Cyber Security and the Single Lead Employer Model. The Committee was pleased to note the mitigating actions designed to limit the impact on trainees due to issues associated with the implementation of the Single Lead Employer Model and that progress continued to be made in implementing the Cyber Security Implementation Plan.

9. Monitoring Progress

The Committee has also monitored continuing improvement in the arrangements for:

- Information Governance and Information Management: The Committee was pleased with the overall progress with the Information Governance Work Plan.

Information Governance Toolkit: The Committee was pleased to see the organisation working towards level one compliance and encouraged by the progress against the plan, which aimed to improve compliance with the Information Governance Toolkit.

- Procurement Compliance Activity: The Committee remains focussed regarding the embedding of the Procurement Process within HEIW. An independent review of the HEIW Procurement Systems and Processes was completed in 2020/21 and the Committee received regular reporting against the agreed action plan during 2021/22 .

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- Contracts & Agreements Register. The Committee reviews the Register annually.

- Audit Recommendation Tracker: The Committee continued to monitor HEIW's Audit Tracker throughout 2021/22, scrutinising management responses to audit reports and the completion of actions to address the recommendations.

10. Financial Management Control and Systems Monitoring

The Committee has continued to seek improvements in the financial systems and approved revised Financial Control Procedures which reflected how HEIW was maturing as an organisation.

10.1 Annual Accounts

In May 2021, the Committee reviewed the draft and audited accounts for 2020-2021 and considered reports on the Accounts received from Audit Wales. The Committee was able to recommend to the Board that the Accounts be adopted and signed by the Chairman and Chief Executive; this was completed in June 2021.

In February 2022, the Committee received the Annual Accounts Plan and Draft Annual Report Timetable for 2021/22 and noted the changes to the submission deadline dates.

11. Counter Fraud

The Committee agreed the Counter Fraud Strategy and Annual Work Plan 2021/22, and received regular progress reports. The Committee reviewed the Counter Fraud Annual Report 2020/21 and received regular updates on the Counter Fraud Initiative, monitoring the progress of investigations into high priority matches.

12. Information Governance

In May 2021, the Committee considered the Senior Information Risk Owner (SIRO) Annual Report 2020/21 and received regular updates on the Information Governance Toolkit noting progress against the agreed action plan. The Committee also reviewed the Information Governance and Information Management Group Terms of Reference and received regular updates on the group's work.

13. Self Assessment

In April 2021 the Committee undertook a review of its effectiveness and considered the outcome of that review at its meeting in May 2022. Overall, the Committee considered it had been effective and consistent in its approach to providing assurance and had continued to develop its role in scrutinising areas such as Digital, Cyber and Procurement policy. A number of improvement actions were highlighted, and these were progressed during 2021/22.

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14. Key Risks

The Committee had identified a number of risk areas, which have been highlighted in this report; these will be the focus of attention during the coming year.

15. Recommendations

During 2021/22 the Audit and Assurance Committee made the following recommendations to Board.

- That the updated Standing Orders be approved.
- That the proposed amendments to the Delegated Financial Limits, which had been amended to reflect the Board's Capital Delegated Financial Limit accurately, be approved.
- That the Board Assurance Framework be approved.
- That the Risk Management Policy be approved.
- That the updated Information Governance and Information Management Groups Terms of Reference be approved.
- That the ISA 260 and final Letter of Representation be considered.
- That the Annual Accountability Report 2020/21 be approved for submission to Welsh Government.
- That the Performance Report 2020/21 be approved for submission to Welsh Government.
- That the audited accounts for 2020/21 be approved.

- The Board was also asked to note the Audit and Assurance Committee Annual Report 2020/21.

16. Key Areas of Focus for the Coming Year

During 2022/23, the Committee will continue to focus on the following areas:

- The annual commissioning process for Education and Training

- Risk Management
- Board Assurance Framework
- Performance Management Framework
- Information Management and Information Governance, particularly cyber security and the digital agenda

Sponsored by: **Gill Lewis**
Chair of Audit and Assurance Committee

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Date: April 2022

Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.11**
Teitl yr Adroddiad	**Cofrestr Risg Corfforaethol a Risgiau Strategol**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Darparu trosolwg o'r risgiau a nodir ar hyn o bryd yn y Gofrestr Risg Corfforaethol a nodi cymeradwyaeth Risgiau Strategol AaGIC.		
Prif Faterion	Mae'r adroddiad hwn yn rhoi diweddariad ar y Gofrestr Risg Corfforaethol (CRR), sydd ynghlwm yn Atodiad 1. • Mae'r CRR yn cadarnhau bod - cyfanswm o ddeuddeg risg - pedwar risg statws 'coch' - wyth risg statws 'melyn'. • Cafodd un risg werdd (Risg 16) ei dileu gan y Pwyllgor Archwilio a Sicrwydd yn ei gyfarfod diwethaf ar 7 Chwefror 2022. • Tair risg newydd – Risgiau 24, 25 a 26 wedi'u hychwanegu at y CRR a phob un wedi'u hasesu fel statws 'coch'. Mae Risgiau Strategol AaGIC, a gymeradwywyd gan y Bwrdd yn ei gyfarfod ar 31 Mawrth ynghlwm yn atodiad 2 er gwybodaeth.		

Camau Penodol Gofynnol **(✓ticiwch un yn unig)**	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
	✓		✓	

Argymhellion	Gofynnir i'r Pwyllgor: • **Nodi'r** adroddiad o ran y CRR er sicrwydd. • **Nodi** Risgiau Strategol AaGIC er gwybodaeth.

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COFRESTR RISG CORFFORAETHOL A RISGIAU STRATEGOL

1. RHAGARWEINIAD

Gofynnir i'r Pwyllgor nodi'r sefyllfa bresennol ynghylch y Gofrestr Risg Gorfforaethol (Atodiad 1) fel yr amlinellir yn yr adroddiad hwn. Gofynnir i'r Pwyllgor hefyd nodi Risgiau Strategol AaGIC (Atodiad 2), a gymeradwywyd gan y Bwrdd ar 31 Mawrth 2022.

2. ASESIAD

Ar hyn o bryd mae **12** risg ar y Gofrestr Risg Corfforaethol, ac mae'r risgiau hyn wedi eu hasesu fel a ganlyn: **4** risg statws 'Coch', **8** risg statws 'Melyn' a **0** risg statws 'Gwyrdd'. Ac eithrio paragraff 2.1, sy'n rhoi diweddariad ar y Risg Goch sy'n bodoli eisoes, mae'r sylwebaeth isod yn amlygu'r newidiadau i'r Gofrestr Risg Corfforaethol ers yr adroddiad diwethaf.

2.1. Risgiau Coch

Risg 8 - Os na fydd AaGIC yn sicrhau bod pob cam rhesymol yn cael ei gymryd o ran seiberddiogelwch, gallai fod yn agored i dor data, dirwyon posibl gan Swyddfa'r Comisiynydd Gwybodaeth a chyhoeddusrwydd gwael cysylltiedig.

Lliniaru: Mae hyn yn gofyn am roi'r argymhellion a amlygwyd yn Adroddiad Asesu Seiberddiogelwch AaGIC ar waith. Hefyd, mae angen drafftio'r Cynllun Gweithredu Seiberddiogelwch a'i roi ar waith.

Cynnydd: Mae'r argymhellion yn Adroddiad Asesiad Seiberddiogelwch AaGIC wedi neu yn cael eu rhoi ar waith ar hyn o bryd. Mae gweithgareddau i gefnogi'r gwaith o gyflawni'r Cynllun Seiberddiogelwch ar y gweill.

Datblygiadau diweddar: Mae gweithgareddau i gefnogi'r gwaith o gyflawni'r Cynllun Seiberddiogelwch ar y gweill ac mae datblygiadau diweddar yn cynnwys:

- Mae cyfweliadau ar gyfer y swydd seiberddiogelwch newydd wedi dod i ben, ac mae cynnig cyflogaeth amodol wedi'i wneud yn amodol ar fodloni'r gwiriadau a'r gofynion recriwtio arferol.

Amlinellir y tri risg coch newydd (risgiau 24, 25 a 26) ym mharagraff 2.5 isod.

2.1. Risg gyda Sgôr Uwch

Ni fu unrhyw risgiau gyda sgôr uwch ers yr adroddiad diwethaf

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2.2. Risgiau gyda Sgôr Is

Ni fu unrhyw risgiau gyda sgôr is ers yr adroddiad diwethaf

2.2. Risgiau Newydd

Mae tair risg newydd wedi'i hychwanegu at y CRR ers yr adroddiad diwethaf.

Risg 24 – Os na all PCGC ymestyn eu cylch gwaith noddi fisa i'w galluogi i weithredu fel noddwyr ar gyfer meddygon teulu sydd newydd gymhwyso nad ydynt yn gymwys i wneud cais am Ganiatâd Amhenodol i Aros (ILR) bydd yn rhaid i sawl meddyg teulu sydd newydd gymhwyso naill ai chwilio am waith mewn ysbytai neu swyddi meddygon teulu yn Lloegr er mwyn aros yn y DU.

Lliniaru: Casglu gwybodaeth am nifer yr hyfforddeion sy'n debygol o gael eu heffeithio. Ar 11 Mawrth 2021, ni fydd 18 hyfforddai allan o 3 chynllun yn gymwys ar gyfer ILR ar adeg y dystysgrif cwblhau hyfforddiant (CCT). Bydd AaGIC yn gweithio gyda PCGC i roi gwybodaeth iddynt ar gyfer eu hachos i ymestyn nawdd i'r Swyddfa Gartref. Bydd AaGIC yn tynnu sylw'r Prif Weithredwr a Llywodraeth Cymru at y broblem ac yn archwilio'r hyn y mae gwledydd cartref eraill yn ei wneud mewn perthynas â'r mater hwn.

Cynnydd: Mae AaGIC yn rhan o weithgor a ffurfiwyd gan Bartneriaeth Cydwasanaethau GIG Cymru (PCGC) i archwilio opsiynau am atebion i'r broblem hon. Yr ateb a ffafrir yw i Bartneriaeth Cydwasanaethau GIG Cymru ddarparu cymorth gweinyddol ac o bosibl cymorth ariannol i bractis sy'n dymuno noddi meddyg teulu sydd newydd gymhwyso.

Mae hon yn broblem ledled y DU. O ganlyniad, ochr yn ochr â'r gwaith sy'n mynd rhagddo yng Nghymru, mae cynrychiolwyr o'r pedair gwlad wedi cysylltu â'r Swyddfa Gartref i geisio datblygu datrysiad.

Asesiad: Asesir y risg hon fel 16 a statws 'Coch'.

Risg 25 - Os na ellir datrys problemau gyda'r Rhestr Cyflawnwyr Meddygol (MPL), ni fydd graddedigion meddygol rhyngwladol na allant ddarparu tystlythyrau gan glinigwyr yn y DU yn gallu cael lle ar yr MPL ar ddechrau hyfforddiant meddygon teulu, a bydd hyn yn ansefydlogi cynlluniau i gynyddu niferoedd gan ddefnyddio model 1+2.

Lliniaru: Casglu gwybodaeth gan gydweithwyr mewn rhannau eraill o'r DU ynghylch trefniadau MPL yno. Codi'r mater yng nghyfarfodydd Cyfarwyddwyr Meddygol Cyswllt Gofal Sylfaenol Cymru Gyfan. Gweithio gyda Chyfarwyddwyr Meddygol i ddatblygu dull a datrysiad cyffredin ledled Cymru.

Cynnydd: Mae adolygiad o'r MPL yn Lloegr wedi'i gynnal. Mewn ymateb i hyn, mae Llywodraeth Cymru wedi ffurfio grŵp i edrych ar ddiwygio MPL Cymru gyfan. Mae gan AaGIC gynrychiolaeth ar y grŵp hwn a bydd yn chwarae rhan lawn yn y gwaith o gynhyrchu ateb hirdymor i'r broblem hon

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Asesiad: Asesir y risg hon fel 25 a statws 'Coch'.

Risg 26 – Os bydd costau recriwtio mwy o feddygon teulu yn parhau i fod yn uwch na'r gost a ragwelwyd, oherwydd eu bod yn cymryd mwy o amser i ennill

cymhwyster (oherwydd cynnydd yn y nifer sy'n cymryd absenoldeb Rhiant, llai na hyfforddiant llawn amser, a materion eraill yn ymwneud ag anawsterau a brofir gan raddedigion meddygol rhyngwladol) a diogelu cyflogau, gallai fod risg ariannol a risg i enw AaGIC os na allwn gyflawni'r rhaglen a chytuno ar ffrwd ariannu newydd gyda Llywodraeth Cymru

Lliniaru: Mae Deoniaeth Feddygol a Chydweithwyr Cyllid wedi edrych yn fanwl i ganfod achosion y gorwariant. Mae dadansoddiad o'r data wedi rhoi rhesymau clir dros y gorwariant. Mae'r gorwariant wedi'i liniaru gan danwariant sylweddol mewn cyllidebau eraill. Bydd y gor-recriwtio dros 160 yn cael ei reoli'n ofalus yn y dyfodol i leihau'r risg ariannol gyffredinol gyda niferoedd cynyddol wrth barhau i fod ar darged i recriwtio o leiaf 160 o feddygon teulu dan hyfforddiant bob blwyddyn.

Cynnydd: Eleni, byddwn yn recriwtio hyd at 160 o Feddygon Teulu dan hyfforddiant fel y cynlluniwyd, a bydd unrhyw niferoedd uwchlaw hynny yn gyfyngedig o'i gymharu â blynyddoedd blaenorol, a disgwylir i hyn liniaru rhai o'r costau ychwanegol sydd yn y system ar hyn o bryd.

Asesiad: Asesir y risg hon fel 15 a statws 'Coch'.

2.3. Risgiau sydd wedi'u Dileu

Ers yr adroddiad diwethaf, mae un risg wedi'i hasesu fel statws 'Gwyrdd' a'i dileu o'r CRR yn dilyn cymeradwyaeth gan y Pwyllgor Archwilio a Sicrwydd yn ei gyfarfod diwethaf ar 7 Chwefror.

Risg 16 – Os bydd cynnydd yn nifer yr achosion o COVID 19 sy'n effeithio ar y gwasanaethau 'arferol' a ddarperir, mae'n bosibl y bydd tarfu ar gyfleoedd lleoliadau ar gyfer hyfforddeion a myfyrwyr gan effeithio ar eu gallu i symud ymlaen, graddio neu gwblhau hyfforddiant yn eu maes. Bydd hyn yn ei dro yn effeithio ar y gweithlu gyda phrinder a allai gael effaith hirdymor ar gyflenwi gwasanaethau.

3. Risgiau Strategol AaGIC

Caiff Risgiau Strategol AaGIC eu hadolygu'n flynyddol ac maent yn rhan allweddol o'n Fframwaith Sicrwydd Bwrdd. Cymeradwywyd Risgiau Strategol AaGIC gan y Bwrdd yn ei gyfarfod ar 31 Mawrth ac maent yn cyd-fynd â'n Nodau Strategol wedi'u diweddaru yn unol ag IMTP 2022-25.

Mae'r Risgiau Strategol ynghlwm yn Atodiad 2 er gwybodaeth.

4. MATERION LLYWODRAETHU A RISG

Mae rheoli risg drwy'r Gofrestr Risg Corfforaethol a Risgiau Strategol AaGIC yn arf craidd ar gyfer llywodraethu risg o fewn AaGIC.

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5. GOBLYGIADAU ARIANNOL

Mae rheoli risg drwy'r Gofrestr Risg Corfforaethol a Risgiau Strategol AaGIC yn un o swyddogaethau craidd AaGIC fel Awdurdod Iechyd Arbennig. Ni ragwelir unrhyw oblygiadau cost ychwanegol.

6. ARGYMHELLIAD

Gofynnir i'r Pwyllgor:

• **Nodi'r** adroddiad o ran y CRR er sicrwydd.
• **Nodi** Risgiau Strategol AaGIC er gwybodaeth.

Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol

Ansawdd, Diogelwch a Phrofiad Cleifion	
Y Gofrestr Risg Corfforaethol yw'r adnodd craidd i sicrhau bod risg yn cael ei reoli'n effeithiol o fewn AaGIC. Mae dull cadarn o reoli risg yn fwy tebygol o gael effaith ffafriol ar ddiogelwch a phrofiad cleifion a staff.	
Goblygiadau Ariannol	
Mae rheoli risg yn un o swyddogaethau craidd AaGIC fel Awdurdod Iechyd Arbenigol. Ni ragwelir unrhyw gostau ychwanegol.	
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)	
Nid oes unrhyw oblygiadau cyfreithiol yn gysylltiedig â'r adroddiad hwn.	
Goblygiadau o ran Staff	
Nid oes unrhyw oblygiadau staffio yn gysylltiedig â'r adroddiad hwn.	
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)	
Y CRR yw adnodd craidd AaGIC i reoli risg.	
Hanes yr Adroddiad	Cyflwynir y CRR i'r Tîm Gweithredol a'r Uwch Dîm Arweinyddol yn fisol. Mae'r Pwyllgor Archwilio a Sicrwydd yn ei adolygu bob chwarter. Darperir y CRR i'w adolygu ym mhob cyfarfod o'r Pwyllgor.
Atodiadau	Atodiad 1 – CRR

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	Atodiad 2 – Risgiau Strategol AaGIC

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HEIW CORPORATE RISK REGISTER (MARCH 2022)

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Residual Risk			RAG Status	Progress
		Details of the risk. If… then… impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.	Impact	Probability	Overall Score	R/A/G & Trend	
8. April 2020	**1**	If HEIW does not ensure that all reasonable steps are taken in respect of cyber security it may be vulnerable to a data breach, possible fines from the Information Commissioner's Office and associated bad publicity. **Board Secretary**	**5**	**5**	**25**	LOW	This requires the implementation of recommendations highlighted within HEIW's Cyber Security assessment report. This includes the recruitment of a Head of Cyber Security. Cyber Security Implementation Plan to be drafted and implemented	**5**	**4**	**20**		The recommendations within HEIW's Cyber Security assessment report have or are being implemented. The new Head of Cyber Security joined HEIW on 29 June and commenced working on a new Cyber Security Implementation Plan. **February 2022** Interviews for the new cyber security post have completed and a conditional offer of employment has been made on the basis that recruitment checks and requirements are fully satisfied.
12. July 2020	**1.**	If HEIW is unable to access workforce data from other NHS organisations, then its workforce will not be able to provide modelling data and fail to meet expectations in respect of the same and have an adverse impact on NHS workforce planning. **Director of Workforce and Organisational Development**	**4**	**3**	**12**	LOW	HEIW to request access to live data from ESR and other workforce information systems as well as the current Data Warehouse information Requests for additional access to information in line with NHS Digital/Health Education England.	**4**	**2**	**8**		**March 2022 –** we have scheduled a series of meetings with NWSSP, to ensure we have access to the data we need. Work is also ongoing in the context of scoping our data strategy and centre of excellence for workforce intelligence. We have agreed with DHCW that we will set up a three-way strategic conversation with NWSSP to ensure roles and requirements are clearly understood and aligned.
13. July 2020	**9.**	If HEIW does not have sufficient capacity this may have an impact on its ability to support the NHS, delivery of Annual Plan commitments and levels of performance. **Director of Workforce and Organisational Development**	**4**	**4**	**16**	LOW	Assessment &costing of workforce requirements made as part of the development of the IMTP.	**4**	**2**	**8**		**March 2022 –** discussions ongoing aligned with financial allocation and IMTP planning processes. Process for considering additional capacity via in-year business cases has been confirmed with ET.

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15. **Aug 2020**	**2**	If there are insufficient employment opportunities available for graduating Allied Health Professionals (AHP's) and Health Care Science (HCS) students who have opted into the bursary tie in the investment in education for these students may be lost. **Director of Nurse and Health Professional Education**	**3**	**5**	**15**	HIGH	Enhanced monitoring and Targeted Support process implemented Revised recruitment approach implemented for 2022 graduates Appeals process reintroduced, Quarterly written reports to Executive; and to Board as needed. Implemented a revised managed process (Streamlining) for all AHP and HCS students graduating	**4**	**3**	**12**		**<u>February 2022</u>** Revised streamlining process introduced which is proving to be effective in improving the process and engagement with HBs and Trust to. All Wales picture is shared with Directors of Therapies (DoTHs), Directors of Finance (DoFs), CEOs, and WoDs and members of HB and Trust planning and delivery groups. Overall vacancy and student engagement is very positive compared to this time last year. Insufficient vacancies identified for cardiac physiology, BMS and podiatry. Email from Lisa Llewelyn to HBs and Trusts asking to assistance to increase vacancies. Will be reviewed in March.
19. **Dec 2020**	**3**	If we continue to commission post reg and post grad education from HEI's in England and Wales without a contract, then HEIs may withdraw education provision or fail to provide high quality education that can be performance managed in the usual contractually governed way. **Director of Nurse and Health Professional Education**	**3**	**4**	**12**	MODERATE	Strategic Review 2 Board, reporting to Executive Team. Strategic review 2 Project plan, timetable, and risk register. HEIW subject experts linked to programmes, supported by strategic education adviser Strategic review phase 2 to be a standing item in contract meetings with HEI's. Engage with regular discussions with the National School (4 countries meetings held quarterly) Phased approach with those programmes most at risk in first wave.	**3**	**4**	**12**		**<u>February 2022</u>** Healthcare Support Worker (HCSW) programme out to tender Approvals process recommended to Board. Clinical Associate in Applied Psychology (CAAPs) course being developed for 22/23 Wider engagement through Stakeholder Reference Group (SRG)

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20.	**3**	**Strategic Review 1** If successful HEIs fail to mobilise the new programmes within the time specified by contract, then new students will be unable to benefit from programmes in 2022. **Director of Nurse and Health Professional Education**	**3**	**4**	**12**	MODERATE	Strategic Review 1 Implementation Board Implementation plan agreed with each HEI. Reports to Strategic Review 1 and Executive Team. Senior member of the Education, Commissioning and Quality Team (ECQ) on each HEIs implementation project board to ensure processes are followed for validation, recruitment, and curriculum implementation.	**2**	**4**	**8**		**February 2022** Implementation meetings with HEIs are ongoing. HEIs are currently on track to deliver programmes on time.
21	**2**	**Nurse Staffing Programme** If HEIW fails to identify & implement a national data capture and reporting solution health boards/NHS Trusts will be unable to access the data required to meet the requirements of the Nurse Staffing Levels (Wales) Act and adhere to the 'Once for Wales' approach. **Director of Nurse and Health Professional Education**	**4**	**3**	**12**	Moderate	Undertake scoping of existing and requirements of national solution. Identify & implement a national data capture and reporting solution. Implement the use of Power BI across section 25B areas Appoint to IT posts Scope IT systems & map data flows. Complete Data Protection Impact Assessments (DPIA's) Collaborative working with IT team/HEIW, health boards/trusts, NDR unit/ Digital Health Care Wales (DHCW) to identify means of support. Identify responsibilities for organisations – formalise arrangements.	**4**	**3**	**12**		**February 2022** Digital programme manager starts Feb 2022 Key actions delayed or on hold due to absence of IT support for the programme over a prolonged period. Identifying key priorities actions that digital programme manager can progress. Unable to appoint to senior information analyst – post to be readvertised. (5th advert). Inability to undertake data analytical work and key actions on hold.
22 **Oct 2021**	**2**	If implementation of the single lead employer model processes does not meet expected standards and impacts on trainee experience, then this would potentially have an adverse reputational impact for HEIW and for Wales as a place to train.	**4**	**5**	**20**	Moderate	• Group established between NWSSP, HEIW and UHBs to begin process mapping of data flow and other employment processes to identify weaknesses	**4**	**3**	**12**		**04.02.2022** General improvement maintained with strong collaborative working. Agreement reached to onboard remaining specialties between March and May. Would suggest the residual risk could be amended to 9 from 12. This will remain the same until at least until

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		Medical Director					• Paused roll out for secondary care specialties from December 2021 until clarity on resolution of existing issues • NWSSP to review and where appropriate address internal capacity to deliver the service • Weekly updates for HEIW executive team on progress					the Autumn as there will be several key challenges between now and then. **28.02.2022** February onboarding of new trainees has been successful. No change otherwise since 04.04.2022
23 Dec 2021	**7**	If the procurement and implementation of the HEIW learning management system (Y Ty Dysgu) is significantly delayed beyond financial year 22/23, then this would potentially have an adverse impact on the IMTP and a reputational impact for HEIW. **Digital Director**	**4**	**4**	**16**	High	• Recommencement of procurement agreed to begin in January 2022. • Ongoing engagement established between NWSSP and HEIW to ensure robust process followed • Y Ty Dysgu steering group has been stood down and Y Ty Dysgu Programme Board established	**4**	**3**	**12**		**February 2022** Further extension for current pilot system contract agreed until end July. ITT closed on 22 February. Procurement team assessing the stage 1 qualification responses made by the 4 bidders, all of whom are expected to progress to evaluation, subject to satisfying a few outstanding clarifications. The evaluation team will meet w/c 28/02 and w/c 07/03 to review and score the bid responses. Initial IMTP impact undertaken, and key areas noted. Digital to work with the SROs to prioritise onboarding of teams in new system and to support interim solutions as required
24 Mar 2022	**5**	**Visa sponsorship for newly qualified GP Trainees** If NWSSP cannot extend their visa sponsorship remit to enable them to act as sponsors for newly qualified GP trainees who are not eligible to apply for Indefinite Leave to Remain (ILR), multiple newly qualified GPs will either have to seek work in hospital or GP posts	**4**	**4**	**16**	Moderate	• Gather information on the number of trainees likely to be affected. As at 11/3/21 18 trainees out of 3 schemes will not be eligible for ILR at the point of certificate of completion of training (CCT). • Work with NWSSP to provide them with information for their case to extend	**4**	**4**	**16**		**<u>February 2022</u>** We are part of a Working Group formed by NWSSP to explore options for solutions to this problem. Favoured solution is for NWSSP to provide administrative and possibly financial support to practices that wish to sponsor a newly qualified GP. This is a UK wide problem. Consequently, in parallel with the work going on in Wales, representatives of the 4 nations have made

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		in England in order to remain in the UK **Medical Director**					sponsorship to the Home Office. • Highlight the problem to HEIW Chief Executive and Welsh Government. • Explore what other home nations are doing in respect to this issue.					approaches to the Home Office to try to progress a solution.
25 Mar 2022	**5**	**Medical Performers List (MPL)** If a resolution to problems with the MPL cannot be resolved, international medical graduates who cannot provide references from UK based clinicians will not be able to get onto the MPL at the start of GP training and this will destabilise plans to increase numbers using 1+2 model, and necessitate extensions to training resulting in extra costs. **Medical Director**	**5**	**5**	**25**	Moderate	• Gather information from colleagues in other parts of the UK regarding MPL arrangements there. • Raise at All Wales Associate Medical Directors of Primary Care meetings. • Work with Medical Directors to develop a common approach and solution across Wales.	**5**	**5**	**25**		Various solutions to resolve problems discussed with Primary Care AMDs, HEIW and NWSSP. This included the development of an MOU to cover GP Trainees however, this was deemed outside the regulations by Welsh Government and was therefore abandoned. In the meantime, while a long-term solution is developed, HEIW has prepared a letter that the MPL admin team will proactively send to AMDs where a trainee may struggle to supply acceptable references. This sets out the competences satisfied as part of the process of application to GP Training and the level of supervision and assessments trainees will be required to undertake during their training. **<u>February 2022</u>** A review of the MPL in England has been undertaken. In response to this, Welsh Government has formed a group to look at reform of all-Wales MPL. HEIW has representation on this group and will be fully involved in generating a long-term solution to this problem
26 March 2022	**7**	**GP Training excess funding Requirement** If the costs of the increased recruitment of GPs continues to exceed the amounts forecast, due to them taking longer to reach	**5**	**3**	**15**	High	• Medical Deanery and Finance Colleagues have done a deep dive to ascertain the causes of the overspend • Analysis of the data has provided clear reasons for the overspend	**5**	**3**	**15**		**March 2022** Prior to 2018 we recruited 135 GP trainees per year. We are now recruiting 160 with the option to increase up to 200 if sufficient candidates of the required standard are interviewed. This has been successful even before COVID and the withdrawal of the labour market test for Overseas Doctors.

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		qualification (due to increased uptake of Parental leave, less than full time training, and other issues relating to difficulties experienced by International medical graduates) and pay protection, there could be a financial and reputational risk to HEIW if we cannot deliver the programme and agree a new funding stream with Welsh Government.					• The overspend has been mitigated by significant underspends in other budgets • The over-recruitment above 160 will be carefully managed in the future to reduce the overall financial risk with increased nubers while remaining on target to recruit at least 160 trainee GPs each year.					This year we will recruit up to 160 GP trainees as planned and any numbers above that will be limited compared to previous years, and this will be expected to mitigate against some of the additional costs that are currently in the system

Risk Scoring Matrix

LIKELIHOOD						
	Probable	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		Negligible	Minor	Moderate	Major	Critical
		IMPACT				

Level	Colour	Score Range
Low		1 – 6
Moderate		7 – 14
High		15 – 25

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Risk Appetite Levels

Appetite Level	Described as:	What this means
None	Avoidance of risk and uncertainty is a key organisational objective.	Avoidance of loss is key objective, play safe, avoidance of developments. Priority for tight controls and oversight.
Low	Minimal, or as little as reasonably possible, is preferred for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.	Prepared to accept the possibility of very limited financial loss if essential. Win any challenges re compliance. Innovations avoided unless essential.
Moderate	Cautious is preferred for safe delivery options that have low degree of inherent risk and may only have limited potential for reward.	Prepare to accept some possibility of some financial loss. Limited tolerance for sticking neck out. Tendency to stick with status quo, innovation in practice avoided unless really necessary
High	Open and willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and Value for Money).	Prepared to invest for return & minimise the possibility of financial loss. Value and benefits considered. Gains outweigh adverse consequences. Innovation supported.
Very High	Seek and be eager to be innovative and too chose options offering potentially higher business rewards (despite greater inherent risk). Or also described as mature and confident in setting high levels of risk appetite because controls, forwards scanning, and responsiveness systems are robust.	Investing for best possible return & acceptance of possibility of financial loss. Chances of losing any challenge are real and consequences would be significant. Desire to break the mould. High levels of devolved authority – management by trust, not control.

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HEIW's Strategic Risks

Strategic Risk 1	**Workforce skills and expertise given specialist nature of organisation.** There is a risk that HEIW may find itself without the workforce with the requisite skills it requires to deliver on its Strategic Objectives. This could be caused by a lack of staff with relevant skills in the external market, or education system, or internally due to a lack of staff skills, career mobility, succession planning and skills management, or due to undesirable employee attrition and sickness absence of key individuals. The continued impact on staff wellbeing due the COVID pandemic renders this risk to be particularly serious.
Strategic Risk 2	**Capacity to deliver a growing range of functions and responsibilities.** The risk of lack of capacity may be caused by a lack of sufficient workforce capacity to deliver the growing functions of the organisation, which could be a result of insufficient planning and an over reliance on existing ways of working, not embracing innovation, new ways of working and not investing in appropriate technology.
Strategic Risk 3	**Cultural change required to deliver an integrated, multi professional approach.** There is a risk that HEIW could fail to maintain and continue to develop a positive organisational culture which enables, encourages and develops staff engagement in embracing the multi professional approach. This could be caused by an over reliance on existing ways of working or a lack of time and attention focused on Organisational Development and a failure to embed Compassionate Leadership principles.
Strategic Risk 4	**Effective engagement to ensure that we are influencing and shaping the agenda as system leader and can deliver our plans.** Acting as a system leader will require effective horizon scanning and insight into the NHS system and workforce trends and clear communication and engagement for coalition building to encourage system change. The risk of failing to influence the agenda as system leader could be caused by a failure to communicate and engage effectively with stakeholders within health and social care including our newly established Stakeholder Reference Group.
Strategic Risk 5	**Effective engagement with our partners to ensure the delivery of shared objectives and aims**. The successful implementation of HEIW's aims and objectives in several areas will rely on engagement and co-operation with our partners in health, social care and education. The risk of failing to deliver in these areas could be caused by insufficient capacity, not effectively

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	maintaining engagement with partners or a failure to achieve buy in from our partners.
Strategic Risk 6	**Volatility of HEIW's financial position including the reliance on commissioning plans, student choices and associated budgets.** This could be exacerbated by the increasing financial challenges faced by government and our education providers particularly post COVID, leading to a reduction in our flexibility to respond to developments.
Strategic Risk 7	**Workforce intelligence and Data.** The risk that the quality of workforce intelligence captured and reported within the NHS does not support accurate decision making and planning for the NHS's future workforce requirements. This could lead to both overcapacity and under capacity within the workforce.

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Dyddiad y Cyfarfod	**12 Ebrill 2022**	**Eitem ar yr Agenda**	**2.12**
Teitl yr Adroddiad	**System Tracio Argymhellion Archwiliad**		
Awdur yr Adroddiad	Catherine English, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Cyflwyno'r System Tracio Argymhellion Archwiliad i'r Pwyllgor Archwilio a Sicrwydd, at ddibenion cydymffurfio a sicrwydd. Mae'r System Tracio Argymhellion Archwiliad yn cynnwys y camau gweithredu y cytunwyd arnynt ar hyn o bryd mewn ymateb i'r argymhellion a'r ystyriaethau cynghorol yn yr adroddiadau Archwilio a dderbyniwyd gan ffynonellau megis Archwilio Mewnol ac Archwilio Cymru. Rhoi diweddariad ar statws RAG nifer o argymhellion, yn dilyn adolygiad o gynnydd o ran y camau gweithredu o fewn y System Tracio gan y Tîm Gweithredol.		
Prif Faterion	Mae'r system tracio, y mae ei statws yn cael ei gynrychioli gan ddefnyddio sgôr Coch; Melyn; Gwyrdd (RAG), ar hyn o bryd yn cynnwys **21** o argymhellion ac ystyriaethau cynghorol. Mae'r System Tracio ynghlwm yn Atodiad 1.		

Camau Penodol Gofynnol (✓ticiwch un yn unig)	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓

Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd: • **Nodi'r** adroddiad; • **Ystyried** y cynnydd; • **Cymeradwyo'r** argymhellion gwyrdd sydd wedi'u hasesu fel wedi'u cwblhau, neu'n gyflawn a chynigir eu bod yn cael eu dileu o'r System Tracio.

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SYSTEM TRACIO ARGYMHELLION ARCHWILIAD

1. RHAGARWEINIAD

Mae'r System Tracio Argymhellion Archwiliad yn cofnodi cynnydd yr holl argymhellion ym mhob un o'r adroddiadau Archwilio Mewnol ac Allanol a gwblhawyd ers sefydlu AaGIC.

Bydd y System Tracio'n ffynhonnell o sicrwydd i'r Pwyllgor Archwilio a Sicrwydd bod yr argymhellion hynny'n cael eu datblygu, eu monitro a'u cwblhau.

2. CEFNDIR

Dylai'r Pwyllgor chwarae rhan hanfodol wrth gefnogi llywodraethu effeithiol AaGIC. Dylai chwarae rhan ganolog wrth sicrhau bod AaGIC yn gweithredu yn unol â llywodraethu da, gan gymhwyso safonau cyfrifeg ac archwilio priodol, a mabwysiadu trefniadau rheoli risg priodol.

3. MATERION LLYWODRAETHU A RISG

Yn unol â llywodraethu da, mae'r elfen o gydlynu ac adrodd ar gamau gweithredu sefydliadol ar gyfer gweithgarwch archwilio yn elfennau allweddol o drefniadau sicrwydd cyffredinol AaGIC.

Mae'r System Tracio'n monitro statws argymhellion ac ystyriaethau cynghorol Archwilio Mewnol ac Allanol. Mae hyn yn rhoi adnodd ymarferol i AaGIC sy'n ei gwneud yn bosibl i graffu'n fanylach ar argymhellion archwiliad ac mae wedi'i gynllunio i roi ffocws manylach ar y rhesymau pam y mae argymhellion yn hwyr neu nad ydynt wedi datblygu o fewn yr amserlenni y cytunwyd arnynt. Bydd hyn yn amlygu meysydd a allai fod angen cefnogaeth ychwanegol ac yn sicrhau bod mecanweithiau clir ar waith i fynegi unrhyw broblemau.

Taenlen Excel yw'r System Tracio sydd wedi'i wahanu i chwe thab:

- Adolygiadau Archwilio Mewnol
- Allanol - Adolygiadau Swyddfa Archwilio Cymru ac Adolygiadau Allanol eraill
- Adolygiadau Cynghori Mewnol
- Adolygiad Archwilio Mewnol wedi'i gwblhau
- Adolygiad Archwilio Allanol wedi'i gwblhau
- Cynghori Mewnol Wedi'i gwblhau

Blaenoriaethu Argymhellion

Mae argymhellion archwiliad yn cael eu categoreiddio yn ôl lefel eu blaenoriaeth ac, fel arweiniad, dylid eu cwblhau o fewn yr amserlenni a ganlyn oni bai y cytunir ar amserlen fwy priodol ar adeg yr archwiliad.

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Uchel - i'w gwblhau ar unwaith
Canolig - i'w gwblhau cyn pen mis
Isel - i'w gwblhau cyn pen tri mis

- **Tab 1 – Crynodeb o Adroddiadau Archwilio Mewnol**

Ar adeg cyhoeddi'r adroddiad, mae **21** o argymhellion archwilio mewnol cyfredol ar y system tracio.

Mae'r System Tracio'n dangos yr argymhellion hynny sydd wedi'u cwblhau ac y bwriedir eu dileu o'r system tracio, y rhai sydd wedi gwneud cynnydd sylweddol ond nad ydynt wedi'u cwblhau'n llawn o hyd a'r rhai lle mae ychydig o gynnydd wedi'i wneud ond mae nifer o ffactorau'n parhau o hyd, sy'n atal y cam gweithredu rhag cael ei gwblhau'n llawn.

Mae'r **21** argymhelliad yn y tab archwilio mewnol wedi'u categoreiddio yn y tabl isod:

Coch	**0**	Dim cynnydd a thu allan i'r amserlen targed gwreiddiol. Mae dyddiadau cau diwygiedig wedi'u neilltuo.
Gwyrdd	**11**	Aseswyd bod y cam gweithredu wedi'i gwblhau neu'n gyflawn.
Melyn	**10**	Cynnydd sylweddol ond heb ei gwblhau'n llawn eto neu Nid yw'r cam Gweithredu wedi cyrraedd y dyddiad cau eto.

Yr **11** cam gweithredu 'Gwyrdd' sydd wedi'u hasesu fel rhai sydd wedi'u cwblhau, neu sy'n gyflawn, ac y cynigir eu dileu o'r System Tracio gyda chytundeb y Pwyllgor Archwilio a Sicrwydd.

Cyfanswm Argymhellion Archwilio Mewnol sy'n Hwyr

Mae **7** argymhelliad yn hwyr ar y system tracio a osodir yn eu cyd-destun isod.

Mae llawer o'r argymhellion hwyr yn yr archwiliad mewnol yn ymwneud â'r broses recriwtio a dethol. Mae gwaith yn mynd rhagddo yn y maes hwn a bydd yr argymhellion sy'n weddill yn cael eu symud ymlaen fel rhan o'r Cynllun Cynhwysedd a gyflwynwyd i'r Tîm Gweithredol ym mis Rhagfyr.

Mae'r argymhellion hwyr yn cael eu gwahanu yn ôl lefel blaenoriaeth fel y disgrifir yn y tabl isod:

Lefel Blaenoriaeth	Nifer yr argymhellion hwyr
Uchel	3
Canolig	4
Isel	0
Cyfanswm	**7**

Mae'r argymhellion sydd â sgôr 'Uchel' yn ymwneud â:

- Rhestrau eiddo'n cael eu paratoi i gefnogi'r holl asedau sydd wedi'u grwpio ar y gofrestr asedau a'r gofyniad bod pob ased a restrir ar y gofrestr asedau yn cael ei ddyrannu yn erbyn rheolwr asedau a enwir.

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Mae'r holl asedau cyfrifiadurol o 2021 wedi'u rhestru ar restr asedau TG ar SharePoint ac mae gwaith yn parhau i ychwanegu dyfeisiau 'sydd wedi'u

dyddio' at y rhestr hon o'r taenlenni Excel ar wahân sy'n cael eu storio ar hyn o bryd. Ysgrifennwyd y fanyleb adnodd darganfod asedau ac mae'r adran caffael wedi bod allan i dendr ddwywaith ond ni dderbyniwyd unrhyw gynigion. Mae TG bellach yn ymchwilio i'r defnydd/mynediad o'r system WASP sy'n eiddo i DHCW, sydd eisoes yn cynnwys rhestr o'n holl asedau.

- Rheolwyr yn sicrhau bod ffurflen cymeradwyo recriwtio awdurdodedig yn cael ei chwblhau ar gyfer pob swydd wag er mwyn cipio'r broses cychwyn recriwtio.

  Mae proses dros dro ar waith ar gyfer cymeradwyo swyddi, a chaiff swyddi eu cymharu yn erbyn y strwythur gwaelodlin i gadarnhau eu bod yn swyddi a ariennir ar hyn o bryd. Ar gyfer swyddi newydd, gofynnir am gadarnhad o gymeradwyaeth ar hyn o bryd.

- Dylai bod pob cam o'r broses cyn recriwtio a gwblheir gael ei gofnodi a'i fonitro gan yr Adran Gweithlu a Datblygu Sefydliadol i ddynodi unrhyw lithriad yn y broses neu anghenion hyfforddiant posibl rheolwyr recriwtio.

  Bydd hyn hefyd yn cael ei ystyried yn rhan o waith y Cynllun Cynhwysedd, yn dibynnu ar amserlen y broses y cytunwyd arni, y gellir ei gofnodi a'i fonitro. Yn y cyfamser, mae'r dyddiad y mae swyddi'n cael eu cyflwyno i'w cymeradwyo bellach yn cael ei gofnodi fel rheng flaen y broses recriwtio. Bydd edrych ar sut y gellir cofnodi'r broses cyn-recriwtio yn cael ei gynnwys yn adolygiad cyfredol y Polisi Recriwtio a Dethol er bod y sefyllfa reoli yn parhau i fod yr un fath gan ei bod yn anodd olrhain y cam cyn-recriwtio oherwydd yr amrywiaeth o newidynnau.

Manylir ar nifer yr argymhellion hwyr yn ôl graddfeydd sicrwydd isod:

Graddfa Sicrwydd	Nifer yr Argymhellion Hwyr
Cyfyngedig	0
Rhesymol	6
Sylweddol	1
Heb raddfa sicrwydd	0
Cyfanswm	**7**

Mae gwaith pellach ar y gweill i sicrhau bod y camau gweithredu sy'n weddill ar y gronfa ddata yn cael eu cwblhau fel y cytunwyd.

- **Tab 2 – Crynodeb o Adroddiadau Archwilio Allanol**

Mae Tab 2 yn disgrifio'r argymhellion a wnaed yn dilyn Asesiadau Strwythuredig Archwilio Cymru ac unrhyw adroddiadau archwilio allanol eraill. Ar adeg cyhoeddi'r adroddiad, nid oes **dim** argymhelliad archwilio allanol cyfredol ar y system tracio.

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Statws	Nifer yr Argymhellion
Hwyr	0
Ddim yn ddyledus eto	0
Cwblhawyd y cyfnod hwn	0
Parhaus	0
Cyfanswm	**0**

- **Tab 3 – Crynodeb o Adolygiadau Cynghori Archwilio Mewnol**

Nid oes unrhyw ystyriaethau cynghori ar hyn o bryd.

Statws	Nifer yr Argymhellion
Hwyr	0
Ddim yn ddyledus eto	0
Cwblhawyd y cyfnod hwn	0
Parhaus	0
Cyfanswm	**0**

4. GOBLYGIADAU ARIANNOL

Gall fod canlyniadau ariannol i gamau gweithredu unigol; fodd bynnag, nid oes unrhyw effaith ariannol uniongyrchol yn gysylltiedig â'r adroddiad hwn ar hyn o bryd.

5. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd:

- **Nodi'r** adroddiad;
- **Ystyried** y cynnydd;
- **Cymeradwyo'r** argymhellion gwyrdd sydd wedi'u hasesu fel wedi'u cwblhau, neu'n gyflawn ac y cynigir eu bod yn cael eu dileu o'r System Tracio.

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Llywodraethu a Sicrwydd			
Dolen i nodau strategol IMTP ***(ticiwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu a lles gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*.	**Nod Strategol 2:** Trawsnewid addysg a hyfforddiant gofal iechyd i wella cyfleoedd, mynediad ac iechyd y boblogaeth.	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru trwy adeiladu arweinyddiaeth dosturiol a chyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu atebion gweithlu cenedlaethol i gefnogi'r gwaith o gyflawni blaenoriaethau gwasanaeth cenedlaethol a gofal cleifion o ansawdd uchel.	**Nod Strategol 5:** Bod yn gyflogwr da ac yn le gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol

Ansawdd, Diogelwch a Phrofiad Cleifion
Amlygir yr effaith ar ansawdd, diogelwch a phrofiad cleifion lle bo'n briodol yn y camau gweithredu unigol a'r gofynion sicrwydd.
Goblygiadau Ariannol
Efallai y bydd goblygiadau ariannol i gamau gweithredu unigol ond nid oes unrhyw oblygiadau ariannol uniongyrchol yn gysylltiedig ar hyn o bryd.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Nid oes goblygiadau cyfreithiol.
Goblygiadau o ran Staff
Nid oes goblygiadau o ran staff.
Goblygiadau Hir Dymor (gan gynnwys effaith y Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Bydd ystyriaethau WBFGA yn cael eu cynnwys wrth ystyried camau gweithredu unigol lle y bo'n briodol.

Hanes yr Adroddiad	Adolygwyd gan y Tîm Gweithredol
Atodiadau	• Atodiad 1 – System Tracio Argymhellion Archwiliad.

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HEIW Ref. No.	Year	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Recommendation	Management Response	Agreed Deadline	Status	Due	Reason overdue	Progress	Proposed completion date / Date completed	No. of months past agreed deadline	If action is complete, can evidence be provided upon request?	If closed and not complete, please provide justification	ET Sign Off	Risk Register? Yes/No
80	19/20	Performance Management March 2020	Reasonable	Director Planning, Performance & Corporate Services	Director of Planning, Performance & Corporate Services	Low	The dashboard KPIs reported could be extended to improve the information used for decision making. For example, the 'Fill Rate' is reported for a number of professions. Reporting of the associated 'Attrition Rate' would add an extra dimension to the management decision making process.	Work is ongoing with teams to enhance the data available to add value and insight and support future decision making. This includes furthering team interactions to learn from each other and share best practice.	Jun-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** This has been delayed given the impact of COVID-19. As information flows recommence, we will review the feasibility and requirements for additional information. This will undoubtedly include COVID-19 specific information. **Progress as at October 2020:** We had identified additional data to add value to performance reports prior to COVID-19 but implementation of this was put on hold. Work has continued however to ensure validated data is available to enhance performance reporting. This will be articulated in the performance framework when finalised. **Progress as at January 2021:** See the entries above for development of the KPIs and the Dashboard. The Glossary will continue to be updated as the KPIs are agreed and the Dashboard is developed. **Progress as at May 2021:** A Performance Dashboard Steering Group has been established to drive the development of KPIs and the Dashboard, framing it around the Six Strategic Aims. Departments were asked to identify local KPIs through the mid-year Service Reviews which took place in November 2020. Development of KPIs for Strategic Aims 2 and 4 have been agreed as the priorities and the Performance Dashboard Steering Group are making steady progress with the development of the priority KPIs for Strategic Aims 2 and 3 with a particular focus on enhancing the dashboard aligned to information related to the Education and Training pipeline. **Progress as at June 21:** Progress and developments have been shared and discussed with the Executive Team and at the Board Development Session in June. **Progress as at September 21** - Work aligned to developing detailed performance information on the various stages of the education and training pipeline across professions within HEIW is ongoing with a readiness assessment of data availability being undertaken and shared with the Executive team which included a recommendation to consider a HEIW approach to managing data standards. **Progress as at Jan 22) -** - The latest update of the readiness assessment was considered by the Executive Team in December. A monthly task and finish group has been established to share learning and add pace to the development of the performance information on the various stages of the education and training pipeline with each profession represented. A further update presentation is scheduled for the Board Development Session in February. **Current Progress (April 2022)** - The latest update of the readiness assessment was considered by the Executive Team in December. A monthly task and finish group has been established to share learning and add pace to the development of the performance information on the various stages of the education and training pipeline with each profession represented. Since the last readiness assessment the education to employment pipeline, including the agreed stages from recruitment to supply has been completed for Pharmacy, Nursing, GP Trainees and Foundation Trainees and the reminaing professions will be worked through during 2022/23.	Jan-21	21				
94	19/20	IT Review April 2020	Reasonable	Digital Manager/ IT Manager/ Head of Cyber Security	Director of Digital	Low	Work should continue to complete the Disaster Recovery Plan.	This is acknowledged. This work will be progressed further following appointment of Cyber Security Lead (offer made) and allowing for recovery after the impact of COVID-19.	Sep-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at September 21 -** The Digital Services Recovery Plan was shared with members of the SLT 15/07/2021 for comment. The updated plan will be presented to the IGIM group 28/09/2021. **Progress as at October 21 -** The Digital Services Recovery Plan is on the whole complete. Some minor updates relating to supporting infrastructure and recovery positions for a small number of managed essential functions are still to be documented but are due to be completed imminently. Once completed the Digital function senior team will be meeting to discuss service and support arrangements (15th Oct 2021). **Progress as at Jan 22 -** Awaiting update for 1 key and essential function. It is important to note that the Digital Services Recovery Plan will be regularly updated by the Digital function. On-going programmes of work such as the continued migration to the cloud will influence the Digital Services Recovery Plan and its content. **Current Progress (Mar 22) -** All essential functions/systems and supporting information have been captured in the Digital Services Recovery Plan. It is however important to remember that the Digital Services Recovery Plan will be regularly reviewed and updated to reflect changes across our technical estate, some of which are currently in progress.	Apr-21	18				
116	20/21	Financial Systems January 2021	Reasonable	Director of Digital	Director of Finance	High	1. Inventory lists should be prepared to support all grouped assets on the asset register. 2. Each asset listed in the asset register should be allocated as the responsibility of a named asset manager in line with the requirements of the Asset Register Financial Control Procedure.	1. Agree - A full inventory list will be prepared to provide the required backing to the asset register.	Mar-21	Partially complete	Overdue		Progress as at March 2021: Work is ongoing at the paper submission deadline for the Audit & Assurance Committee and it is anticipated that this will be complete by the end of March. Most assets have been identified and recorded and any discrepancies will be dealt with as part of the accounts closure process during April. Progress as at 17/06/2021: Paper outlining the recommendation of an asset management solution has been created and submitted to the Information Governance and Information Management group. Once approved this will go to the executive team for approval. Following this, it is hoped that a solution will be in place early in quarter 2. Progress (Sept 21) - The asset management paper has now been sent to Execs for consideration on 22/09/2021. Paper outlines SharePoint based asset management complimented by a hardware discovery tool to track assets and their use. **Progress as at Oct 21** - revised board paper was take to execs that outlined the following approach: • HEIW IT would build hardware asset lists into SharePoint and migrate information from multiple spreadsheets into this single, manageable list. (work has started and will be completed in Q4) • HEIW It would wite a feature specification for a 'discovery tool' to go to procurement and to go out to tender.(This will be in place by the end of Q3) **Progress as at Jan 22 -** HEIW IT has built a SharePoint list and migration of computer asset data has started (roughly 30% added). Asset discovery tool information is with procurement and a tender exercise is about to take place using requirements written up by HEIW IT. **Current Progress (Mar 22) -** IT SharePoint asset list has all computer assets from 2021 listed, work is continuing to add 'legacy' devices to this list from the separate excel spradsheets they are currently stored. Asset discovery tool specification was written and procurement has been out twice but no bidders recieved. IT are now researching the use/access to a system called WASP owned by DHCW which already has all of our assets listed.	Mar-21	12				
133	20/21	Performance Management May 2021	Substantial	Assistant Director of Planning, Performance and Corporate Services	Director of Planning, Performance & Corporate Services	Medium	2. Where possible targets should be developed for all the data sets reported in the dashboard, which should also show the direction of travel from the previous performance report and comparative data from the previous year where this is relevant.	Agreed – As part of our agreed programme of work, during 2021/22 work will be undertaken to agree targets (where relevant) and indicate trends in data movement where not provided currently.	Dec-21	Partially complete	Overdue		**Progress as at June 21 -** Work is being taken forward by the Performance Management Steering Group and directorate teams to enable comparative data to be included in future reports as applicable. **Progress as at Sept 21** - Work continues to be taken forward by the Performance Management Steering Group and directorate teams to enable comparative data to be included in future reports as applicable. This is a complex area of work and it is unlikely all areas will have targets by December 2021 **Progress as at Jan 22** - Work continues to be taken forward by the Performance Management Steering Group and directorate teams to enable comparative data to be included in future reports as applicable. Where possible and there is the available data to draw comparisons this is does as routine. However there will be a necessary cumulative time period needed as performance measures are introduced. **Current Progress (April 22) -** Work continues to be taken forward by the Performance Management Steering Group and directorate teams to enable comparative data to be included in future reports as applicable. Where possible and there is the available data to draw comparisons this is does as routine. However there will be a necessary cumulative time period needed as performance measures are introduced. The newly appointed Performance Analyst will further develop the comparartive data to be included and benchmarking processes.		3				
135	20/21	Performance Management May 2021	Substantial	Assistant Director of Planning, Performance and Corporate Services	Director of Planning, Performance & Corporate Services	Low	The success factors, as defined in the organisation's IMTP, should also be included in the integrated performance report with progress monitored and reported quarterly.	Agreed - For the Annual Plan 2021-22, success measures have been identified for each objective and the Plan will be Board-approved and submitted to Welsh Government by the end of June (and will therefore be in the public domain). The inclusion of quantifiable success factors in the report and dashboard will be tested with the Leadership programme (Strategic Aim 3), with the aim of rolling out across the rest of our Strategic Aims through the planning/performance cycle.	May-22	Complete	Complete		**Progress (June 21) -** This will be taken forward following the end of the financial year within the End of Year Performance Report to enable reflection and reporting of whether indicated success factors defined in the plan have been achieved. **Progress as at (Sept 21) -** This will be taken forward following the end of the financial year within the End of Year Performance Report to enable reflection and reporting of whether indicated success factors defined in the plan have been achieved. **Progress (Jan 22) -** This will be taken forward following the end of the financial year within the End of Year Performance Report to enable reflection and reporting of whether indicated success factors defined in the plan have been achieved. **Current Progress (Apr 22) -** The Performance Report has been reshaped to include our success by Strategic Aim and to give a rounded picture of progress and outcomes. This work will continue to iterate and evolve during 2022/23.		0				
145	21/22	Recruitment	Reasonable	Interim Head of People and OD/People Projects Lead	Director of Workforce and OD	Medium	(1) Management should ensure that the review of the recruitment and selection policy that is currently in draft is completed and approved and made available to staff within a reasonable timescale. It should be ensured the revised policy cross references the recruitment procedure.	The Recruitment and Selection Policy is currently under review with a target date for completion of 30th November 2021, following this it will go through the approval process for new policies including going out for general consultation within HEIW	Nov-21	Partially complete	Overdue		**Progress (Jan 22) -** Due to long-term sickness of the People Projects Lead who leads on policy development the review of the policy has been delayed, however, additional support has been identified and the policy is now being re-drafted and an accompanying toolkit developed. **Current Progress (Mar 22) -** the initial draft of the policy is now complete and a survey of recruiting managers has been undertaken. There are a number of stages to complete before the policy is approved for use and a project plan is in place to complete this by August 2022	Aug-22	4				
147	21/22	Recruitment	Reasonable	Interim Head of People and OD/Assistant Director Succession & Leadership	Director of Workforce and OD	Medium	(3) Management should consider developing a succession plan to help minimise the risk that skills, talents and knowledge existing within the organisation are not lost to other organisations and that relevant leadership skills for the current and future needs of the organisation can be met.	A paper on internal talent and succession arrangements has been drafted and will be considered at Executives Committee on 6th October 2021. In addition to participation in the aspiring directors programme HEIW will look at identifying and developing future leaders at Band 7/8 and provide a development package to enable them to be ready for their next career move.	Mar-22	Partially complete	Not yet due		**Progress (Jan 22) -** The People Team is working with the Leadership Team to develop an internal succession plan **Current Progress (Mar 22) -** Work on talent management is on-going and this is part of the People Team work programme for 2022/23		0				
148	21/22	Recruitment	Reasonable	Interim Head of People and OD/People Business Partner	Director of Workforce and OD	High	2/4 (4.2) Management should ensure that an authorised recruitment approval form is appropriately completed for all vacancies so as to capture the recruitment initiation process.	The authorisation process in TRAC acts as the sign off process for recruitment where posts are like for like replacements or posts are within existing budgets and no new job description is required. As generic job descriptions are used more widely this will be the commencement of the recruitment process.	Oct-21	Partially complete	Overdue		**Progress (Jan 22) -** The scrutiny of posts prior to posts being input into TRAC is being considered as part of the recent work on the Capacity Plan, a paper was presented to Executives in December 2021 and the process for scrutiny is being worked through **Current Progress (Mar 22) -** An interim process is in place for the approval of posts and posts are compared against the baseline structure to confirm that they are existing funded posts, for new posts confirmation of approval is requested at this point.		5				
148	21/22	Recruitment	Reasonable	Interim Head of People and OD/People Business Partner	Director of Workforce and OD	High	3/4 (4.3) Where applicable, an appropriately completed and approved business case in a standard format should be prepared by the recruiting manager for submission, with a job description, to the job evaluation panel and subsequent consistency review panel.	For new posts we will ensure that an approved business case in line with HEIW process is completed and signed off, however in ensuring that we are able to respond to service and organisational needs there will be occasions when new posts are approved directly from Executives and Executive approval acts as the signed off business case (Plans on a page including staffing requirements and the IMTP).	Oct-21	Complete	Complete		**Progress (Jan 22)** - This will also be considered as part of the scrutiny process as outlined above **Current Progress (Mar 22) -** Executive level approval is sought for all new posts, and completed business cases where completed. The business case process is not the responsibility of the People Team.		5				
148	21/22	Recruitment	Reasonable	Interim Head of People and OD/People Business Partner	Director of Workforce and OD	Low	4/4 (4.4) Consideration should be given to including all necessary documentation in the form of a checklist to ensure all documents required have been completed and are available for scrutiny / approval before a vacancy can be passed to the next stage.	We will consider the use of a checklist within the context of using TRAC as the primary tool for recruitment and CAJE for job evaluation. Consideration will be given to using a form for Job Evaluation.	Oct-21	Complete	Complete		**Progress (Jan 22) -** This will also be considered as part of the scrutiny process as outlined above **Current Progress (Mar 22) -** Consideration has been given to the use of a checklist however the requirements for advertising are contained in TRAC and will be included in the Recruitment and Selection Policy and Toolkit. There is a check and a double-check within TRAC to check that all the documentation is completed therefore an additional checklist is not required		2				
150	21/22	Recruitment	Reasonable	Interim Head of People and OD	Director of Workforce and OD	High	1/2 (6.1) Management should set indicative timescales for completion of each stage of the pre-recruitment process as documented in the procedure approved by the Executive Team in January 2019.	We will look at setting indicative timescales for each part of the process however outside of the job evaluation process and the recruitment process once initiated in TRAC, timescales would only be indicative as there are a number of possible variables to consider for example where a business case has agreement for additional staffing there may be discussions on how the additional staffing is to be sourced before a job description is submitted for matching.	Dec-21	Complete	Complete		**Progress (Jan 22) -** Timescales will be considered as part of the Capacity Plan work **Current Progress (Mar 22) -** This has been considered and a flow chart and KPIs that give timescales will now be part of the Recruitment and Selection Policy and toolkit		1				

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150	21/22	Recruitment	Reasonable	Interim Head of People and OD	Director of Workforce and OD	High	2/2 (6.2) The completion of each stage of the pre-recruitment process should be recorded and monitored by Workforce & OD to identify any slippage in the process or potential training needs of recruiting managers.	In terms of pre-recruitment process this is difficult to track, recruitment may start at different stages, for like for like replacement posts recruitment would commence from the time the vacancy is loaded in TRAC. For new posts this may be when a business case is completed or a job is submitted for job evaluation, work is coming out of the Right Sizing Group is going to look at this process to see how it can be improved	Dec-21	Partially complete	Overdue		**Progress (Jan 22) -** This will also be considered part of the Capacity Plan work, depending on the agreed process timescales can be recorded and monitored **Current Progress (Mar 22) -** In the interim period the date that posts are now submitted for approval is recorded as the front end of the recruitment process. Looking at how the pre-recruitment process can be recorded will be captured by the current review of the Recruitment and Selection Policy although the management position remains the same in that the tracking the pre-recruitment stage is difficult due to the range of variables.		1				
151	21/22	Financial Planning 2021/22	Substantial	Interim Director of Finance	Interim Director of Finance	Low	1/2 (1.1) - A documented reconciliation should be prepared between the figures in the Education Commissioning Finance Plan and the finance plan contained within the organisation's Annual Plan / IMTP.	A reconciliation will be prepared detailing any differences between the Education Commissioning Plan and IMTP/Annual Plan, providing explanations and supporting evidence to substantiate the differences.	Jun-22	Complete	Complete		**Current Progress (Mar 22) - Completed** - a reconciliation has been prepared which details any differences between the Education Commissioning Plan and IMTP/Annual Plan, providing explanations and supporting evidence to substantiate the differences.		0				
151	21/22	Financial Planning 2021/22	Substantial	Interim Director of Finance	Interim Director of Finance	Low	2/2 (1.2) - A documented reconciliation should be prepared to record any differences between supporting schedules used to calculate pay and non-pay figures and those figures used in the Annual plan.	A reconciliation will be prepared detailing differences between Pay and Non Pay figures disclosed in the Annual Plan and supporting schedules used to calculate these figures, providing explanations to substantiate the differences.	Jun-22	Complete	Complete		**Current Progress (Mar 22) - Completed** - A reconciliation has been prepared which details the differences between Pay and Non-Pay figures disclosed in the Annual Plan and supporting schedules used to calculate these figures, providing explanations to substantiate the differences.		0				
152	21/22	MARS 2021/22	Reasonable	Head of Digital Services	Director of Digital	Medium	(1.1) - Consideration should be given to periodically forcing a change of password.	This is being looked at but we aiming to follow the NHS Wales password policy of making passwords more secure and not requiring a forced change of password.	Feb-22	Partially complete	Overdue		**Current Progress (Mar 22) -** The MARS Medical, DAS and Wales Pro instances (migrated to Azure), adhere to the NHS Wales password policy for any new users, Communication will be planned to ask existing users to update their passwords. MARS GP is still to be migrated and will gain the updated password policy as part of the migration.		1				
152	21/22	MARS 2021/22	Reasonable	Head of Digital Services	Director of Digital	Medium	(1.2) - Account lockouts should be enacted after repeated failed login attempts.	We are building this functionality into the system.	Feb-22	Partially complete	Overdue		**Current Progress (Mar 22) -** MARS, DAS and Wales PRO code bases now have account lockouts. This has been added to live instances of MARS Medical, DAS and Wales PRO. Medical GP will gain this functionality on migration to Azure.		1				
152	21/22	MARS 2021/22	Reasonable	Head of Digital Services/ Head of Revalidation Support Unit	Director of Digital/Medical Director	Medium	(1.3) - The generic administrator account should be removed and staff required to use individual accounts to ensure accountability.	We will work with stakeholders to remove these accounts.	Mar-22	Partially complete	Not yet due		**Current Progress (Mar 22)** - Stakeholders have started to consolidate generic accounts. These will be reviewed further with then aim of all users having their own logins to the systems.		0				
153	21/22	MARS 2021/22	Reasonable	Head of Digital Services	Director of Digital	Medium	2 - The process for regular testing of back-ups should be reinstated.	We are migrating to Azure cloud with automated backups. Once in this environment we will be undertaking regular backup tests as of our standard maintenance processes.	Mar-22	Partially complete	Not yet due		**Current Progress (Mar 22) -** Backup regimes are being set up as part of each system migration, The database backups will be reviewed and verified.		0				
154	21/22	MARS 2021/22	Reasonable	Head of Digital Services/ Head of Revalidation Support Unit	Director of Digital/Medical Director	Low	3 - The role, responsibilities and functions of the system administrator and developers should be formally defined.	The roles are mildly defined in the system and documented by the business process owners. We will look to do more in the way of role documentation.	Apr-22	Complete	Complete		**Current Progress (Mar 22)** - The systems' roles and defined and applied within the system by administrators. These are reviewed by the system owners.		0				
155	21/22	MARS 2021/22	Reasonable	Head of Digital Services	Director of Digital	High	4 - The system should be updated with the latest stable releases.	There is a large piece of work to migrate this system into Microsoft Azure cloud hosting. The method we have chosen to use within this environment will allow us to more easily upgrade to newer PHP and MySQL versions. They will also be automatically patched for us. Apache will be replaced with NGINX which will also be auto patched/updated	Feb-22	Complete	Complete		**Current Progress (Mar 22) -** MARS Medical, DAS and Wales PRO are running on updated PHP and MySQL versions which will be auto patched by Microsoft. MARS GP will be updated once migrated to Azure. Final system to be migrated 23/03.		0				
156	21/22	MARS 2021/22	Reasonable	Head of Digital Services	Director of Digital	Medium	5 - Patching should be a scheduled job that is undertaken on a regular basis. The basis for patching and the process should be formally documented.	Migrating to Microsoft Azure allows our systems to be auto patched by Microsoft.	Feb-22	Complete	Complete		**Current Progress (Mar 22) -** MARS Medical, DAS and Wales PRO have been migrated to Azure and environment patching is now managed by Microsoft. Patching for MARS GP will take place once migrated. Final system to be migrated 23/03.		0				

Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

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Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

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HEIW Ref. No.	Year	Report Title	Responsible Officer	What We Found	What Could Be Done Differently	Comments	Agreed Deadline	Status	Due	Reason overdue / Reason closed	Progress	Proposed completion date / Date completed	No. of months past agreed deadline	ET Sign Off	Risk Register? Yes/No

Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

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