Y Pwyllgor Archwilio a Sicrwydd

Wed 07 April 2021, 13:30 - 16:00

Drwy gyfrwng Microsoft Teams/Telegyfathrebu

Agenda

13:30 - 13:40
10 min

TRAFODAETHAU PREIFAT AELODAU'R PWYLLGOR GYDA'R GWASANAETH GWRTH-DWYLL, ARCHWILWYR MEWNOL AC ALLANOL

13:40 - 13:50
10 min

1. MATERION CYCHWYNNOL

1.1 Croeso a Chyflwyniadau

Cyflwynydd: Cadeirydd - Llafar

1.2 Ymddiheuriadau

Cyflwynydd: Cadeirydd - Llafar

1.3 Datganiadau Buddiannau

Cyflwynydd: Cadeirydd - Llafar

1.4 Cofnodion Drafft Cyfarfod y Pwyllgor Archwilio a Gynhaliwyd ar 18 Ionawr 2021

Cyflwynydd: Cadeirydd - Atodiad

1.4 - Cofnodion DRAFFT y Pwyllgor Archwilio a Sicrwydd.pdf (13 pages)

1.5 Cofnod Gweithredu

Cyflwynydd: Cadeirydd - Atodiad

1.5 - Cofnod Gweithredu_ACC_2021-01-18 (Open) V2 cym.pdf (5 pages)

1.6 Materion yn Codi

Cyflwynydd: Cadeirydd - Llafar

13:50 - 15:55
125 min

2. MATERION I'W HYSTYRIED

2.1 Gwrth-dwyll:

CY 2.1 - Cover Sheet - Counter Fraud HEIW Audit Committee - 07.04.2021(F) cym.pdf (5 pages)

2.1.1 Adroddiad Cynnydd

Cyflwynydd: Rheolwr Gwrth-dwyll - Atodiad

2.1.1 - Counter Fraud Progress Report.pdf (5 pages)

2.1.2 Diweddariad ar Gychwyn Twyll Cenedlaethol 2020/21

Cyflwynydd: Rheolwr Gwrth-dwyll - Atodiad

2.1.2 - Update on National Fraud Initiative.pdf (4 pages)

2.1.3 Cynllun Gwrth-dwyll Blynyddol 2021/22

Cyflwynydd: Rheolwr Gwrth-dwyll - Atodiad

2.1.3 - Annual Counter Fraud Workplan 2021-2022.pdf (11 pages)

2.2 Archwilio Mewnol:

Cym 2.2 - Report coversheet - Progress report for IA - April 2021 cym.pdf (1 pages)

2.2.1 Adroddiad Cynnydd

Cyflwynydd: Archwilio Mewnol - Atodiadau

2.2.1 - IA Progress Report - April 2021 (1).pdf (5 pages)

2.2.2 Adroddiad Archwiliad Mewnol i Diwylliant y Gweithle

Cyflwynydd: Archwilio Mewnol - Atodiad

2.2.2 - HEIW 20.21 04 Workplace Culture Final Report - ISSUED (1).pdf (22 pages)

2.2.3 Adroddiad Archwiliad Mewnol i Trefniadau Llywodraethu

Cyflwynydd: Archwilio Mewnol - Atodiad

2.2.3 - Governance Arrangements during Covid-19 IA Report.pdf (10 pages)

2.2.4 Cynllun Archwilio Blynyddol 2021/22

Cyflwynydd: Archwilio Mewnol - Atodiadau

CY 2.2.4a - Cover Report- Internal Audit - Annual Plan 2021-22 cym.pdf (1 pages)
2.2.4b - HEIW Internal Audit Plan 2021.22 - Final.pdf (31 pages)

2.3 Archwilio Cymru

CY 2.3 - AW Cover Report_Assurance_Committee_April 2021_open_ cym.pdf (1 pages)

2.3.1 Ardoddiad Cynnydd

Cyflwynydd: Archwilio Cymru - Atodiad

2.3.1 - AW Progress Report.pdf (8 pages)

2.3.2 Cynllun Archwilio Blynyddol 2021 a Ffi Archwilio

Cyflwynydd: Archwilio Cymru - Atodiad

2.3.2 - AW Annual Audit Plan Final.pdf (14 pages)

2.3.3 Ei Wneud yn Wahanol, Ei Wneud yn Iawn?

Cyflwynydd: Archwilio Cymru - Atodiad

2.3.3 - AW - Doing-it-right-Eng.pdf (20 pages)

2.4 Ymholiadau Acrhwiliadau Archwilio Cymru i rai sydd yn Gyfrifol am Lywodraethu a Rheoli

Cyflwynydd: Cyfarwyddwr Cyllid - Atodiadau

Cym 2.4a - Audit Enquiries Letter cym.pdf (4 pages)
2.4b - Appendix 1 - HEIW audit enquiries letter 2020-21.pdf (20 pages)

EGWYL

2.5 Adolygiad o Adroddiad Atebolrwydd Drafft:

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiad

2.5.1 Datganiadau Llwodraethiant Blynyddol

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiad

- 2.5a - Datganiad Llywodraethu Blynyddol Drafft 2020.21 .pdf (3 pages)
- 2.5b - Draft Annual Governance Statement for the Period Ended 31 March 2021.(31.03.21)docx.pdf (28 pages)

2.6 Adroddiad Blynyddol Drafft y Pwyllgor 2020/21

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiadau

- Cym 2.6a - Audit_Assurance_Committee Annual Report_2020-2021 Cover Report_DRAFT v1 cym.pdf (4 pages)
- 2.6b - HEIW AAC Annual Report 2020-2021_DRAFT v1.pdf (11 pages)

2.7 Adroddiad Effeithiolrwydd Drafft y Pwyllgor 2020/21

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiadau

- CY 2.7a - AAC Self Assessment Checklist Cover Report_DRAFT v1 cym.pdf (3 pages)
- 2.7b - Appendix 1 AAC Self Assessment Checklist 2020-21_DRAFT v1.pdf (10 pages)

2.8 Adroddiad Llywodraethu Gwybodaeth a Rheoli Gwybodaeth

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiad

- CY_2.8 - DRAFT IG and IM Update for AAC (April 2021) V2 cym.pdf (19 pages)

2.9 Adroddiad Cydymffurfiaeth Caffael

Cyflwynwyr: Cyfarwyddwr Cyllid ac Pennaeth Caffael - Arodiadau

- Cym 2.9(a) - Procuement Compliance Report_Mar_2021 V2 cym.pdf (3 pages)
- 2.9(b) Procurement Compliance Mar-21 V2.pdf (3 pages)

2.10 Cofrestr Risgiau Corfforaethol

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiadau

- 2.10a - Cofrestr Risg Gorfforaethol (CRG) - Cover Paper_April 2021.docx .pdf (6 pages)
- 2.10b - Appendix 1 - Corporate Risk Register (March 2021) V2.pdf (12 pages)

2.11 Cofnodwr Argymhellion Archwiliad

Cyflwynydd: Ysgrifennydd y Bwrdd - Atodiadau

- CY_2.11a - Audit Recommendation Tracker Cover Report_April 2021 v1 cym.pdf (6 pages)
- 2.11b - HEIW Audit Tracker as at 19-03-2021 - Copy - Copy.pdf (22 pages)

15:55 - 16:00
5 min

3. CLOI

3.1 Unrhyw Fater Arall

Cyflwynydd: Cadeirydd - Llafar

3.2 Dyddiad y Cyfarfod Nesaf:

3.2.1 Cyfarfod Cyfrifon Drafft

Dydd Iau 6 Mai 2021 a, 13:30 drwy gyfrwng Microsoft Teams/Ystafell Gyfarfod AaGIC 1, Ty Dysgu

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

HEB EU CADARNHAU

Cofnodion DRAFFT y Pwyllgor Archwilio a Sicrwydd
a gynhaliwyd ar 18 Ionawr 2021
Drwy gyfrwng Microsoft Teams/Telegynadledda (drwy Tŷ Dysgu)

Yn bresennol:

Gill Lewis	Aelod Annibynnol (Cadeirydd)
John Hill Tout	Aelod Annibynnol (Is-gadeirydd)
Dr Ruth Hall	Aelod Annibynnol
Dr Heidi Phillips	Aelod Annibynnol

Mynychwyd gan:

Alex Howells	Prif Weithredwr
Dafydd Bebb	Ysgrifennydd y Bwrdd
Eifion Williams	Cyfarwyddwr Cyllid
Martyn Pennell	Pennaeth Cyfrifyddu Ariannol
Paul Dalton	Pennaeth Archwilio Mewnol (NWSSP)
Emma Samways	Dirprwy Bennaeth Archwilio Mewnol (NWSSP)
Ken Hughes	Rheolwr Archwilio (NWSSP)
Ann-Marie Harkin	Cyfarwyddwr Ymgysylltu, Archwilio Cymru
Clare James	Arweinydd Archwilio Perfformiad, (Archwilio Cymru)
Helen Goddard	Rheolwr Archwilio Archwiliad Allanol, Archwilio Cymru
Nigel Price	Is-Reolwr Gwrth-Dwyll (BIP Caerdydd a'r Fro)
Christine Thorne	Pennaeth Caffael (NWSSP)
Rhian Sadler	Rheolwr Busnes Caffael (NWSSP)
Kay Barrow	Rheolwr Gwasanaethau Corfforaethol (Ysgrifenyddiaeth)

RHAN 1	MATERION CYCHWYNNOL	Gweithredu
AAC: 18/01/1.1	**Croeso a Chyflwyniadau**	
	Croesawyd pawb gan y cadeirydd i'r cyfarfod, ac yn arbennig Dr Heidi Phillips (Aelod Annibynnol), oedd yn mynychu ei chyfarfod cyntaf ers ei phenodi yn aelod o'r Pwyllgor, ac Ann-Marie Harkin (Cyfarwyddwr Ymgysylltu, Archwilio Cymru) oedd yn mynychu ei chyfarfod Pwyllgor cyntaf yn dilyn ymddeoliad ei rhagflaenydd Mike Usher. Rhoddwyd croeso cynnes hefyd i Nigel Price oedd yn mynychu o'r Gwasanaeth Gwrth-Dwyll Lleol.	
AAC: 18/01/1.2	**Ymddiheuriadau**	
	Derbyniwyd ymddiheuriad gan Craig Greenstock (Rheolwr Gwrth-Dwyll, BIP Caerdydd a'r Fro). Anfonodd y Pwyllgor eu dymuniadau gorau i Craig am wellhad buan.	

AAC: 18/01/1.3	**Datganiadau Buddiannau**	
	Ni dderbyniwyd unrhyw ddatganiadau buddiannau.	
AAC: 18/01/1.4	**Cofnodion y Cyfarfod a gynhaliwyd ar 20 Hydref 2020**	
	Derbyniwyd a chymeradwywyd cofnodion y cyfarfod a gynhaliwyd ar 20 Hydref 2020 fel cofnod cywir o'r cyfarfod.	
AAC: 18/01/1.5	**Cofnod Gweithredu**	
	Derbyniodd y Pwyllgor y Cofnod Gweithredu a nodi bod y camau gweithredu naill ai wedi eu cyflawni; wedi eu gohirio o ganlyniad i effaith Pandemig COVID-19 neu'n faterion i'w hystyried ar agenda heddiw. Byddai'r camau gweithredu hynny sydd heb eu cyflawni yn cael eu cadw ar y Cofnod Gweithredu nes eu bod yn cael eu cyflawni. Derbyniwyd y diweddariadau canlynol: • **AAC: 20/10/2.7 Adolygiad Annibynnol o Systemau a Phrosesau AaGIC:** Nododd y Pwyllgor y byddai diweddariad ar lafar yn cael ei ddarparu yn y Sesiwn 'Pwyllgor Caeedig' fyddai'n dilyn y cyfarfod 'Agored'. • **AAC: 20/10/2.12 Polisi Cwynion:** Nododd y Pwyllgor bod y Polisi drafft wedi cael ei rannu i Aelodau'r Bwrdd er mwyn rhoi sylwadau. Nodwyd y byddai'r Bwrdd yn ystyried y Polisi Cwynion ar gyfer ei gymeradwyo yn ei gyfarfod a drefnwyd ar gyfer 28 Ionawr 2021.	
Penderfynwyd	Nododd y Pwyllgor y Cofnod Gweithredu a'r diweddariadau a dderbyniwyd.	
AAC: 18/01/1.6	**Materion yn Codi**	
	Nid oedd unrhyw fater yn codi.	
PART 2	**MATERION I'W HYSTYRIED**	
AAC: 18/01/2.1	**Memorandwm Cyd-ddealltwriaeth a Chytundeb Rhannu Gwybodaeth gyda'r Cyngor Fferylliaeth Cyffredinol**	
	Derbyniodd y Pwyllgor Adroddiad a Memorandwm Cyd-ddealltwriaeth (MOU) a Chytundeb Rhannu Gwybodaeth (ISA) gyda'r Cyngor Fferylliaeth Cyffredinol (GPhC). Wrth gyflwyno'r adroddiad, hysbysodd Dafydd Bebb y Pwyllgor mai hwn oedd y MOU cyntaf gyda Rheoleiddiwr. Dechreuwyd ar ddeialog gyda'r Cyngor Meddygol Cyffredinol (GMC) er mwyn trefnu cytundebau cyffelyb. Er nad yw'r MOU yn gyfreithiol rhwymedig, cadarnhawyd ei fod yn diffinio disgwyliadau'r ddau barti. Roedd yr ISA yn gyfreithiol rhwymedig ac yn egluro'r llif o wybodaeth rhwng y ddau barti er mwyn cydymffurfio â'r Rheoliadau Diogelu Data Cyffredinol (GDPR). Cadarnhawyd bod y Tîm Gweithredol wedi cymeradwyo'r MOU a'r ISA ym mis Gorffennaf 2020 cyn llofnodi'r ddwy ddogfen. Gofynnodd y Pwyllgor a oedd y ddwy ddogfen wedi cael eu hadolygu gan y Gwasanaethau Cyfreithiol a Risg. Dywedodd	

	Dafydd Bebb y byddai ISA fel arfer yn cael ei adolygu gan naill ai Swyddog Rheoli Gwybodaeth neu gan y Gwasanaethau Cyfreithiol a Risg ac y byddai'n cadarnhau'r sefyllfa.	
Penderfynwyd	Y Pwyllgor: • Nodwyd y MOU a'r ISA; • Gofynnwyd am gadarnhad bod y MOU a'r ISA wedi cael eu hadolygu gan y Gwasanaethau Cyfreithiol a Risg neu Swyddog Rheoli Gwybodaeth cyn eu llofnodi.	**DB**
AAC: 18/01/2.2	**Gwrth-dwyll:**	
AAC: 18/01/2.2.1	**Adroddiad Cynnydd**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Nigel Price bod 27.5 diwrnod gwaith a gomisiynwyd wedi cael eu cwblhau ac nad oedd yna unrhyw ymchwiliadau cyfredol cysylltiedig ag AaGIC. Roedd lefel y diddordeb a ddangoswyd gan gyfarwyddiaethau ac adrannau mewn perthynas â sesiynau ymwybyddiaeth o dwyll 'rhithiol' yn cael ei gynnal gydag un diwrnod o bob mis yn cael ei neilltuo ar gyfer Sesiynau Anwytho a chodi ymwybyddiaeth staff. Cadarnhawyd bod yr holl ddata AaGIC oedd yn ofynnol ar gyfer y Fenter Dwyll Genedlaethol (NFI) ar gyfer 2020/21 wedi cael ei gyflwyno i NFI. Dyddiad rhyddhau unrhyw ddata cyfatebol oedd 31 Ionawr 2021. Byddai unrhyw ddata cyfatebol yn cael ei adolygu a byddid yn adrodd ar hynny i'r Pwyllgor yn ei gyfarfod nesaf. Holodd y Pwyllgor ynghylch cyflawni 22.5 diwrnod arall y Cynllun oedd ar ôl ar gyfer 2020/21. Cadarnhawyd y byddai'r Tîm Gwrth-dwyll yn defnyddio'r amser yma i atgyfnerthu mwy ar gamau atal. Byddai hynny yn cynnwys mwy o sesiynau ymwybyddiaeth staff a chyfleoedd i wella camau cyfathrebu llywodraethu da ac arferion da yn yr amgylchedd rhithiol.	
Penderfynwyd	Y Pwyllgor: • Nodwyd yr adroddiad; • Bydd yn derbyn diweddariad ar ddata cyfatebol NFI yn ei gyfarfod nesaf; • Bydd yn derbyn diweddariad am y camau fydd yn cael eu cymryd er mwyn cyflawnir dyddiau sydd ar ôl yn y Cynllun ar gyfer 2020/21.	**Gwrth-dwyll/ EW**
	Ymunodd Alex Howells â'r cyfarfod.	
AAC: 18/01/2.3	**Archwilio Cymru:**	
AAC: 18/01/2.3.1	**Adroddiadau Archwiliad Blynyddol 2020**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Clare James bod hwn yn grynodeb o ganfyddiadau'r gwaith archwilio a wnaethpwyd yn ystod y flwyddyn ac y byddai'n cael ei gyhoeddi ar wefan Archwilio	

	Cymru. Eglurodd bod y prosiect lleol ar gyfer 2020/21 yn cael ei gwmpasu ar hyn o bryd ac y byddai'n canolbwyntio ar reoli trefniadau comisiynu Addysg i Weithwyr Iechyd Proffesiynol. Roedd y cyfarfod yn cael ei drefnu gydag Eifion Williams a Martin Riley yn ystod Chwefror 2021 er mwyn trafod y broses o gwmpasu'r gwaith archwilio yn fwy manwl. Eglurwyd y dylai Angela Parry gael ei chynnwys hefyd yn y cyfarfod yma fel arweinydd Addysg i Weithwyr Iechyd Proffesiynol. Croesawodd y Pwyllgor yr adroddiad cadarnhaol a chydnabod yr ymgysylltu da a'r gweithio hyblyg gan y ddau barti yn ystod Pandemig COVID-19, er gwaethaf gweithio mewn amgylchedd rithiol. Roedd y Pwyllgor yn dymuno cofnodi ei ddiolchgarwch yn ffurfiol i Dîm Archwilio Cymru a swyddogion AaGIC gan gydnabod y berthynas weithio a'r cydweithredu cadarn. Eglurwyd bod y ffi archwilio yn gymesur â chyrff eraill y GIG a archwiliwyd a'i fod yn adlewyrchu'r gwaith y disgwyliwyd i Archwilio Cymru ei wneud.	
Penderfynwyd	Nododd y Pwyllgor yr adroddiad.	
AAC: 18/01/2.3.2	**Cynllun Archwilio Blynyddol Dangosol 2021**	
	Derbyniodd y Pwyllgor y Cynllun Archwilio Blynyddol Dangosol ar gyfer 2021. Wrth gyflwyno'r Cynllun Archwilio Dangosol, dywedodd Helen Goddard bod y gwaith archwilio ariannol wedi dechrau, er ei fod yn destun cynllunio manwl ac ailasesu'r archwiliad o'r risgiau datganiad ariannol. Byddid yn hysbysu swyddogion AaGIC a'r Pwyllgor am unrhyw faterion fyddai'n codi cyn y cyfarfod nesaf, petai angen hynny. Roedd y gwaith archwilio ariannol wedi ei amserlennu i gael ei gwblhau erbyn Mehefin 2021 ar ôl derbyn cadarnhad gan Lywodraeth Cymru. Mae'r dyddiad cyflwyno wythnos yn hwyrach na'r amserlen wreiddiol ar gyfer Cyfrifon Blynyddol 2019/2020. Dywedodd Eifion Williams bod AaGIC yn cynllunio i ddarparu'r cyfrifon ariannol yn unol ag amserlenni byrrach y flwyddyn flaenorol. Er mwyn cyflawni hynny pan fo'n ymarferol bosibl, dylai swyddogion AaGIC weithio'n agos gyda Thîm Archwilio Cymru. Darparwyd trosolwg o'r cynllun archwilio perfformiad oedd yn cynnwys y gwaith craidd mewn perthynas â dau gam Asesiad strwythuredig 2021 a'r gwaith oedd yn dilyn argymhellion archwiliadau blaenorol. Amlygwyd y byddai'r gwaith archwilio lleol yn cael ei gwmpasu yn ddiweddarach yn ystod y flwyddyn. Roedd hynny o ganlyniad i oedi o ran cynllunio, cwmpasu a chwblhau prosiect archwilio lleol 2020/21 oedd yn mynd rhagddo. Mewn perthynas ag Asesiad Strwythuredig Cam 1 ar gyfer 2021, eglurodd Alex Howells bod AaGIC eisoes wedi cyflwyno eu Cynllun	

	Blynyddol Ch3/Ch4 i Lywodraeth Cymru a'u bod ar hyn o bryd yn datblygu'r Cynllun Blynyddol ar gyfer 2021/22 i'w gyflwyno i Lywodraeth Cymru ar ôl iddo gael ei ystyried gan y Bwrdd yn ei gyfarfod sydd wedi ei drefnu ar gyfer 28 Ionawr 2021. Dywedodd Clare James y byddai cwmpas Cam 1 y gwaith cwmpasu yn cael ei drafod yn y cyfarfod a drefnwyd gyda Nicola Johnson. Dywedodd Helen Goddard bod y Cynllun Ffioedd wedi cael ei gyflwyno i Bwyllgor Cyllid y Senedd i'w ystyried, a byddid yn ei gadarnhau yn ysgrifenedig maes o law gyda'r cynllun archwilio diwygiedig. Ond, eglurwyd na fyddai hynny yn atal unrhyw waith archwilio rhag mynd rhagddo.	
Penderfynwyd	Nododd y Pwyllgor yr adroddiad.	
AAC: 18/01/2.4	**Archwilio Mewnol:**	
AAC: 18/01/2.4.1	**Adroddiad Cynnydd**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, amlygodd Paul Dalton statws y cynllun archwilio mewnol ar gyfer 2020/2021. Eglurodd bod COVID19 yn parhau i achosi heriau, ond bod pob ymdrech yn cael ei wneud i sicrhau bod y rhaglen waith llawn yn cael ei chwblhau. Cadarnhaodd, er nad oedd yna unrhyw bryderon i AaGIC ar hyn o bryd, bod dull y cynllun cyflawni yn hyblyg gyda'r nod cyffredinol o ddarparu Barn y Pennaeth Archwilio Mewnol ar gyfer yr adroddiad diwedd blwyddyn. O ganlyniad i'r oedi o ran gweithredu'r Pecyn Rheoli Gwybodaeth gan Lywodraeth Cymru, byddai'r gwaith archwilio a gynlluniwyd ar gyfer 2020/21 yn cael ei ohirio ac yn cael ei ychwanegu i Gynllun Archwilio 2021/22. Eglurwyd bod y gwaith o gwblhau'r archwiliad o Ddiwylliant y Gweithle yn mynd rhagddo ac y byddai'n cael ei gwblhau yn ystod yr wythnosau nesaf. Holodd y Pwyllgor am gapasiti Archwilio Mewnol i gyflawnir cwta 60 diwrnod oedd ar ôl o'r Cynllun Archwilio. Cadarnhaodd Paul Dalton bod yna ddigon o gapasiti ac adnoddau gan Archwilio Mewnol i gyflawni gweddill y Cynllun Archwilio, ond roedd yn ymwybodol o rwymedigaethau blaenoriaethol unigolion allweddol a byddai'n cynnal cyfathrebu clir gyda swyddogion AaGIC ynglŷn â'r sefyllfa. Mynegodd y cadeirydd bryderon ynghylch sicrwydd y Farn diwedd flwyddyn. Eglurwyd bod yr Adolygiad Ymgynghorol o Drefniadau Rheoli yn ystod COVID-19 mewn cydweithrediad ag Archwilio Cymru yn ddarn o waith ychwanegol fyddai yn gymorth o ran darparu sicrwydd ynghylch y darlun rheoli cyffredinol. Eglurodd hefyd y byddai Archwilio Mewnol yn gwneud darn bach o waith archwilio dilynol er mwyn adolygu sut y gweithredir y camau fydd yn deillio o waith yr Adolygiad Ymgynghorol.	

	Mewn perthynas â chynllunio ar gyfer Cynllun Archwilio 2021/22, amlygwyd bod cyfarfodydd ag unigolion allweddol yn cael eu trefnu wrth baratoi ar gyfer cyflwyno'r Cynllun Archwilio i'r Pwyllgor yn ei gyfarfod nesaf.	
Penderfynwyd	Y Pwyllgor: • Nodwyd yr adroddiad; • Bydd yn derbyn y Cynllun Blynyddol ar gyfer 2021/22 yn y cyfarfod nesaf.	**Archwilio Mewnol**
AAC: 18/01/2.4.2	**Adroddiad Archwiliad Mewnol ar Brosesau Adolygu Datblygiad Personol**	
	Derbyniodd y Pwyllgor yr adroddiad ac ymateb y rheolwyr. Wrth gyflwyno'r adroddiad, dywedodd Emma Samways mai'r asesiad cyffredinol oedd sicrwydd rhesymol. Nid oedd canfyddiadau'r adolygiad wedi amlygu unrhyw faterion o ran dyluniad y systemau/camau rheoli, ond nodwyd bod pedwar gwendid yng ngweithrediad y system/camau rheoli a ddyluniwyd ar gyfer y Broses Adolygu Datblygiad Personol (PDR). Roedd yna bedwar argymhelliad oedd â blaenoriaeth ganolig. Ers nad oedd AaGIC yn cyrraedd targed Llywodraeth Cymru o 85% o ran cyfradd cyflawni gwerthusiadau, roedd gwaith sylweddol wedi cael ei wneud er mwyn datblygu a gweithredu proses PDR oedd yn seiliedig ar Fframwaith Gwerthoedd ac Ymddygiad AaGIC ac a oedd yn cydymffurfio â Pholisi Datblygiad Cyflog Cymru Gyfan. Croesawodd y Pwyllgor yr adroddiad cadarnhaol ond cwestiynodd a oedd gan AaGIC wendid pan nad oedd staff oedd yn perfformio'n wael wedi derbyn gwerthusiad cyfredol pan fyddid yn delio â materion o'r fath. Er bod yr egwyddor bod staff yn derbyn gwerthusiad blynyddol amserol yn bwysig, cydnabuwyd nad oedd AaGIC yn gwerthuso cymhwysedd clinigol ond y gallu i ddarparu addysg a hyfforddiant. O ganlyniad i hynny, roedd yr effaith yn llawer llai eithafol nag yn y Bwrdd Iechyd neu'r Ymddiriedolaeth sydd yn delio â gofal/triniaeth uniongyrchol i gleifion. Amlygwyd bod staff clinigol yn destun Proses ail-ddilysu gylchol.	
Penderfynwyd	Nododd y Pwyllgor yr adroddiad.	
AAC: 18/01/2.4.3	**Adroddiad Archwiliad Mewnol i Systemau Ariannol**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Ken Hughes bod hwn yn archwiliad cylchol oedd yn adolygu gwahanol elfennau o'r systemau ariannol. Roedd cwmpas yr archwiliad yn cynnwys adolygiad o'r gofrestr asedau; rheoli arian parod; cyfriflyfr cyffredinol; incwm a dyledwyr a thaliadau papur. Nid oedd canfyddiadau'r adolygiad wedi canfod unrhyw faterion a ystyriwyd yn wendidau yng nghamau rheoli/dyluniad y system yn	

	achos y Systemau Ariannol a adolygwyd. Er bod canfyddiadau'r adolygiad wedi canfod saith mater a ystyriwyd yn wendidau yng ngweithrediad y system/camau rheoli a ddyluniwyd ar gyfer y Systemau Ariannol a adolygwyd. Y lefel sicrwydd cyffredinol oedd sicrwydd rhesymol. Rhoddwyd saith o argymhellion, gydag un ohonynt yn flaenoriaeth uchel; tair yn flaenoriaeth canolig a thair yn flaenoriaeth isel. Roedd Martyn Pennell yn fodlon gyda'r adroddiad oedd yn adlewyrchu'r sefyllfa bresennol. Cadarnhaodd bod pump o'r saith argymhelliad wedi eu cwblhau eisoes. Roedd gwaith sylweddol eisoes wedi cael ei wneud gyda'r Tîm TG/Digidol mewn perthynas â'r rhestr TG er mwyn cefnogi'r Gofrestr Asedau, a dylai gael ei gwblhau erbyn diwedd Mawrth 2021.	
Penderfynwyd	Nododd y Pwyllgor yr adroddiad a'r cynnydd oedd yn cael ei wneud o ran mynd i'r afael â'r argymhellion.	
AAC: 18/01/2.4.4	**Adroddiad Crynodol COVID-19 Cymru Gyfan**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad dywedodd Paul Dalton bod yr adroddiad yn darparu darlun trosfwaol ledled Cymru o'r themâu cyffredin yn yr holl feysydd a adolygwyd a'r meysydd i'w hystyried yn y dyfodol. Croesawodd y Pwyllgor yr adroddiad a gofynnodd a yw'r Tîm IT/Digidol a'r Tîm Diogelwch Seiber wedi gweld adroddiadau archwilio sydd yn cynnwys materion sydd yn berthnasol i'w maes cyfrifoldeb nhw. Cadarnhawyd y gellir rhannu'r adroddiadau archwilio os bydd angen. Dywedodd Clare James bod Archwilio Cymru wedi cyhoeddi adroddiad cyffelyb 'Ei Wneud yn Wahanol, Ei Wneud yn Iawn?' oedd yn crynhoi llywodraethiant yn y GIG yn ystod argyfwng COVID-19 ac sydd yn amlinellu'r themâu, gwersi a chyfleoedd allweddol. Roedd copi o'r adroddiad eisoes wedi cael ei ddarparu i Alex Howells a Dafydd Bebb a byddai hefyd yn cael ei rannu ag Aelodau'r Pwyllgor. Byddai'r adroddiad yn cael ei gyflwyno i gyfarfod nesaf y Pwyllgor er cyflawnder. Dywedodd Clare James bod Archwilio Cymru wedi cynnal adolygiad o Gydnerthedd Seiber ac y byddai'r adroddiad yn cael ei gyflwyno i gyfarfod nesaf y Pwyllgor yn ystod ei Sesiwn 'Pwyllgor Caeedig'.	
Penderfynwyd	Y Pwyllgor: • Nodwyd yr adroddiad; • Cytunwyd rhannu Adroddiad Archwilio Cymru 'Ei Wneud yn Wahanol, Ei Wneud yn Iawn?' i Aelodau'r Pwyllgor; • Derbyn Adroddiad Archwilio Cymru 'Ei Wneud yn Wahanol, Ei Wneud yn Iawn?' yng nghyfarfod nesaf y Pwyllgor;	**DB** **Archwilio Cymru**

	• Derbyn Adroddiad Cydnerthedd Seiber Cymru Gyfan yng nghyfarfod nesaf y Pwyllgor yn ei Sesiwn 'Pwyllgor Caeedig'.	**Archwilio Cymru**
AAC: 18/01/2.5	**Adroddiad Rheoli Gwybodaeth**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Dafydd Bebb mai cyfnod yr adroddiad oedd 1 Hydref 2020 i 31 Rhagfyr 2020. Roedd y Cynllun Gwaith Rheoli Gwybodaeth (IG) wedi cael ei ddiweddaru er mwyn ymateb i'r 10 Cam Atebolrwydd. Roedd y Cynllun Gwaith yn cynnwys 30 cam, yr aseswyd bod 23 ohonynt yn statws 'Gwyrdd' a saith yn statws 'Ambr'. Roedd y Swyddog IG oedd newydd ei benodi yn parhau i weithio drwy'r broses 10 Cam Atebolrwydd. Roedd y Pwyllgor yn croesawu dull adolygedig y Cynllun Gwaith IG. Er bod Hyfforddiant Ymwybyddiaeth IG yn y dosbarth wedi cael ei ohirio o ganlyniad i gyfyngiadau presennol COVID-19, eglurwyd y byddai hynny yn digwydd yn 'rhithiol' drwy gyfrwng Microsoft Teams. Darparwyd diweddariad mewn perthynas â'r saith cais Rhyddid Gwybodaeth (FOI) ac un Cais Mynediad i Destun Data (DSAR) a dderbyniwyd yn ystod cyfnod yr adroddiad. Eglurwyd y gellid cymhwyso mwy nag un esemptiad i ymateb FOI oedd yn egluro pam fod nifer yr esemptiadau a gymhwyswyd ar gyfer cyfnod yr adroddiad yn uwch o'i gymharu â nifer y ceisiadau FOI a dderbyniwyd. Nodwyd y byddai cynnydd yn erbyn y cynllun gwaith diogelwch seiber yn cael ei ddarparu yn ystod Sesiwn 'Pwyllgor Caeedig' y cyfarfod.	
Penderfynwyd	Nododd y Pwyllgor yr adroddiad er sicrwydd.	
AAC: 18/01/2.6	**Adolygiad Blynyddol o Reolau Sefydlog**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, cadarnhaodd Dafydd Bebb bod yr adolygiad o Reolau Sefydlog AaGIC wedi cael ei gynnal mewn dwy ran. Y rhan cyntaf oedd y diweddariadau er mwyn adlewyrchu'r diwygiadau a gymeradwywyd gan y Bwrdd yn ystod 2020 fel y nodwyd hynny yn Adran 2 yr adroddiad eglurhaol. Ail ran yr adolygiad oedd diwygiadau eraill a gynigiwyd, oedd yn deillio o'r adolygiad fel y'u nodir isod: • Ail-bennu'r terfyn amser ar gyfer cynnal y Cyfarfod Cyffredinol Blynyddol (AGM) ar 30 Medi bob blwyddyn; • Diwygio'r Cynllun Dirprwyo er mwyn adlewyrchu penodiad a chyfrifoldebau'r Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a'r Cyfarwyddwr Gwasanaeth Digidol; • Adlewyrchu'r teitl priodol ar gyfer rôl Cyfarwyddwr Cyllid;	

	• Pennu terfyn ariannol dirprwyedig o £50,000 ar gyfer Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a Chyfarwyddwr Gwasanaethau Digidol ar gyfer Contractau Anaddysgol a Hyfforddi.	
Penderfynwyd	Y Pwyllgor: • Nodwyd y diwygiadau i Reolau Sefydlog AaGIC yn 2020 fel y nodwyd hynny yn adran 2 yr adroddiad eglurhaol; • Cefnogwyd ac argymhellwyd i'r Bwrdd gymeradwyo'r diwygiadau ychwanegol i Reolau Sefydlog AaGIC fel y nodir hynny isod: o Ail-bennu'r terfyn amser ar gyfer cynnal y Cyfarfod Cyffredinol Blynyddol (AGM) ar 30 Medi bob blwyddyn; o Diwygio'r Cynllun Dirprwyo er mwyn adlewyrchu penodiad a chyfrifoldebau'r Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a'r Cyfarwyddwr Gwasanaeth Digidol; o Adlewyrchu'r teitl priodol ar gyfer rôl Cyfarwyddwr Cyllid; o Pennu terfyn ariannol dirprwyedig o £50,000 ar gyfer Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a Chyfarwyddwr Gwasanaethau Digidol ar gyfer Contractau Anaddysgol a Hyfforddi. • Argymhellwyd y fersiwn adolygedig o Reolau Sefydlog AaGIC i'r Bwrdd eu cymeradwyo yn ei gyfarfod a drefnwyd ar gyfer 28 Ionawr 2021.	**DB** **DB**
AAC: 18/01/2.7	**Cynllun Cyfrifon Blynyddol 2020/21**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, darparodd Martyn Pennell drosolwg o'r cynllun cau cyfrifon arfaethedig ar gyfer blwyddyn ariannol 2020/21. Eglurodd bod y broses gynllunio wedi canfod nifer o faterion ariannol a thechnegol allweddol allai effeithio ar gau'r cyfrifon. Ond, roedd y gwaith o fynd i'r afael â'r materion hyn eisoes wedi mynd rhagddo gan sicrhau ymgysylltu cynnar â'r unigolion priodol er mwyn canfod datrysiad. Dywedwyd y byddai efallai angen symud y dyddiadau a bennwyd ar gyfer cyflwyno'r cyfrifon terfynol i'r Pwyllgor ar 26 Mai 2021, ac i'r Bwrdd lofnodi'r cyfrifon terfynol ar 27 Mai 2021, er mwyn cynnwys y cyfnod archwilio estynedig arfaethedig, a'r dyddiad cyflwyno erbyn hanner dydd ar ddydd Gwener 11 Mehefin 2021. Eglurwyd, er mwyn crynodi tâl gwyliau, bod gan staff AaGIC hawl i gario pum diwrnod gwyliau blynyddol i 2021/22, ac na fyddai hynny yn bryder mawr mewn perthynas â'r cyfrifon terfynol. Dywedwyd y byddai cyfrifon terfynol y Bwrdd Iechyd a'r Ymddiriedolaeth yn cynnwys crynodiad gwyliau hyfforddeion.	
Penderfynwyd	Y Pwyllgor: • Nododd y Cynllun Cyfrifon Blynyddol ar gyfer 2020/21 er sicrwydd;	**DB**

	• Petai'r angen yn codi cytunwyd y byddai Aelodau'r Pwyllgor a Swyddogion yn cynorthwyo o ran hwyluso unrhyw newid o ran dyddiadau ar gyfer llofnodi'r cyfrifon terfynol gan y Pwyllgor a'r Bwrdd petai'r angen yn codi.	
	Gadawodd John Hill-Tout y cyfarfod. Ymunodd Christine Thorne a Rhian Sadler y cyfarfod.	
AAC: 18/01/2.8	**Adroddiad Cydymffurfiaeth Caffael**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad darparodd Christine Thorne drosolwg o'r gweithgaredd caffael a ddigwyddodd yn ystod y cyfnod 1 Hydref 2020 - 31 Rhagfyr 2020, ac yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheiriannu) y Cyfarwyddiadau Ariannol Sefydlog. Nid oedd yna unrhyw oblygiadau ariannol yn deillio o'r gweithgaredd caffael ar gyfer y cyfnod adrodd yma a dim achos pryder, ond dygwyd y gweithgaredd canlynol i sylw'r Pwyllgor: • HEIW-STA-556: Er bod hyn o werth uchel, roedd yn gymwys fel Gweithred Tendr Unigol (STA) gyda'r Coleg Nyrsio Brenhinol (RCN) fel yr unig opsiwn oedd ar gael yn y DU. Ond, oherwydd bod hwn yn ymrwymiad ariannol i'r RCN, byddai Gwasanaethau Caffael NWSSP yn adolygu Rhaglen Strategaeth Gaffael a Chontractau AaGIC er mwyn sicrhau bod gweithgareddau fel hyn yn cael eu monitro a'u rheoli yn briodol. • HEIW-FN-084: Roedd hynny wedi codi o ganlyniad i salwch hirdymor yn y Tîm Deintyddol, ond roedd wedi ei reoli'n briodol fel STA. Nododd y Pwyllgor bod Llawlyfr Caffael adolygedig wedi cael ei lansio gan Wasanaethau Caffael NWSSP a'u bod yn gweithio gyda'r Academi Gyllid er mwyn datblygu hyfforddiant ymwybyddiaeth ar gyfer cyflwyno'r Llawlyfr Caffael ledled sefydliadau GIG Cymru. Holodd y Pwyllgor ynghylch y gweithgareddau canlynol: • HEIW-FN-082: Eglurwyd nad Prifysgol Abertawe oedd yr unig ddarparwr a'i bod yn rhan o gydweithrediad a bod hynny yn rhan o'r cyllid y gellid ei briodoli i Brifysgol Abertawe. • CCN-HEIW-037: Eglurwyd bod y taliad ar gyfer caffael deunyddiau traul ar gyfer Penaethiaid Deintyddol gyda'r darparwr presennol nad oedd wedi ei gynnwys yn y contract gwreiddiol. Byddai hynny yn cael ei gwmpasu i'r adolygiad contract er mwyn sicrhau bod deunyddiau sbâr yn cael eu cynnwys fel rhan o'r broses gyffredinol o adnewyddu contract.	
Penderfynwyd	Nododd y Pwyllgor yr sefyllfa.	

AAC: 18/01/2.9	**Cofrestr Risgiau Corfforaethol**	
	Derbyniodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r Gofrestr, darparodd Dafydd Bebb drosolwg o'r asesiad o'r 12 risg. Dywedodd bod yna wall mewn perthynas â Risg 19 oedd yn risg newydd erbyn hyn. Eglurodd bod y risg wedi cael ei asesu'n wreiddiol fel un statws 'Gwyrdd', ond yn dilyn adolygiad o'r risg fe'i hailaseswyd fel un statws 'Ambr'. Felly, y categorïau risg oedd dau statws 'Coch', wyth statws 'Ambr' a dau statws 'Gwyrdd'. Y ddau statws risg 'Coch' cysylltiedig â Risg 8: Diogelwch Seiber a Risg 15: Cyfleoedd Cyflogaeth ar gyfer Cynnwys Bwrsariaeth. Nododd y Pwyllgor y newidiadau canlynol i'r Gofrestr Risgiau Corfforaethol: • Uno Risgiau: o Roedd Risg 1 yn canolbwyntio'n bennaf ar y risg i addysg a hyfforddiant yr holl fyfyrwyr a hyfforddeion o ganlyniad i'r don gyntaf o bandemig COVID-19. Roedd Risg 16 yn canolbwyntio ar y risg i addysg a hyfforddiant myfyrwyr Nyrsio o ganlyniad i ail don y pandemig. Yn ddarostyngedig i gymeradwyaeth y Pwyllgor, cynigwyd bod y ddwy risg yn cael eu huno i fod yn Risg 16 unigol a bod Risg 1 yn cael ei dileu. Myfyriodd y Pwyllgor ar y Gofrestr Risgiau Corfforaethol a nodi bod effaith COVID-19 wedi bod yn sylweddol ar waith craidd AaGIC. Yn dilyn asesiad risg manwl o'r risgiau cyfredol, eglurwyd bod y prif bryder i AaGIC yn gysylltiedig â gallu Hyfforddeion Deintyddol a Llawfeddygol i ddatblygu, ac y byddai hynny yn effeithio ar weithlu'r GIG. Mewn ateb i ymholiad mewn perthynas â Risg 19 a sefyllfa'r contract, eglurwyd mai sefyllfa gwaddol oedd honno. Eglurwyd y byddai'r risg yma yn aros ar y CRR nes y byddid yn ei thynnu i ffwrdd gan y Pwyllgor. Byddai Cam 2 Adolygiad Strategol Contractau Addysg Gweithwyr Iechyd Proffesiynol yn adolygu'r trefniadau yma fel meysydd blaenoriaethol.	
Penderfynwyd	Y Pwyllgor: • Nodwyd y Gofrestr Risgiau Corfforaethol a'r asesiad o'r risgiau; • Cytunwyd i uno Risg 1 a Risg 16 i fod yn un Risg 16, ac i ddileu Risg 1; • Cytunwyd i ddileu unrhyw risgiau yr aseswyd eu bod yn rhai statws 'Gwyrdd'.	**DB** **DB**
AAC: 18/01/2.10	**Cofnodwr Argymhellion Archwiliad**	
	Derbyniodd y Pwyllgor y Cofnodwr.	

	Wrth gyflwyno'r adroddiad, dywedodd Dafydd Bebb bod yna 19 o argymhellion cyfredol yn yr Archwiliad Mewnol. O blith yr wyth oedd yn hwyr, roedd un yn y categori blaenoriaeth uchel. Roedd yna 13 o argymhellion cyfredol yn yr archwiliad allanol, a saith o'u plith yn hwyr. Nododd y Pwyllgor bod nifer o'r argymhellion yn hwyr o ganlyniad i effaith COVID-19 ac oedi o ran recriwtio i ddwy swydd Cyfarwyddwr newydd. Dechreuodd y Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol ym Medi 2020, ac roedd cynnydd da yn cael ei wneud o ran datblygu'r Fframwaith a'r Dangosfwrdd Perfformiad. Bydd y Cyfarwyddwr Gwasanaethau Digidol yn dechrau yn ei swydd ym mis Chwefror 2021. Hysbysodd Paul Dalton y Pwyllgor bod Archwilio Mewnol yn rheolaidd yn olrhain unrhyw argymhellion sydd yn deillio o adroddiadau archwilio sicrwydd 'cyfyngedig' a hefyd yn cynnal gwiriad rhesymeg mewn perthynas ag argymhellion sydd wedi eu cwblhau er mwyn archwilio'r dystiolaeth o'r camau a gymerwyd i gau'r argymhellion. Cadarnhaodd Alex Howells bod y Tîm Gweithredol yn cynnal adolygiadau manwl o'r Cofnodwr Archwilio cyn ei gyflwyno i'r Pwyllgor. Roedd y Pwyllgor yn fodlon â'r sefyllfa gyffredinol ac roedd yn disgwyl i'r sefyllfa mewn perthynas ag argymhellion hwyr wella erbyn cyfarfod nesaf y Pwyllgor.	
Penderfynwyd	Y Pwyllgor: • Nodwyd y cynnydd; • Cymeradwywyd dileu'r argymhellion gwyrdd yr aseswyd eu bod wedi eu cwblhau.	**DB**
AAC: 18/01/2.11	**Blaenraglen Waith 2021/22**	
	Derbyniodd y Pwyllgor Blaenraglen Waith 2021/22. Mynegodd y Pwyllgor bryderon ynghylch swm y busnes a gynlluniwyd i'w ystyried yn ei gyfarfod ym mis Ebrill 2021 a'r amser fyddai ar gael i ystyried pob eitem yn briodol.	
Penderfynwyd	Y Pwyllgor: • Nodwyd y Blaenraglen Waith; • Gofynnwyd bod adolygiad o'r busnes a gynlluniwyd i'w ystyried yn ei gyfarfod ym mis Ebrill 2021 yn cael ei gynnal, a bod Cadeirydd y Pwyllgor yn cael ei hysbysu am y deilliant.	**DB**
RHAN 3	**CLOI**	
AAC: 18/01/3.1	**Unrhyw Fater Arall**	
	Heb unrhyw fater arall, penderfynodd y Pwyllgor symud ymlaen i'r sesiwn gaeedig.	
AAC: 18/01/3.2	**Dyddiad y Cyfarfod Nesaf**	

	Dyddiad y cyfanfod nesaf i gael ei gynnal fydd dydd Mercher 7 Ebrill 2021 am 13.30, a byddir yn cadarnhau y bydd yn cael ei gynnal naill ai drwy gyfrwng Microsoft Teams/Telegyfathrebu neu yn Ystafell gyfarfod 1 AaGIC, Tŷ Dysgu, Nantgarw.	

....

Gill Lewis (Cadeirydd) **Dyddiad:**

Pwyllgor Archwilio a Sicrwydd (Agored)
18 Ionawr 2021
Cofnod Gweithredu

(Mae'r Daflen Gweithredu hefyd yn cynnwys camau y cytunwyd arnynt mewn cyfarfodydd blaenorol y Pwyllgor Archwilio a Sicrwydd y disgwylir iddynt gael eu cwblhau neu sydd wedi eu hamserlennu i'w hystyried gan y Pwyllgor yn y dyfodol. Mae'r rhain wedi eu harlliwio yn yr adran gyntaf. Pan y'u llofnodir gan y Pwyllgor Archwilio a Sicrwydd bydd y camau yma yn cael eu tynnu oddi ar y daflen gweithredu dreigl.)

Cyfeirnod y Cofnodion	Camau Cytunedig	Arweinydd	Dyddiad Targed	Cynnydd/ Cwblhawyd
AAC: 27/10/2.10	**Datganiadau Buddiannau - Adolygiad o Arferion mewn sefydliadau eraill**			
	• Y Pwyllgor i dderbyn adborth gan yr adolygiad 'ôl-weithredol' o'r eitemau hynny yr adroddwyd arnynt yn yr Adroddiad Cydymffurfiaeth Caffael fel rhai 'na chymeradwywyd' mewn perthynas ag unrhyw wrthdaro buddiannau.	**Pennaeth Caffael**	I'w Gadarnhau	Yng ngoleuni Pandemig Coronafeirws, bydd yr adolygiad yma yn cael ei gynnal ar ôl ailafael mewn 'busnes fel arfer'.
AAC: 01/04/3.1	**Disgwyliadau Gafael a Rheoli Llywodraeth Cymru**			
	• Unrhyw gynigion mewn perthynas ag arferion da i'w mabwysiadu gan AaGIC i gael eu cyflwyno mewn cyfarfod o'r Pwyllgor yn y dyfodol.	**Cyfarwyddwr Cyllid**	I'w Gadarnhau	Mae'r Cynigion Arferion Da yn cael eu hadolygu. Bydd unrhyw rai fydd angen eu mabwysiadu yn cael eu hychwanegu i Flaenraglen Waith y Pwyllgor fel bo'r angen ar gyfer eu hystyried.
AAC: 18/01/2.1	**Memorandwm Cyd-ddealltwriaeth a Chytundeb Rhannu Gwybodaeth gyda'r Cyngor Fferylliaeth Cyffredinol**			
	• Bydd y Pwyllgor yn derbyn cadarnhad bod y MOU a'r ISA wedi cael eu hadolygu gan y Gwasanaethau Cyfreithiol a Risg neu Swyddog Rheoli Gwybodaeth cyn eu llofnodi.	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Derbyniwyd cadarnhad bod y Rheolwr Rheoli Gwybodaeth wedi adolygu'r MOU a'r ISA cyn cael cymeradwyaeth y Tîm Gweithredol.

Cyfeirnod y Cofnodion	Camau Cytunedig	Arweinydd	Dyddiad Targed	Cynnydd/ Cwblhawyd
AAC: 18/01/2.2.1	**Adroddiad Cynnydd Gwrth-dwyll**			
	• Bydd y Pwyllgor yn derbyn diweddariad ar ddata cyfatebol NFI 2020/21 yn ei gyfarfod nesaf.	**Cyfarwyddwr Cyllid/ Rheolwr Gwrth-dwyll:**	Ebrill 2021	Eitem ar agenda'r Pwyllgor ar gyfer Ebrill 2021.
	• Bydd y Pwyllgor yn derbyn diweddariad am y camau fydd yn cael eu cymryd er mwyn cyflawni'r dyddiau sydd ar ôl yn y Cynllun ar gyfer 2020/21.	**Cyfarwyddwr Cyllid/ Rheolwr Gwrth-dwyll:**	Ebrill 2021	Diweddariad i gael ei gynnwys yn yr Adroddiad Cynnydd Gwrth-dwyll.
AAC: 18/01/2.4.1	**Adroddiad Cynnydd Archwiliad Mewnol**			
	• Bydd y Pwyllgor yn derbyn y Cynllun Blynyddol ar gyfer 2021/22 yn y cyfarfod nesaf.	**Archwilio Mewnol**	Ebrill 2021	Eitem ar agenda'r Pwyllgor ar gyfer Ebrill 2021.
AAC: 18/01/2.4.4	**Adroddiad Crynodol COVID-19 Cymru Gyfan**			
	• Bydd Adroddiad Archwilio Cymru 'Ei Wneud yn Wahanol, Ei Wneud yn Iawn?' yn cael ei rannu ag Aelodau'r Pwyllgor;	**Ysgrifennydd y Bwrdd**	O fewn 1 wythnos	Cwblhawyd.
	• Bydd y Pwyllgor yn derbyn Adroddiad Archwilio Cymru 'Ei Wneud yn Wahanol, Ei Wneud yn Iawn?' yn ei gyfarfod nesaf.	**Archwilio Cymru**	Ebrill 2021	Eitem ar agenda'r Pwyllgor ar gyfer Ebrill 2021
	• Bydd y Pwyllgor yn derbyn Adroddiad Cydnerthedd Seiber Cymru Gyfan yng nghyfarfod nesaf y Pwyllgor yn ei Sesiwn 'Pwyllgor Caeedig'.	**Archwilio Cymru**	Ebrill 2021	Eitem ar agenda'r 'Pwyllgor Caeedig' ar gyfer Ebrill 2021

Cyfeirnod y Cofnodion	Camau Cytunedig	Arweinydd	Dyddiad Targed	Cynnydd/ Cwblhawyd
AAC: 18/01/2.6	**Adolygiad Blynyddol o Reolau Sefydlog**			
	• Mae'r Pwyllgor yn argymell bod y Bwrdd yn cymeradwyo'r diwygiadau ychwanegol i Reolau Sefydlog AaGIC fel y nodir hynny isod: ○ ail-bennu'r terfyn amser ar gyfer cynnal y Cyfarfod Cyffredinol Blynyddol (AGM) ar 30 Medi bob blwyddyn; ○ Diwygio'r Cynllun Dirprwyo er mwyn adlewyrchu penodiad a chyfrifoldebau'r Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a'r Cyfarwyddwr Gwasanaeth Digidol; ○ Adlewyrchu'r teitl priodol ar gyfer rôl Cyfarwyddwr Cyllid; ○ Pennu terfyn ariannol dirprwyedig o £50,000 ar gyfer Cyfarwyddwr Gwasanaethau Cynllunio, Perfformiad a Chorfforaethol a Chyfarwyddwr Gwasanaethau Digidol ar gyfer Contractau Anaddysgol a Hyfforddi	**Ysgrifennydd y Bwrdd**	Dydd Llun, 28 Ionawr 2021	Cymeradwyodd y Bwrdd y diwygiadau i'r Rheolau Sefydlog yn ei gyfarfod a gynhaliwyd ar 28 Ionawr 2021.
	• Mae'r Pwyllgor yn argymell y fersiwn adolygedig o Reolau Sefydlog AaGIC i'r Bwrdd eu cymeradwyo yn ei gyfarfod a drefnwyd ar gyfer 28 Ionawr 2021.	**Ysgrifennydd y Bwrdd**	Dydd Llun, 28 Ionawr 2021	Cymeradwyodd y Bwrdd y diwygiadau i'r Rheolau Sefydlog yn ei gyfarfod a gynhaliwyd ar 28 Ionawr 2021.
AAC: 18/01/2.7	**Cynllun Cyfrifon Blynyddol 2020/21**			
	• Petai'r angen yn codi cytunwyd y byddai Aelodau'r Pwyllgor a Swyddogion yn cynorthwyo o ran hwyluso unrhyw newid o ran	**Ysgrifennydd y Bwrdd**	I'w Gadarnhau	Mae'r Pwyllgor a drefnwyd ar gyfer 26 Mai 2021 er mwyn ystyried y cyfrifon terfynol wedi cael ei aildrefnu ar gyfer 9 Mehefin 2021 yng

Cyfeirnod y Cofnodion	Camau Cytunedig	Arweinydd	Dyddiad Targed	Cynnydd/ Cwblhawyd
	dyddiadau ar gyfer llofnodi'r cyfrifon terfynol gan y Pwyllgor a'r Bwrdd.			ngoleuni dyddiad hwyrach Llywodraeth Cymru ar gyfer cyflwyno'r Cyfrifon Blynyddol a'r Adroddiad Blynyddol.
AAC: 18/01/2.9	**Cofrestr Risgiau Corfforaethol**			
	• Uno Risg 1 a Risg 16 i fod yn un Risg 16, ac i ddileu Risg 1.	**Ysgrifennydd y Bwrdd**	O fewn 1 wythnos	Cwblhawyd.
	• Dileu unrhyw risgiau a aseswyd eu bod yn rhai statws 'Gwyrdd'.	**Ysgrifennydd y Bwrdd**	O fewn 1 wythnos	Cwblhawyd.
AAC: 18/01/2.10	**Cofnodwr Argymhellion Archwiliad**			
	• Bydd argymhellion Gwyrdd a aseswyd fel rhai wedi eu cwblhau yn cael eu dileu o'r Cofnodwr.	**Ysgrifennydd y Bwrdd**	O fewn 1 mis	Cwblhawyd.
AAC: 18/01/2.11	**Blaenraglen Waith 2021/22**			
	• Cynnal adolygiad o'r busnes a gynlluniwyd i'w ystyried gan y Pwyllgor ym mis Ebrill 2021, a bod Cadeirydd y Pwyllgor yn cael ei hysbysu am y deilliant.	**Ysgrifennydd y Bwrdd**	O fewn 1 mis	Mae adolygiad o'r busnes a gynlluniwyd ar gyfer y Pwyllgor ym mis Ebrill wedi cael ei gwblhau.

Dyddiad y Cyfarfod	7 Chwefror 2021	**Eitem ar yr Agenda**	**2.1**
Teitl yr Adroddiad	Adroddiad Cynnydd o ran Atal Twyll – ar gyfer y cyfnod 1 Ionawr 2021 i 31 Mawrth 2021		
Awdur yr Adroddiad	Nigel Price – Arbenigwr Atal Twyll Lleol (LCFS)		
Noddwr yr Adroddiad	Cyfarwyddwr Cyllid		
Cyflwynwyd gan	Nigel Price – LCFS		
Rhyddid Gwybodaeth	Caeedig		
Pwrpas yr Adroddiad	Pwrpas yr Adroddiad Cynnydd o ran Atal Twyll yw darparu adroddiad cyfredol i'r Pwyllgor Archwilio a Sicrwydd ar holl waith Atal Twyll y GIG a wnaed yn AaGIC rhwng 1 Ionawr 2021 a 31 Mawrth 2021. Cafodd arddull yr adroddiad ei fabwysiadu yn dilyn ymgynghoriad â'r Cyfarwyddwr Cyllid, a'i brif amcan yw hysbysu a diweddaru aelodau'r Pwyllgor Archwilio a Sicrwydd ynghylch manylion unrhyw newidiadau sylweddol yn yr achosion y gweithiwyd arnynt yn ystod y cyfnod, yn ogystal ag unrhyw faterion gweithredu cyfredol.		
Materion allweddol	I gydymffurfio â Chyfarwyddiadau'r Ysgrifennydd Gwladol dros Iechyd ar gyfer Atal Twyll yn y GIG, mae'n rhaid cyflwyno adroddiadau cynnydd rheolaidd i Bwyllgor Archwilio a Sicrwydd y Cyrff Iechyd. Mae'r adroddiad yn amlinellu sefyllfa bresennol unrhyw waith Atal Twyll a Llygredd sy'n cael ei wneud yn y Corff Iechyd hyd at ddyddiad cyfarfod y Pwyllgor. Ar y cyd â'r Cyfarwyddwr Cyllid, mae'n rhaid i'r LCFS gynllunio a chytuno ar Gynllun Gwaith Blynyddol yn cynnwys nifer awgrymedig o ddiwrnodau sy'n fframwaith ar gyfer datblygu trefniadau Atal Twyll cadarn ac sy'n argymell, i'r Pwyllgor Archwilio a Sicrwydd, yr adnoddau sydd eu hangen er mwyn gallu gweithio'n effeithiol ar draws y meysydd gweithredu sydd wedi'u hamlinellu ym Mholisïau a Gweithdrefnau Atal Twyll y GIG.		

Cam Penodol i'w Gymryd *(un ✓ yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓

Argymhelliad	Gofynnir i Aelodau'r Pwyllgor:

	• Nodi'r cynnydd sydd wedi'i wneud yn erbyn Cynllun Atal Twyll 2020/21; • Nodi'r wybodaeth ddiweddaraf am Fenter Dwyll Genedlaethol 2020/21; • Cymeradwyo Rhaglen Waith Atal Twyll Flynyddol yr LCFS ar gyfer 2021/22.

ADRODDIAD CYNNYDD O RAN ATAL TWYLL

1. CYFLWYNIAD

Pwrpas yr Adroddiad Cynnydd o ran Atal Twyll yw darparu adroddiad cyfredol i'r Pwyllgor Archwilio a Sicrwydd ar holl waith Atal Twyll y GIG a wnaed yn AaGIC rhwng 1 Ionawr 2021 a 31 Mawrth 2021.

Cafodd arddull yr adroddiad ei fabwysiadu yn dilyn ymgynghoriad â'r Cyfarwyddwr Cyllid, a'i brif amcan yw hysbysu a diweddaru aelodau'r Pwyllgor Archwilio a Sicrwydd ynghylch manylion unrhyw newidiadau sylweddol yn yr achosion y gweithiwyd arnynt yn ystod y cyfnod, yn ogystal ag unrhyw faterion gweithredu cyfredol.

2. CEFNDIR

Yn unol â Chyfarwyddiadau'r Ysgrifennydd Gwladol Dros Iechyd ar gyfer Atal Twyll yn y GIG, mae'n rhaid cyflwyno adroddiadau cynnydd rheolaidd i Bwyllgor Archwilio a Sicrwydd AaGIC. Dylai'r adroddiad amlinellu sefyllfa bresennol unrhyw waith Atal Twyll a Llygredd a wnaed yn y sefydliad hyd at ddyddiad cyfarfod y Pwyllgor.

3. Y CYNNIG

Ar y cyd â'r Cyfarwyddwr Cyllid, yr LCFS i gynllunio a chytuno ar Gynllun Gwaith Blynyddol yn cynnwys nifer awgrymedig o ddiwrnodau sy'n fframwaith ar gyfer datblygu trefniadau Atal Twyll cadarn ac sy'n argymell, i'r Pwyllgor Archwilio a Sicrwydd, yr adnoddau sydd eu hangen er mwyn gallu gweithio'n effeithiol ar draws y meysydd gweithredu sydd wedi'u hamlinellu ym Mholisïau a Gweithdrefnau Atal Twyll y GIG.

4. MATERION LLYWODRAETHU A RISG

Drwy fabwysiadu strwythur llywodraethu cadarn, dylai AaGIC ganolbwyntio ar brosesau effeithiol ar gyfer asesu risgiau twyll. Yn sgil hyn dylid canolbwyntio ar atal twyll, canfod twyll, ac ymchwilio i dwyll. Rhaid ystyried asesiadau o risgiau twyll a'r tair prif elfen, sef:

- canfod risgiau cynhenid twyll (risgiau twyll);
- asesu tebygolrwydd ac arwyddocâd pob risg gynhenid twyll;
- ymateb i risgiau cynhenid tebygol a/neu arwyddocaol.

I asesu'r materion risg, rhaid i staff AaGIC ddeall bod y mwyafrif yn ymwneud â dogfennau ffug, llofnodau ffug, adroddiadau twyllodrus, camddefnyddio neu lygredd.

Wrth edrych ar feysydd fel hyn, dylid ystyried y canlynol:

- Cymhellion, pwysau a chyfleoedd o ganlyniad i wendidau yn y system;
- Y perygl bod Uwch Reolwyr yn anwybyddu polisïau a/neu'n diystyru rheoliadau;
- Technoleg Gwybodaeth;
- Risgiau twyll o ran rheoliadau, y gyfraith neu enw da.

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

- Hanes twyll yn y sefydliad;
- Amlder y twyll yn y GIG gydag unrhyw achosion tebyg;
- Cymhlethdod y risg;
- Y risgiau i unigolion neu adrannau penodol;
- Nifer y bobl neu'r trafodiadau dan sylw.

Wrth amcangyfrif yr arwyddocâd, dylid ystyried rhwymedigaeth y sefydliad o ran gweithrediadau, enw da a'r gyfraith (troseddol, sifil a rheolaethol).

Hefyd dylid cofnodi asesiadau o risgiau twyll AaGIC gan ddefnyddio fframwaith strwythuredig a dylid adrodd unrhyw ganfyddiadau i'r Pwyllgor Archwilio a Sicrwydd.

Dylai'r broses gyfan fod yn ddogfen "fyw" a dylid canolbwyntio'n bennaf ar welliant parhaus. Gellir datblygu hyn drwy sicrhau, drwy amrywiol sesiynau ymwybyddiaeth, digwyddiadau a chyhoeddiadau, bod staff a rheolwyr ar bob lefel yn AaGIC:

- wedi darllen ac yn deall eu cyfrifoldebau fel yr amlinellir ym mholisi a gweithdrefnau Atal Twyll y Cyrff Iechyd;
- yn deall twyll ac yn nodi unrhyw feysydd sy'n peri pryder;
- yn deall eu rolau a'u cyfrifoldebau unigol o fewn y fframwaith rheolaeth mewnol, yn enwedig mewn perthynas ag unrhyw wendidau posibl yn y system;
- yn creu diwylliant gwrth-dwyll drwy sicrhau amgylchedd rheoli cadarn;
- yn rhoi gwybod am unrhyw amheuon a/neu achosion honedig o dwyll;
- yn cydweithio'n llawn ag unrhyw ymchwiliadau sy'n ymwneud â thwyll.

Gallai unrhyw gyhoeddusrwydd negyddol o ganlyniad i adroddiadau yn y cyfryngau effeithio ar enw da AaGIC. Ond byddai cyhoeddi unrhyw gamau a gymerwyd yn erbyn yr unigolyn neu'r unigolion yn dangos na fydd twyll yn erbyn y GIG yn cael ei oddef, a gallai hyn rwystro pobl eraill.

5. GOBLYGIADAU ARIANNOL

Mae gan dwyll yn erbyn y GIG effaith ariannol, oherwydd byddai AaGIC wedi dioddef colled ariannol gychwynnol o ganlyniad i weithredoedd yr unigolyn.

Mae gwaith y staff Atal Twyll yn cael ei wneud er mwyn ceisio lleihau lefel y twyll neu lygredd yn AaGIC a'i gadw ar y lefel isaf bosibl er mwyn rhyddhau adnoddau ar gyfer addysg a hyfforddiant.

6. ARGYMHELLIAD

Gofynnir i Aelodau'r Pwyllgor:

- Nodi'r cynnydd sydd wedi'i wneud yn erbyn Cynllun Atal Twyll 2020/21;
- Nodi'r wybodaeth ddiweddaraf am Fenter Dwyll Genedlaethol 2020/21;
- Cymeradwyo Rhaglen Waith Atal Twyll Flynyddol yr LCFS ar gyfer 2021/22.

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig ***(rhowch ✓)***	**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:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol yn GIG Cymru drwy ddatblygu capasiti arwain tosturiol a chydweithredol ar bob lefel
	✓		
	Nod Strategol 4: Datblygu'r gweithlu er mwyn helpu i ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio ynddo	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
Ansawdd, Diogelwch a Phrofiad Cleifion			
Dim wedi'u nodi			
Goblygiadau Ariannol			
Mae gan dwyll yn erbyn y GIG effaith ariannol, oherwydd byddai AaGIC wedi dioddef colled ariannol gychwynnol o ganlyniad i weithredoedd yr unigolyn. Mae gwaith y staff Atal Twyll yn cael ei wneud er mwyn ceisio lleihau lefel y twyll neu lygredd yn AaGIC a'i gadw ar y lefel isaf bosibl er mwyn rhyddhau adnoddau ar gyfer addysg a hyfforddiant.			
Goblygiadau Cyfreithiol (gan gynnwys asesiad o gydraddoldeb ac amrywiaeth)			
Lle mae tystiolaeth o dwyll prima facie yn cael ei nodi, gofynnir am gyngor gan Adran Dwyll Arbenigol Gwasanaeth Erlyn y Goron ar y camau nesaf ac a oes digon o dystiolaeth i gefnogi erlyniad troseddol.			
Goblygiadau Staffio			

Dim	
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)	
Dim	
Hanes yr Adroddiad	Dim
Atodiadau	Atodiad 1 Adroddiad Cynnydd yr LCFS a'r Wybodaeth Ddiweddaraf am y Fenter Dwyll Genedlaethol Atodiad 2 Cynllun Gwaith Blynyddol yr LCFS 2020/21

Meeting Date	7th February 2021	**Agenda Item**	**2.1**
Report Title	Counter Fraud Progress Report – for the period 1st January 2021 to 31st March 2021		
Report Author	Nigel Price– LCFS		
Report Sponsor	Director of Finance		
Presented by	Nigel Price – Local Counter Fraud Specialist (LCFS)		
Freedom of Information	Closed		
Purpose of the Report	The purpose of the Counter Fraud Progress Report is to provide the Audit and Assurance Committee with an updated report of all NHS Counter Fraud work undertaken, for HEIW between 1st January 2021 and 31st March 2021. The report's style has been adopted, in consultation with the Finance Director, with the prime objective of informing, and updating, the Audit and Assurance Committee members of the outline detail of significant changes in cases that have been worked on during the period, in addition to any current operational issues.		
Key Issues	In compliance with the Secretary of State for Health Directions on Countering Fraud in the NHS, regular progress update reports are required to be presented to the Health Bodies' Audit and Assurance Committee. The report outlines the current standing of any Counter Fraud and Corruption work carried out within the Health Body as at the date of the Audit and Assurance Committee meeting. The LCFS is required to plan and agree, with the Finance Director, an Annual Work-Plan containing a suggested number of days that is a framework on which to build and develop robust Counter Fraud arrangements and which recommends, to the Audit and Assurance Committee, the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures.		
Specific Action Required ***(please ✓ one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Recommendation	Committee members are asked to: • Note the progress made against the 2020/21			

	Counter Fraud Plan; • Note the update on the National Fraud Initiative 2020/21; • Approve the LCFS Annual Counter Fraud Work Plan 2021/22.

COUNTER FRAUD PROGRESS REPORT

1. INTRODUCTION

The purpose of the Counter Fraud Progress Report is to provide the Audit and Assurance Committee with and update report of all NHS Counter Fraud work undertaken, for the period between 31st January and 31st March 2021, within HEIW.

The report's style has been adopted, in consultation with the Finance Director, with the prime objective of informing, and updating, the Audit and Assurance Committee members of the outline detail of significant changes in cases that have been worked on during the period, in addition to any current operational issues.

2. BACKGROUND

In compliance with the Secretary of State for Health Directions on Countering Fraud in the NHS, regular progress update reports are required to be presented to HEIW's Audit and Assurance Committee, which should outline the current standing of any Counter Fraud and Corruption work carried out within the organisation as at the date of the Audit and Assurance Committee meeting.

3. PROPOSAL

The LCFS to plan and agree, with the Finance Director, an Annual Work-Plan containing a suggested number of days that is a framework on which to build and develop robust Counter Fraud arrangements and which recommends, to the Audit and Assurance Committee, the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures.

4. GOVERNANCE AND RISK ISSUES

By adopting a strong governance structure, the focus of HEIW should be on effective processes for fraud risk assessment which, in turn, must be followed by a focus on fraud prevention, fraud detection and fraud investigation. Fraud risk assessments must be considered and the three key elements being:

- identifying inherent fraud risk (the risk of frauds);

- assessing the likelihood and significance of each inherent fraud risk;
- responding to likely and/or significant inherent risks.

To assess the risk issues, HEIW staff must understand that the majority relate to false documents, forged signatures, fraudulent reporting, misappropriation or corruption.

When looking at such areas, the following should be considered:

- Incentives, pressures and opportunities due to system weaknesses;
- The risk of Senior Management not adhering to policy or overriding controls;
- Information Technology;
- Regulatory, legal or reputational fraud risks.

When assessing the likelihood and significance of any fraud risks, any assessment should consider the following:

- The past history of fraud in the organisation;
- The incidence of the fraud within the NHS with any similar cases;
- The complexity of the risk;
- The risks for particular individuals or departments;
- The number of people or transactions involved.

When estimating significance, consideration should be given to the organisation's operations, reputational and legal liability (criminal, civil and regulatory).

HEIW's fraud risk assessment should also be documented using a structured framework and any findings reported to the Audit and Assurance Committee.

The entire process should be a "living" document and ongoing with the main focus being on continuous improvement. This can be taken forward by ensuring, through the various fraud awareness sessions, events and publications, that all levels of management and staff within HEIW will :

- read and understood their responsibilities, as outlined in the Health Bodies' Counter Fraud policy and procedure;
- have an understanding of fraud and identifying any areas of concern;
- have an understanding of their individual roles and responsibilities in the internal control framework and especially in relation to any potential system weaknesses;
- create an anti-fraud culture by ensuring a strong control environment;
- report any suspicions or alleged incidences of fraud;
- provide full co-operation in any fraud related investigation.

Any negative publicity received as a result of media reports may have an effect on the reputation of HEIW. However, by publicising any action taken against the individual(s) would also show that fraud committed against the NHS will not be tolerated and this may also serve as a deterrent to others.

5. FINANCIAL IMPLICATIONS

Fraud committed against the NHS has a financial impact, since HEIW would have suffered an initial financial loss as a result of the subject's actions.

The work of 's Counter Fraud staff undertaken in order to attempt reduce the level of fraud or corruption within HEIW to a minimum and keep it at that level in order to free up resources for education and training.

6. RECOMMENDATION

Committee members are asked to:

- Note the progress made against the 2020/21 Counter Fraud Plan;
- Note the update on the National Fraud Initiative 2020/21;
- Approve the LCFS Annual Counter Fraud Work Plan 2021/22.

Governance and Assurance			
Link to IMTP strategic aims ***(please ✓)***	**Strategic Aim 1:** To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of '*A Healthier Wales*'	**Strategic Aim 2:** To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs	**Strategic Aim 3:** To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓		
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality	**Strategic Aim 5:** To be an exemplar employer and a great place to work	**Strategic Aim 6:** To be recognised as an excellent partner, influencer and leader

Quality, Safety and Patient Experience
None identified
Financial Implications
Fraud committed against the NHS has a financial impact, since the Health Body would have suffered an initial financial loss as a result of the subject's actions. The work of Counter Fraud is undertaken in order to attempt reduce the level of fraud or corruption within HEIW to a minimum and keep it at that level in order to free up resources for education and training .
Legal Implications (including equality and diversity assessment)
Where there is any evidence of prima facie fraud identified then advice as to how best to proceed and whether there is sufficient evidence to support a criminal prosecution is sought from the CPS Specialist Fraud Division.
Staffing Implications

None	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
None	
Report History	None
Appendices	Appendix 1 LCFS Progress Report and Update on the National Fraud Initiative Appendix 2 LCFS Annual Work Plan for 2020/21

NHS WALES
Health Education & Improvement Wales

Audit & Assurance Committee 7th April 2021
Counter Fraud Update

Nigel Price
Counter Fraud Investigator
Cardiff and Vale University Health Board

AUDIT COMMITTEE 7th April 2021

COUNTER FRAUD UPDATE

1. **Introduction**
2. **Case Update**
3. **Progress and General Issues**
4. **Appendix 1 - Summary of Plan**

Mission Statement

To provide 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.

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 (Audit Committee) on the work that has been carried out against the agreed work-plan.

This update provides the Audit Committee with an update for the period from 1st January 2021 to 31st March 2021

2. CURRENT CASE UPDATE

2.1 As at 31st March 2021, a total of **39** days have been spent on counter fraud work for HEIW. The breakdown of this work is detailed in **Appendix 1**.

2.2 Since January 2021 there are no investigations linked to HEIW.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

Face-to-face fraud awareness sessions for HEIW staff have been cancelled due to COVID-19 restrictions, but in this reporting period two sessions have been conducted through 'Teams' to 19 delegates. For the period from 1st April 2020 to 31st March 2021 16 presentations have been given to 225 delegates. Based on the feedback of those who have attended these presentations 52% "Strongly Agreed and 45% "Agreed" the sessions improved their knowledge of fraud in the NHS. For 2021 there are 'Teams' awareness session booked for each month until December.

3.2 System Weaknesses and Lessons Learn from investigations

Nothing to report for this quarter.

3.3 National Fraud Initiative 2020/21

Following enquiries raised with the Auditor General for Wales, on whether HEIW was required to be involved and take part in the National Fraud Initiative (NFI) 2020-21 process, this has since been confirmed. Given this an individual NFI account for HEIW has now been set up.

The NFI is designed to help Public Bodies build their fraud detection capability through data matching at a national level because fraud is a diverse and evolving crime. To comply with the NFI requirements and to enable HEIW to submit the required data, arrangements have been made with NWSSP colleagues (i.e. Procurement and Payroll) for the relevant information to be made available to meet the deadlines. In addition, Fair Processing Notices have also been included on staff payslips to make HEIW staff aware, as is required, that their personal data is being shared in this format.

The data was released on the 31st January 2021. There are 26 Matches linked to HEIW which are considered to be a priority and an additional 96 matches which are considered low-risk. All the priority matches and about 10% of the other matches will be reviewed. If any appear to be a cause for concern further inquiries will be made.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2020/21

AREA OF WORK	Planned Days	Days to Date
General Requirements		
LCFS Attendance at All Wales Meetings	1	1
Planning/Preparation of Annual Report and Work Programme	1	2
Production of Reports and attendance at Audit & Assurance	4	4
Liaison with the DoF, NHS CFA, Welsh Government	0	1
Self Review Tool (SRT) and QA Assessment	1	1
Annual Activity		
Create an Anti-Fraud Culture	2	1
Presentations, Briefings, Newsletters etc.	15	10
Fraud Awareness Events	0	0
Deterrence		
Review/develop Policies/Strategies	2	1
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	4
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	15	11
Ensure that Sanctions are applied to cases as appropriate	1	0
Seek redress, where fraud has been proven to have taken place	2	1
TOTAL HEALTH EDUCATION IMPROVEMENT WALES	**50**	**39**

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

HEALTH EDUCATION AND IMPROVEMENT WALES (HEIW) COUNTER FRAUD WORK PLAN 2020-2021

1 Background

1.1 This document draws up the counter fraud arrangements with Health Education and Improvement Wales and should be reviewed annually. The work plan details the counter fraud standards of the Government Functional Standard GovS: 013: Counter Fraud which comes into effect on the 1st April 2021 and consists of 12 'components'. It also recommends the resources which are outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on an annual Quality Assurance Programme which consists of two processes, assurance and assessment. Both are linked to the anti-fraud, corruption and bribery standards set out annually by NHS Counter Fraud Authority

1.2 The Quality Assurance process includes an annual self-review, which is conducted by the Special Health Authority and utilises the required standards. The results are sent to the NHS Counter Fraud Authority (CFA) with the health body's counter fraud annual report. The Quality Assurance process is reviewed by the CFA's Quality and Compliance team and the Special Health Authority.

1.3 The Counter Fraud Service supports the Special Health Authority to formulate its work plan, taking a risk-based approach. The Counter Fraud guidance is used to help provide a framework to develop appropriate arrangements and HEIW thereby establishes its tailor-made plans.

1.4 Audit Wales had the following comments to make:

" Work-plan appears to be a comprehensive and demanding proactive programme of Counter fraud work. If the plan is delivered to a high standard across the NHS in Wales, it will make a significant impact in the prevention of fraud in the NHS.
It may be worth reminding LCFS' of the importance of liaison with External Auditors when planning local Counter fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g. Whistle-Blowing arrangements, Declaration of Interests; Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter fraud arrangements are robust."

Audit Wales recognised that the effective delivery of the plan will represent a substantial programme of work.

1.5 The total number of suggested **pro-active and reactive days** to be allocated in 2021-2022 for HEIW is **50 days**. This response has been allocated using data from organisations in both Primary and Secondary Care Sectors.

1.6 When planning the resources for counter fraud work, it is important that the HEIW Work Plan allows sufficient days for investigative work in order to react to any issues of concern that may arise during the year.

1.7 Pro-Active work, e.g. strategic, culture, deterrence, prevention and detection, should not be absorbed by reactive activity or *vice versa* and to this end NHS Counter fraud Authority strongly encourages pro-active work to be 'ring-fenced'. Effective pro-active work is essential in order to reduce the risk of fraud, corruption or bribery.

1.8 Organisations vary in size and following scale is used to calculate the number of days allocated to counter fraud:

Number of staff	Number of Pro-Active Counter fraud days
Less than 4,999	295
5,000 to 9,999	305
10,000 to 13,999	315
More than 14,000	325

1.9 It is important to note that, while this is a work-plan to ensure effective counter fraud arrangements, it is not a maximum requirement and health organisations are strongly urged to consider further local requirements that might result in the recommended resource levels being exceeded. This work-plan gives guidance for considering Counter fraud arrangements, but it is important that tailor-made plans are carried out on a risk-based approach (see section 2). Given the relatively small number of staff employed by HEIW, it is considered that the number of days suggested by the guidance shown above is not appropriate and the judgement of the DoF and Lead Counter Fraud officer has been used to determine the Pro-Active Days within the Plan.

1.10 Organisations that vary from the standard should provide evidence why decisions on work planning have been taken and these should be shown to NHS CFA or NHS CFS (Wales).

2 The work-plan is the basis to establish robust counter fraud arrangements. However, should it need to vary due to circumstances that arise in-year, then in discussion with the HEIW DoF the Work Plan can be revised to meet any new need or circumstance that may arise.

2 Taking a risk-based approach to planning local counter fraud work

2.1 Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the Local Counter fraud Specialist (LCFS).

2.2 The counter fraud work-plan should be tailor-made for the NHS organisation, for example, utilising local annual staff survey results will identify areas on which to concentrate for raising awareness, while examination of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

2.3 Meeting key personnel in the Special Health Authority and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work.

2.4 The LCFS will liaise with the DoF and those in HEIW who are responsible for managing risks. It is recommended that the LCFS is informed of any incidents of concern in the organisation in order to identify any risks and take action to prevent those happening.

2.5 Any risks which are identified by the LCFS must be placed on the risk register to provide another level of assurance that the risk will be managed.

2.6 While every effort will be made to identify local risks, it is important that information from outside the organisation is taken into account; for example, NHS Counter fraud Authority fraud alerts which must also be included in risk-based planning.

2.7 Accurate records of counter fraud work is crucial to planning investigations, evaluating outcomes, risk register entries and audit reports. The end of year Quality Assurance Programme and Self Risk Assessment requires accurate record keeping and can help to identify strengths and weaknesses.

2.8 To help organisations take a risk-based approach to counter fraud work and planning, The NHS CFA has issued a risk assessment tool. That tool helps the LCFS when assessing the counter fraud arrangements at their own organisation. It is

designed to complement the quality assurance process, and provides a process to review counter fraud arrangements prior to completing the end of year quality assurance programme. The LCFS is accountable to the Counter Fraud Authority and is assessed on reactive and proactive work from the Counter Fraud Services Wales 2019 document. The quality assurance programme comprises of two main processes; assurance and assessment. The assurance process primarily focuses on an annual self-review against the standards which is conducted by the organisation and submitted to the NHSCFA. The assessment process is then conducted by the NHSCFA Quality and Compliance team in partnership with the organisation.

3 Focusing on outcomes and not activity

3.1 Completed counter fraud work will show the results for each investigation or referral. Those outcomes may relate to successful investigations or progress being made in proactive areas, for example, staff feedback on how their knowledge of fraud in the NHS has improved due to attending presentations. For example, for the year 2020-2021, 225 members of staff attended fraud awareness sessions; out of which, 52% said they “Strongly agreed” and 45% said they “Agreed” that the session improved their knowledge of counter fraud work.

3.2 That feedback supports the progress in developing an anti-fraud culture. Another example would be reviewing an organisation’s policies to identify any potential areas which may be susceptible to fraud. An example of this is the childcare funding for student nurses who are eligible for the funding support. A weakness in the process was identified and after taking corrective action, fraud referrals were considerably reduced. Clearly, the NHS must get value for the money it spends on counter fraud work and in planning for the year ahead consideration needs to be given to obtaining evidence to demonstrate this is happening.

4 Work-plan Components

Meets The Requirement	Partially Meets The Requirement	Does Not Meet The Requirement	Local Counter Fraud Service Position
1 Accountable individual There is a member of the executive board or equivalent body who has a clearly defined responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work.	Not applicable to this component	There is no member of the executive board, or equivalent body, who has a clearly defined responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work	The Director of Finance is the lead and accountable Executive Director.
2 Counter fraud bribery and corruption strategy The impact of the organisation's counter fraud, bribery and corruption strategy has been evaluated, and the counter fraud work plan or counter fraud resources has been updated as required as a result.	The organisation's counter fraud, bribery and corruption strategy is aligned to NHSCFA's strategy, and it has been approved at senior management or executive level.	The organisation does not have a counter fraud, bribery and corruption strategy.	The Special Health Authority has a counter fraud policy which follows the NHSCFA strategy. An annual counter fraud plan for the health board is agreed by the Audit and Assurance Committee.
3 Fraud bribery and corruption risk assessment Resources to carry out the work are realistically assessed and suitable for addressing the risk identified within a reasonable timescale, in line with the	Risk assessments have been carried out to identify fraud, bribery and corruption risks at the organisation in line with GCFP fraud risk assessment methodology. These	There is no evidence of any local risk assessments carried out to identify fraud, bribery and corruption risks at the organisation	The Special Health Authority's fraud policy has been reviewed and will be assessed against the risk register. Liaison with other departments such as procurement and internal audit is carried out to identify any areas which may be vulnerable to fraud.

organisational risk policy	risks are recorded in line with the organisational risk management policy.		Resources to carry out the work are reviewed annually and are deemed to be adequate.
4 Policy and response plan There are significant levels of staff knowledge and awareness of the existence of the policy and plan. Levels of awareness are routinely measured, and any resulting corrective or preventative action is implemented and evaluated.	The organisation's policy and plan are in line with the NHSCFA's strategy, and it has been approved at senior management or executive level, implemented and communicated across the organisation.	The organisation does not have a policy and plan, or where one exists, it is not publicised, or it is out of date	Fraud awareness sessions are regularly carried out and the staff complete feedback sheets. for the year 2020-2021, 225 members of staff attended fraud awareness sessions; out of which, 52% said they "Strongly agreed" and 45% said they "Agreed" that the session improved their knowledge of counter fraud work.
5: Annual action plan Risk-based objectives of the work plan are adequately resourced to carry out the work.	The annual work plan has been agreed by the audit committee (or equivalent body). Adequate resources have been assigned to specific areas of activity.	There is no evidence of the annual work plan being agreed by the audit committee (or equivalent body).	The health board's annual counter fraud plan is signed off by the Director of Finance and then approved by the Audit and Assurance Committee who then monitor progress on a quarterly basis.
6 Outcome-based metrics The organisation has agreed targets / outcomes and has metrics in place to monitor progress - these are regularly reviewed by the Audit Committee and revised where necessary. New metrics are appropriately implemented.	The organisation has agreed targets / outcomes but no evidence of tracking or monitoring to measure progress	No metrics are in place (or defined outcomes against counter fraud initiatives or investments).	The targets for the Special Health Authority's counter fraud work is set out at the beginning of the financial year as part of the annual plan. Progress towards those targets for example: the days allocated for investigations, financial recoveries, the number of open and closed cases and the number of fraud awareness sessions is reported to the Audit and Assurance committee at each meeting.

7 Reporting routes for staff, contractors and members of the public The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, including the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool.	The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, including the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool.	The organisation does not have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, or where reporting routes exist, it is not publicised, or it is out of date.	Every fraud presentation covers ways in which staff can report any suspicions or concerns about fraud both internally and the external NHS Fraud Reporting Line. All referrals are recorded on the case management system
8 Report identified loss There is evidence to indicate that the completeness and timeliness of information recorded on the approved NHS fraud case management system is regularly and soundly evaluated and that, where appropriate, findings lead to improvements.	The organisation records all reports of suspected fraud, bribery and corruption, investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises, on the approved NHS fraud case management system in line with NHSCFA guidance.	The organisation does not use the approved NHS fraud case management system to record all reports of suspected fraud, bribery and corruption, investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	All progress and outcomes are recorded on the case management system. Part of the investigation is to identify weaknesses in policies or procedures which are recorded in the investigation report. Appropriate action is taken to prevent similar incidents happening again.
9 Access to trained investigators The organisation has notified any	Not applicable to this requirement	There is no accredited person (or persons) employed or contracted in to carry out the full	The Special Health Authority has 3 accredited fraud investigators in full time employment

/ all changes to nominations to the NHSCFA as soon as reasonably practicable. There is an accredited, nominated and appropriately trained person(s) who is employed or contracted in and conducts the full range of counter fraud, bribery and corruption work on behalf of the organisation		range of counter fraud, bribery and corruption work on behalf of the organisation.	
10 Undertake detection activity Where anomalies are identified which may be indicative of fraud, bribery and corruption, the organisation carries out proactive exercises to address them. Resulting recommendations are actioned	The organisation can demonstrate that it uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption.	There is no evidence that the organisation uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption.	The CF service regularly reviews department policies to identify areas which may be vulnerable to fraud, bribery or corruption. In addition to that proactive work is undertaken by engaging with other departments, for example Accounts Payable, Procurement and Internal Audit
11 Access to and completion of training The organisation has an ongoing programme to raise awareness of fraud, bribery and corruption issues among all staff, using a range of methods that are appropriate to different staff groups. There is evidence that presentations and other	The organisation has an ongoing programme to raise awareness of fraud, bribery and corruption issues among all staff using a range of methods. This may include induction, presentations, newsletters, posters and other awareness	The organisation has not raised awareness of fraud, bribery and corruption issues among staff and has not attempted to create a counter fraud, bribery and corruption culture.	Fraud awareness sessions are regularly given to the Special Health Authority's departments and new employees which is tailor-made to the audience to ensure it is relevant. A counter fraud newsletter is published every 4 months which gives details of contacts

awareness materials are targeted to specific staff groups	materials. The awareness work carried out is in line with NHSCFA's strategy		
12 Policies and registers for gifts and hospitality and Conflicts of Interest The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is proactively communicated to all staff.	The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is available to all staff and includes the appropriate references to fraud, bribery and corruption and the requirements of the Bribery Act 2010	The organisation does not have a managing conflicts of interest policy and registers that include gifts and hospitality or does not publicise it where one exists.	The UHB has policies that cover conflicts of interest and gifts and hospitality. The Director of Governance manages the Conflict of Interest register and liaises with counter fraud if appropriate.

Appendix 1

Number of Days agreed with Health Education and Improvement Wales Finance Director for the 2021- 2022 Financial Year is 50 days.

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2021/22

AREA OF WORK	Planned Days
General Requirements	
LCFS Attendance at All Wales Meetings	1
Planning/Preparation of Annual Report and Work Programme	1
Production of Reports and attendance at Audit & Assurance	4
Liaison with the DoF, NHS CFA, Welsh Government	0
Self Review Tool (SRT) and QA Assessment	1
Annual Activity	
Create an Anti-Fraud Culture	2
Presentations, Briefings, Newsletters etc.	15
Fraud Awareness Events	0
Deterrence	
Review/develop Policies/Strategies	2
Prevention	
The reduction of opportunities for Fraud and Corruption to occur.	0
Detection	
National Pro-Active Exercises (e.g. Procurement)	2
National Fraud Initiative 2020/21	4
Investigation, Sanctions and Redress	

The investigation of any alleged instances of fraud	15
Ensure that Sanctions are applied to cases as appropriate	1
Seek redress, where fraud has been proven to have taken place	2
TOTAL HEALTH EDUCATION IMPROVEMENT WALES	**50**

Agreed by and signed by

Signature: **Date:**

Eifion Williams
Finance Director – Health Education and Improvement Wales

Signature: **Date:**

Nigel Price
Counter Fraud - Cardiff and Vale University Health Board

Dyddiad y Cyfarfod	**Ebrill 2021**	**Eitem ar yr Agenda**	**2.2.1**
Teitl yr Adroddiad	**Adroddiad Cynnydd**		
Awdur yr Adroddiad	Archwilio Mewnol		
Noddwr yr Adroddiad	Pennaeth Archwilio Mewnol		
Cyflwynwyd gan	Archwilio Mewnol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Diweddariad ar y gweithgarwch Archwilio Mewnol		
Materion allweddol	Diweddariad ar y gweithgarwch Archwilio Mewnol		
Cam Penodol i'w Gymryd ***(✓un yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
	✓			
Argymhellion	Amherthnasol			

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

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Health Education and Improvement Wales

INTERNAL AUDIT PROGRESS REPORT

Audit and Assurance Committee - April 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit and 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 the 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.

1. Introduction

1.1. This progress report provides the Audit and Assurance Committee (the 'committee') with the current position regarding the work undertaken by Internal Audit as at **18 March 2021**.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the 2020/21 programme of work, and any required updates.

2. Outcomes from completed audit reviews

2.1 Since the January meeting of the committee two reports have been finalised and two further reports have been issued in draft. We also have ongoing fieldwork in three other reviews. The two reports that have been finalised are:

Assignments	Assurance rating
Workplace culture	Reasonable
Governance arrangements during Covid-19 – Follow up	N/A - Advisory review

3 Delivery of 2020/21 Internal Audit plan

3.1 The detail of the scheduling and current progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A, table 1.

3.2 The schedule includes the planned timing of the audits. These dates may be subject to change as the audit work progresses, and any alterations will be communicated to the committee via future progress reports.

Covid-19 impact

3.3 This year has seen disruption caused by Covid-19 across our health bodies. The pandemic has not impacted on the number of planned reviews for HEIW. However, the first wave meant that there was less activity during this earlier part of the year across our work programmes than would be the case in a normal year as we, and others, adapted to new ways of working.

3.4 We have worked with our health organisations to deliver the agreed work programmes in these circumstances and, as we have previously reported, plan to issue a full opinion in our annual report.

Table 1: Status of 2020/21 assignments

Assignment	Indicative audit days	Status	Assurance	Timing	Notes
Annual Governance Statement	2	Complete	N/A	Q1	No formal report. Internal Audit feed into annual reporting process.
Medical commissioning monitoring	-	Final	Reasonable	-	-
Governance arrangements during Covid-19	-	Final	N/A	-	Advisory work.
Governance arrangements during Covid-19 – All Wales summary report	-	Final	N/A	-	For information.
Personal development process	12	Final	Reasonable	Q2	-
Financial systems	10	Final	Reasonable	Q3	-
Workplace culture	**15**	**Final**	**Reasonable**	Q2 ~~Q4~~	-
Governance arrangements during Covid-19 – follow up	**-**	**Final**	**N/A**	-	-
Cyber security	**15**	**Draft**	**Reasonable**	Q3	Draft issued.
Risk management	**10**	**Draft**	**Substantial**	Q3	Report issued 18.03.21

Assignment	Indicative audit days	Status	Assurance	Timing	Notes
Performance management	15	WIP	-	Q3	Management requested for our fieldwork to start in February. Fieldwork concluding.
Communication and engagement strategy	15	WIP	-	Q4	Fieldwork concluding. Slower progress due to sickness.
Pharmacy – pre-registration	15	WIP	-	Q4	Has taken time to agree scope due to HEIW progress with pre-registration project.
Governance arrangements	15	Planned	-	Q4	Following conclusion of HEIW internal work our governance review planned to start 24.03.21.

Workplace Culture

Internal Audit Report

HEIW

2020/21

February 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	HEIW-2021-04
Report status:	Final Internal Audit Report
Fieldwork commencement:	23 September 2020
Fieldwork completion:	14 November 2020
Draft report issued:	24 November, 18 December 2020 27 January 2021
Management response received:	16 February 2021
Final report issued:	24 February 2021
Auditor:	Ken Hughes, Audit Manager
Executive sign off:	Julie Rogers, Deputy Chief Executive and Director of Workforce and OD
Distribution:	Foula Evans, Head of People
Committee:	Audit and 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 the course of 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 Internal Audit Charter and the Annual Plan, approved by the Audit and 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, 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.

1. Introduction and Background

In line with the 2020/21 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation') a review of workplace culture was undertaken. HEIW was created by merging together three separate organisations and required the integration of NHS and Cardiff University staff, as well as the recruitment of staff from outside of these organisations.

History has shown that culture is one of the major barriers to effective integrations. Our review sought to provide assurance to the Audit and Assurance Committee that there are effective processes in place to manage the risks associated with a negative workplace culture. We focused on the development of the organisation's workplace culture, anti-harassment practices and the processes in place for staff to raise concerns.

Values and conduct are the building blocks of culture which is often described as 'the way we do things around here'. These can provide a practical platform for assessing and improving culture because they are measurable and lend themselves to be formalised in principles and standards. In addition, values and conduct can be tangibly demonstrated by senior management, thereby setting the 'tone at the top'.

Enabling staff to raise concerns without fear of recriminations can also help organisations develop a healthy workplace culture built on openness and accountability. It is vital that staff feel empowered to raise concerns at the earliest opportunity and have confidence that any concerns raised will be properly dealt with. Our audit took into account how the potential impact of Covid-19 and staff working from home may have affected workplace culture and the integration of staff.

The relevant lead for the review is the Deputy CEO / Director of Workforce and OD.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the organisation's workplace culture. The review sought to provide assurance to the Audit and Assurance Committee that risks material to the system's objectives were being managed appropriately.

The areas that the review sought to provide assurance on were:

- The organisation has a documented set of values, and these are actively promoted.
- Acceptable and unacceptable workplace behaviours have been identified and documented.
- There are mechanisms in place to evaluate the organisation's workplace culture, including the cultural assessment toolkit and to take actions where necessary.

- Culture is monitored at an appropriate level in the organisation.
- The use of physical space within the main offices encourages the integration of staff.
- The organisation's structure has been subject to review periodically to ensure it supports integrated working.
- There are policies in place which provide clear guidance to staff in relation to anti-harassment and on the process to apply when raising a concern.
- The raising concerns policy provides alternative channels both inside and outside the organisation to discuss concerns, is subject to regular review.
- The raising concerns and anti-harassment policies are actively promoted and are readily available to staff, including contractors, agency staff and those without IT access.
- Management responsibilities are appropriately defined, and adequate governance and reporting arrangements can be demonstrated; and
- Designated contacts responsible for the handling of concerns raised are aware of their responsibilities and have received adequate training.

3. Associated Risks

The potential risks considered in the review were as follows:

- Undesirable or inappropriate staff behaviour, or lack of effective staff integration which could adversely affect delivery of the annual plan commitments and result in poor performance and reputational damage.
- Unethical organisational or individual behaviour may go unchallenged.
- Unethical behaviour may lead to negative publicity and reputational damage.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with workplace culture is Reasonable Assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** 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.

Our review of workplace culture has concluded that HEIW is keen to develop a supportive workplace culture that allows staff to develop and grow, whilst delivering the best possible service to its partners and stakeholders. To help achieve this the organisation, in conjunction with its staff, set out the type of behaviour that is and is not acceptable within the workplace, and this has been documented within the Values and Behaviours Framework.

The staff appraisal system has been developed to help promote a positive workplace culture, and specifically asks staff to provide examples of how they have demonstrated the organisations values in their behaviour. Regular staff surveys and the annual NHS staff survey are also used to monitor and evaluate workplace culture.

Where staff encounter unacceptable behaviour such as bullying or harassment, they can take action through the Dignity at Work process, or can raise issues via the procedure for NHS staff to raise concerns.

The People Inclusion and Organisational Development Strategy once finalised will be key to promoting and embedding a positive and desirable workplace culture throughout the organisation. In the meantime, the Organisational Development Programme for 2021 includes a range of activities designed to develop and embed HEIW's culture throughout the workforce, some of which have been introduced due to the restrictions and enforced new ways of working as a result of the Covid-19 pandemic. These include the brand new 'Communed'

(Community) micro site that has been developed on the intranet where staff can share information with each other. Communications to staff also increased during the lockdown with a weekly message from the Chief Executive and Deputy Chief Executive. The Chief Executive forums have now become virtual, and HEIW has hosted an innovative event called 'HEIW has got the fun factor', which included informal awards for colleagues.

Since completing our audit fieldwork, we have been informed that the Culture Group that was initially set up when the organisation was created, now ceases to exist. We have been informed that other interventions and wider programmes of work are in place, including the Inclusion Champions Group and Health and Wellbeing Group. We have not undertaken any work in relation to these groups.

Our audit has identified some areas where the promotion and monitoring of workplace culture could be improved. The very low number of completed staff exit questionnaires means that currently this is not an effective mechanism by which to evaluate or monitor workplace culture.

In addition, two actions included in the March 2020 corporate risk register designed to improve the integration of staff have not been undertaken. Whilst we acknowledge that there has been significant changes to working practices since those actions were included on the risk register, there remains some merit in completing the actions.

We also note that a number of relevant workforce policies and procedures were overdue for review, and we were unable to ascertain what training key individuals had received should they be required to handle of concerns raised by staff.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Organisational values				✓
2	Workplace behaviours				✓
3	Culture evaluation mechanisms			✓	
4	Monitoring culture				✓
5	Office layouts			✓	
6	Organisational structure			✓	
7	Anti-Harassment policy			✓	
8	Raising concerns policy				✓
9	Promotion of policies				✓
10	Management responsibilities				✓
11	Staff training			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system control / design for workplace culture.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system / controls for workplace culture.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Unethical organisational or individual behaviour may go unchallenged and may lead to negative publicity and reputational damage.

We note the following areas of good practice:

- HEIW has developed a Values and Behaviours Framework that sets out how they will behave, treat others, work, and support healthcare colleagues.
- The Framework is published on the HEIW website and is referenced in the organisation's IMTP.
- The standard annual appraisal form specifically asks employees to record how they have demonstrated the organisations values in their behaviour.

We did not identify any findings under this objective.

Objective 2: Acceptable and unacceptable workplace behaviours have been identified and documented.

We note the following areas of good practice:

- The People & OD Strategy, Values & Behaviours Framework and Strategic Equality Plan set out acceptable and unacceptable behaviours for staff.
- Unacceptable behaviour by colleagues or managers can be raised as an issue through the staff appraisal process or directly to workforce & OD through the staff complaints procedure.

We did not identify any findings under this objective.

Objective 3: There are mechanisms in place to evaluate the organisation's workplace culture, including the cultural assessment toolkit and to take actions where necessary.

We note the following areas of good practice:

- Regular HEIW staff surveys are undertaken as part of the cultural assessment toolkit, and the results used to evaluate the workplace culture.

- The results of the annual NHS staff survey are used to evaluate the workplace culture.

We identified the following finding:

- The issue and analysis of exit questionnaires is not currently an effective mechanism by which to evaluate or monitor workplace culture (Finding 1).

Objective 4: Culture is monitored at an appropriate level in the organisation.

We note the following area of good practice:

- The Organisational Development Programme for 2021 includes a range of activities designed to develop and embed HEIW's culture throughout the workforce.

Objective 5: The use of physical space within the main offices encourages the integration of staff.

We note the following area of good practice:

- The inappropriate use of physical space within Ty Dysgu had been identified as a risk to the successful integration of staff and had been included in the corporate risk register.

We identified the following finding:

- Ongoing reviews of the use of physical space at Ty Dysgu should continue. (Finding 2).

Objective 6: The organisation's structure has been subject to review periodically to ensure it supports integrated working.

We identified the following finding:

- The March 2020 corporate risk register contained an action to review the organisation's structures one year after formation of the organisation to ensure they support integrated working. Whilst no formal review of the organisation's structures has taken place, incremental changes have occurred and structures should continue to be monitored. (Finding 3).

Objective 7: There are policies in place which provide clear guidance to staff in relation to anti-harassment and on the process to apply when raising a concern.

We note the following area of good practice:

- The Values and Behaviours Framework makes clear that harassment and bullying of colleagues is not acceptable workplace behaviour and the action to take if such situations arise.

We identified the following finding:

- The Dignity at Work Process, Grievance Policy and Disciplinary Policy were overdue for review at the time of our audit, although we acknowledge that these are All Wales policies (Finding 4).

Objective 8: The raising concerns policy provides alternative channels both inside and outside the organisation to discuss concerns, is subject to regular review.

We note the following area of good practice:

- HEIW has adopted the All Wales procedure for NHS staff to raise concerns which is approved and regularly reviewed by the Welsh Partnership Forum.

We did not identify any findings under this objective.

Objective 9: The raising concerns and anti-harassment policies are actively promoted and are readily available to staff, including contractors, agency staff and those without IT access.

We note the following area of good practice:

- All policies are available via the intranet and HEIW internet site, and are signposted to staff during their induction.

We did not identify any findings under this objective.

Objective 10: Management responsibilities are appropriately defined and adequate governance and reporting arrangements can be demonstrated.

We note the following area of good practice:

- The responsibilities of all parties are detailed within the procedure for NHS staff to raise concerns.

We did not identify any findings under this objective.

Objective 11: Designated contacts responsible for the handling of concerns raised are aware of their responsibilities and have received adequate training.

We identified the following finding:

- It was unclear whether the executive team and independent members have received any training in the handling of issues raised by employees in order to fulfil their roles as outlined in the policy (Finding 5).

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**4**	**5**

Finding 1 - Exit Questionnaires (Operating effectiveness)	Risk
All staff that leave HEIW are invited to complete an exit questionnaire which comprises of a series of questions. We understand that since April 2020, nine exit questionnaires have been issued, but to date only one has been completed and returned. In 2019/20 only six completed questionnaires were received back from 36 issued. Whilst immediate action appears to be taken to address any adverse points raised, to date it has not been possible for management to undertake any form of analysis of the responses due to the low volume returned.	Reasons for staff leaving the organisation are not fully understood and issues that may cause further staff resignations are not addressed.
Recommendation	**Priority level**
A review of the exit questionnaire process should be undertaken, including the content and format of the questionnaire to see if it could be made more user friendly and simpler to fill in. Consideration should be given to a combination of scaled and narrative style questions and it should be ensured that questionnaires are issued promptly after resignation is tendered to increase the chances of being returned Furthermore, staff leaving HEIW could be offered an exit interview, either with their line manager or someone from Workforce, before they leave the organisation.	**Medium**

Management Response	Responsible Officer/ Deadline
Although all leavers are offered an exit interview, it is currently optional whether they take this opportunity. Recognising the importance of creating a positive work culture, the feedback from leavers is essential to assess the overall employee experience. In light of this, we will make the following modifications to our process with immediate effect: a) Undertake a review of the current Exit Questionnaire b) Ensure all leavers are offered an Exit Interview and actively encouraged to take up the offer c) Actively offer leavers who did not take up the opportunity of an exit interview, to complete the exit questionnaire post exit and return to the People team.	Head of People and OD / March 2021

Finding 2 - Office Layouts (Control design)	Risk
The March 2020 version of the corporate risk register included a high scoring risk around the use of the physical space within Ty Dysgu and how it may be working against the integration of staff. The mitigating control referred to the need to review the office layout. During a debrief meeting we were informed that a number of office moves did take place prior to the offices closing due to the Covid-19 pandemic. These moves included amongst other things, splitting the Executive team across a number of floors. Management have recognised that the risk register should have been updated to reflect the changes that had occurred and the fact they that felt a complete review was no longer deemed necessary. We acknowledge that since being initially included on the risk register, there has been some relocations within the office and more recently the closure of the office and the move to home working. However, as the office has re-opened albeit on a limited basis, it may be an opportune time to ensure that use of the physical space at Ty Dysgu is used to continually improve the integration of staff and foster a healthy workplace culture.	Use of the physical office space at Ty Dysgu does not encourage a healthy workplace culture.
Recommendation	**Priority level**
Where actions are taken to mitigate against recorded risks, the risk register should be updated accordingly.	**Low**

The use of physical space at Ty Dysgu should continue be reviewed to determine whether it could be used to further improve the integration of staff and develop a healthy workplace culture.	
Management Response	**Responsible Officer/ Deadline**
The recommendation is noted. We had already taken action, prior to the closure of TY Dysgu, to 'mix up' the teams between floors and also taken steps to preserve staff areas for staff use rather than for business. The importance of updating the risk register with the latest information has been reinforced with our teams. It is our intention to keep the use of our physical space under review in line with health and wellbeing, exemplar practices, biodiversity and also the legacy of the covid pandemic which has changed substantially our operating model. Work has been undertaken to plan for a phased return once national guidance permits, this has included a review of accommodation and workstations, as well as use of meeting space in the context of a blended operating model.	Assistant Director of Planning and Corporate Services / Completed

Finding 3 - Organisational Structure (Operating effectiveness)	Risk
HEIW came into being as a Special Health Authority in October 2018 and at the end of August 2020 had 435 staff in post. The March 2020 version of the corporate risk register contained an action to review the organisation's structures one year on to ensure they support integrated working. Therefore, this review should have been undertaken around October 2019. At the time of our audit fieldwork, this review did not appear to have taken place. However during our debrief meeting we were informed that due to incremental changes that have taken place over the course of the first year, such as realignment of responsibilities of the Director of Finance and Corporate Services role and the creation of new posts both within the Executive Team and at other levels within the organisation, there is no longer deemed to be a need for a wholesale review of structure. Again, management recognised that the risk register should have been updated to reflect this.	The organisational structure is not optimised to support integrated working.
Recommendation	**Priority level**
Where actions are taken to mitigate against recorded risks, the risk register should be updated accordingly. Ongoing reviews of the organisational structure should take place to ensure it remains the most appropriate structure for the organisation.	**Low**

Management Response	Responsible Officer/ Deadline
The recommendation is noted. The realignment of Director of Finance and Corporate Services function resulted in the appointment of two new Executive positions, a Director of Digital and a Director of Planning and Performance. Reviews are ongoing across directorates and teams, as part of our annual planning process and in response to changing demands and expectations. This is part of the normal evolution for any organisation in its early years and also best practice. The importance of updating the risk register with the latest information has been reinforced with our teams.	Head of People and OD / Completed

Finding 4 - Policies and procedures (Operating effectiveness)	Risk
HEIW has adopted a number of All Wales policies that support the procedure for NHS staff to raise concerns, in particular the Dignity at Work Process, Grievance Policy and Disciplinary Policy, and these are published on the HEIW website. However, we note that the documents were due for review in September 2017, March 2019 and March 2020 respectively.	Policies and procedures provide out of date or inappropriate guidance to staff.
Recommendation	**Priority level**
Acknowledging that the Dignity at Work Process, Grievance Policy and Disciplinary Policy are All Wales procedures, HEIW should establish when they are due for review and ensure that the versions they have adopted remain fit for the organisation's needs. Where necessary, and if an All Wales review is not imminent, updates should be made.	**Low**
Management Response	**Responsible Officer/ Deadline**
This recommendation is noted. HEIW is part of NHS Wales and subject to all-Wales agreements including in respect of the policies covered in this recommendation. We have no authority to move away from all-Wales policies. HEIW is currently leading conversations across NHS Wales on the establishment of a new Respect and Resolution policy working in partnership with Trade Union colleagues. If approved, this will supersede Disciplinary, Grievance and Dignity	Head of People, & OD and Assistant Director of OD / To ratify new all-Wales policy within 1 month of national agreement being secured.

at Work policies on an all-wales basis. We would look to adopt this new policy, through our internal processes, as soon as it's ratified nationally.	

Finding 5 - Executive team and Board Chair training (Control design)	Risk
In accordance with the procedure for NHS Staff to Raise Concerns, the Chief Executive, Board Secretary, Executive Directors and Chair of the Board have responsibility for dealing with concerns escalated to them should the line manager be deemed not appropriate. It was unclear during our review whether the executive team and independent members have received any training in the handling of issues raised by employees.	Concerns raised by staff are handled inappropriately.
Recommendation	**Priority level**
HEIW should consider / determine whether the Executive Team and Board Chair require any specific training to deal with concerns raised by staff.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Board has regular 'development' days. Legal and Risk Services Team of the Shared Services Partnership (NWSSP) provided training on Upholding Professional Standards to Board and Executive on 19th December 2019. Training on the Raising Concerns policy and procedure for Board and Executive is currently under discussion with Legal Risk Team. The date to be confirmed.	Board Secretary and Leadership and OD Practitioner / April 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** 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.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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

Governance Arrangements during Covid-19 Pandemic Follow Up

Advisory Review Final Report

2020/21

Health Education and Improvement Wales

Audit and Assurance Services

Contents

Review reference:	HE2021.13
Report status:	Final
Fieldwork commencement:	15 February 2021
Fieldwork completion:	26 February 2021
Final report issued:	8 March 2021
Auditors:	Paul Dalton, Head of Internal Audit Ken Hughes, Audit Manager
Executive sign off:	Eifion Williams, Interim Director of Finance Dafydd Bebb, Board Secretary
Distribution:	Executive Board
Committee:	Audit and 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 the course of 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 Internal Audit Charter and the Annual Plan, approved by the Audit and 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, 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.

1. INTRODUCTION

The NHS in Wales continues to face unprecedented pressures in planning and providing services following a third wave of the Coronavirus pandemic, the most severe to date, which peaked at the beginning of 2021.

At the time of this follow-up report, the number of cases of Covid-19 in Wales is again in decline and almost a million people in Wales have received a first dose of an approved coronavirus vaccine. However, case levels are still high and Wales remains in lockdown, with the emergence of virus mutations posing a significant threat to the easing of restrictions.

Our rapid advisory review was undertaken during the summer of 2020, following the first peak of the pandemic. The work was carried out at the request of the All Wales Finance Directors' group and we assessed the adjusted financial and overall governance arrangements that were put in place to enable health organisations to maintain appropriate governance whilst enabling senior leadership teams to respond to the rapidly developing emergency.

We issued our original report to HEIW in September 2020. Our report suggested a number of priorities for the organisation to consider going forward. These were reviewed by HEIW and a management response document was provided to the Audit and Assurance Committee in October 2020.

This follow-up review has sought to verify the actions taken by the organisation in response to our rapid advisory, and where appropriate documentary evidence has been obtained.

2. EXECUTIVE SUMMARY

Our follow-up work has confirmed that HEIW has implemented almost all the priorities suggested in our rapid advisory review.

The crisis and business continuity plan had been refreshed and updated, and the membership of the Crisis Management Team (CMT) had been streamlined. The Board has approved one additional independent member to both the Audit and Assurance Committee, and the Education, Commissioning and Quality Committee.

In addition, Board meetings are now streamed live via the Zoom platform, and are accessible, free of charge, to members of the public. Training sessions on the use of the Zoom platform had been provided to the Executive Team and Independent Members, and this has been supplemented with guidance. Board meetings are now recorded and should be available on the HEIW website for anyone to watch back, however at the time of our audit the recordings were not available.

New 'Working from Home' guidance has been produced, and this has been made available to all staff via Sharepoint.

The table in Appendix 1 sets out our original suggestions, HEIW's responses to them and the current position.

Appendix 1: Detailed Findings and Evidence

IA suggested considerations	HEIW Comments	Follow up Action
Board and Committee Meetings		
Refreshing the crisis and business continuity plan to ensure lessons learned and experiences can be incorporated.	The revised BC Plan is in final draft stage and will be taken through the Executive Team for approval in October.	The Executive Team approved the updated version of the Crisis and Business Continuity Plan in October 2020.
If an additional 'standby' independent member approach is to be maintained, the terms of reference of the committees should be updated to reflect this.	At September Board HEIW increased the membership of the Audit and Assurance Committee and the Education Commissioning and Quality Committee with the aim of improving the capacity and resilience of these committees.	The Board approved the addition of one independent member to both the Audit & Assurance Committee and the Education, Commissioning & Quality Committee at their September 2020 meeting.
Investigate the feasibility of offering 'freephone' dial-in access numbers for members of the public who may not have access to suitable conferencing technology.	Internal Audit have agreed to review the approach of other organisations on 'freephone' dial and revert to HEIW with further information.	The original idea to offer free access to the public was taken from a best practice note. The overarching principle was to provide full transparency to the public, irrespective of whether they had access to the internet. Under the current arrangements, Board meetings are streamed live on Zoom, and members of the public can listen to the live meeting. The latest version of Zoom is also available to download (for free) from the HEIW website. Further to discussions with

IA suggested considerations	HEIW Comments	Follow up Action
		IA colleagues, the provision of 'freephone' dial in access is not now considered feasible, but IA consider that the action taken satisfies the spirit and intention of our original suggestion.
Investigate the feasibility of recording committee sessions (most videoconferencing software has this functionality), including written chat - this should help with recording accurate minutes (by reviewing the recording). HEIW should also consider making this recorded session available to the public to view post-meeting.	The July and August Board were livestreamed via the Zoom platform. This requires significant resource and in line with other NHS organisations we do not have current plans to extend this to Committees. The Open Board meeting and AGM in September were recorded and the recordings have been placed on the website. We will explore this capability further.	The January 2021 Board meeting was livestreamed via the Zoom platform, and members of the public were able to join the open session aspects of the meeting as observers. The January 2021 open Board meeting was also recorded. However, the recording, and those of previous Board meetings are not available on the HEIW website at the current time.
Ensure all members and participants are suitably trained or offered training to make the best use of conference software.	All members have received appropriate training when moving to new platforms for holding virtual meetings.	Training sessions on the use of the Zoom platform were provided to the Executive Team and Independent Members in July 2020. The training was supplemented by guidance documents.

IA suggested considerations	HEIW Comments	Follow up Action
To clearly set out the etiquette arrangements at the start of each meeting, such as muting microphones when not in use, or the process for raising questions.	Chair's outline basic etiquette for Board and Committee meetings at the beginning of meetings.	During our attendance at Audit & Assurance committees and Board meetings, we have observed the etiquette requirements being outlined.
SORD and Decision Making Arrangements		
The effectiveness of the CMT, and in particular the number of members, should be reviewed to ensure decision making is as efficient and streamlined as possible.	At the peak of the crisis there were approximately 30 participants on the CMT, which was good for communication. However, on reflection, HEIW feels that a smaller, discrete group would benefit critical decision making, whilst engaging others where needed.	The membership of the Crisis Management Team (CMT) is set out within the Crisis and Business Continuity Plan. This was updated following the first wave of the pandemic and approved by the Executive Team in October 2020. It now limits the membership of the CMT to 10 senior staff.
Covid-19 Expenditure		
Financial codes could be set up within the financial system specifically to record Covid-19 related expenditure. This approach was commonly taken by other health organisations.	As spend wholly related to Covid 19 is at a low level within HEIW and we are able to identify and report it without specific financial codes we have not set them up. We do however understand that specific financial codes would be useful should the level of	We were informed by the Head of Financial Accounting that although consideration has been given to setting up financial codes specifically for Covid-19 related expenditure, to date this has not been necessary due to the low values involved.

IA suggested considerations	HEIW Comments	Follow up Action
	spend increase or it be indistinguishable from other expenditure.	
Budget and Savings		
Management should consider the impact of Covid-19 on the financial statements for 2020/21 so that if any adjustments are necessary, these can be identified and made in a timely manner.	We will consider the impact of Covid-19 in preparing the financial statements for 2020-21.	We were informed by the Head of Financial Accounting that there has been a minimal impact on the financial statements for 2020/21, and to date only two adjustments have been necessary: a reduction to the nursing budget due to the delay in starting courses and an increase in the year-end annual leave accrual estimate.
Information Governance		
The need to maintain privacy in the household when using video conference / telephone call or other applicable work from other household members.	HEIW will create a guidance document for staff by November to create awareness of the privacy risks around remote working. This will include information on data protection and cyber security risks and tips for mitigating these.	We were informed by the Board Secretary that 'Working from Home' guidance has been produced and made available to all staff. The Information Governance Manager initially placed the information as a blog in the news item section on the intranet, and then placed it in the information governance folder on the intranet so that staff could reference the document later.
Ensuring that laptops are locked when not in use or when staff are away from their desk. This is even more important in a public environment if agile working is to be promoted, for example, at a coffee shop. Consideration could		

IA suggested considerations	HEIW Comments	Follow up Action
be given to reducing the screen lock functionality within Windows.		
How physical copies of information are held and how they should be securely stored away from other household members or visitors.		
The risk that staff using their own devices at home are potentially more susceptible to malware / phishing attacks, as they may have insufficient security on their phones or home computers. This is likely to be more relevant with staff able to access the OneDrive / Office 365 with just an internet connection from any device.		

Audit and Assurance Services
South Central Team
First Floor
Woodland House
Maes-Y-Coed Road
Cardiff
CF14 4HH

Contact Details:

Paul Dalton, Head of Internal Audit - Paul.Dalton@wales.nhs.uk
Ken Hughes, Audit Manager - Ken.Hughes@wales.nhs.uk

Dyddiad y cyfarfod	**Ebrill 2021**	**Eitem ar yr Agenda**	**2.2.4**
Teitl yr Adroddiad	**Archwilio Mewnol – Cynllun blynyddol**		
Awdur yr Adroddiad	Archwilio Mewnol		
Noddwr yr Adroddiad	Pennaeth Archwilio Mewnol		
Cyflwynwyd gan	Archwilio Mewnol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Amlinellu'r rhaglen waith arfaethedig ar gyfer 2021/22		
Materion allweddol	Amlinellu'r rhaglen waith arfaethedig ar gyfer 2021/22		

Cam Penodol i'w Gymryd *(✓un yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓

Argymhellion	Amherthnasol

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

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Internal Audit Plan 2021/22

March 2021

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents **Page**

1. Introduction

This document sets out the Internal Audit Plan for Health Education and Improvement Wales (HEIW or the 'organisation') in 2021/22 ('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.

As a reminder, 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, 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's 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 2021/22. 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.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit 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;
- quantification 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 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 the Covid-19 pandemic. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and operational plan within a longer-term framework

and other changes within the organisation, assurance 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 and Assurance Committee in line with the Internal Audit Charter.

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

In addition, we are also aiming to 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) Annual audit work - areas where annual audit work will support the most efficient and effective delivery of an annual opinion. These cover 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 where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register 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.

We recognise that there is a need to audit in a more agile way and to this end we have agreed with some organisations to plan this component of the work on a half-yearly rather than annual basis (the two half year elements making an annual plan). While we have agreed a full annual programme of work at this stage, we have suggested a review of the programme of work midway through the year to ensure that it remains focused on the right areas of the organisation.

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); Digital Health and Care Wales; Welsh Health Specialised Services Committee (WHSSC); and Emergency Ambulance Services Committee (EASC).

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; thus, we have considered the following:

- a review of HEIW's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the organisation's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its committees (in particular the Audit and Assurance Committee and the Quality, Safety and Improvement Committee);
- key strategic risks identified within the strategic risk register and assurance processes;
- 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 NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS);
- work undertaken by other review bodies including Audit Wales; and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

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, Director of Finance, Director of Planning, Performance and Corporate Services, the Interim 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 the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

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, potential for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2021/22

The Plan is set out in Appendix A and identifies the audit assignment, lead officer, outline scope, and proposed timing.

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

Audit coverage, in terms of Information Governance and IT Security will be delivered by our IM&T Team.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and rolling 3-year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

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 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 and Assurance 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

Internal Audit has the necessary resources to deliver the agreed programme through both the local audit team and access to specialist resources.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

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

The Public Sector Internal Audit Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the organisation is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and will need to be negotiated separately.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2021/22 and:

- approve the Internal Audit Plan for 2021/22;
- 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

Audit Ref.	Area of focus	Strategic and corporate risks reference	Timing	Key officers	Outline scope
1. Annual Audit Work					
1	Annual Governance Statement (AGS)	-	Q1	Board Secretary	• Provide 'sense check' of the AGS and narrative from Internal Audit annual report to be included in AGS. Note Internal Audit work in this area is no longer mandated by Welsh Government.
2	Risk management	SR1-9	Q4	Board Secretary	• To consider how risk is captured and escalated through the organisation. Focus on specific areas to be agreed. • We will also follow strategic risk through into a directorate to consider operational consideration of strategic risks.
3	Financial process	SR6	Q2	Dir of Finance	• Financial planning within the IMTP – To consider if the process of drafting and costing information for the IMTP is collated and flows into the financial planning process.
4	Performance and governance arrangements	-	Q4	Dir of Planning, Performance and Corp. Services	• To consider governance and performance arrangements of an area of the organisation not previously looked at by IA. To consider alignment of outcomes to measures. Area of focus to be agreed.

Audit Ref.	Area of focus	Strategic and corporate risks reference	Timing	Key officers	Outline scope
2. Organisation Based Work					
5	Project and programme management	-	Q3	Dir of Planning, Performance and Corp. Services	• Governance arrangements for projects and programmes across the organisation. To consider if there is good practice that could be shared between individual projects.
6	Integrated planning arrangements	-	Q2	Dir of Planning, Performance and Corp Services	• To consider how finance, workforce and performance are integrated during HEIWs annual planning process.
7	IG Toolkit	SR4 SR7 CRR4	Q1	Dir of Digital	• Based on English IGTK tool kit, co-ordinated by NWIS. Validation and review of action plan.
8	Strategic readiness for digital	-	Q3	Dir of Digital	• To assess the organisations position and preparedness to maximise its use of digital resources for service delivery.

Audit Ref.	Area of focus	Strategic and corporate risks reference	Timing	Key officers	Outline scope
9	MARS: Appraisal system	CRR4	Q2	Medical Director	• To consider the controls in place including sign-off by appraisers. Possible focus on medics as mindful of pilot projects in other areas.
10	Training programme directors	CRR4	Q4	Medical Director	• Following the implementation of the new approach to consider consistency, quality and monitoring and reporting of sessions purchased from health boards.
11	Bursary system	CRR15	Q3	Dir of Nursing	• Following the revised (streamlined) process put in place in 2020/21 to consider how the improvements and benefits of the scheme have been captured and learning for the implementation of the role out to Allied Health Professionals, midwives and health care scientists.
12	Recruitment	SR1 SR2 CRR1	Q1	Dir of Workforce & OD	• To consider the timeliness of approach and forward planning. Consideration of capacity and capability within teams. Are the right people in the right place. If recruiting for projects have the wider implications been considered, such as the need for support staff.
3. Follow up					
-	Internal Audit Tracker	-	-	-	• To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.

Audit Ref.	Area of focus	Strategic and corporate risks reference	Timing	Key officers	Outline scope
4. Work Agreed with Board Secretaries/Directors of Finance/Other Executive Peer Groups					
To be determined.					
5. Audits undertaken at other bodies					
-	Purchase to pay	-	-	-	• Audit undertaken at NWSSP of non-pay expenditure controls.
-	Payroll	-	-	-	• Audit undertaken at NWSSP of pay expenditure controls.
Other activity					
-	Audit management and reporting	-	-	-	• Includes follow up work, attendance at Board and committees, liaison with officers and external partners, annual planning process and annual reporting process.

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2021/22
Audit plan 2021/22 agreed/in draft by 30 April	✓	100%
Audit opinion 2020/21 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	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 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Health Education and Improvement Wales

INTERNAL AUDIT CHARTER

March 2021

Contents

1 Introduction

1.1 This Charter is produced and updated regularly 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 and Assurance 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 and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control[1]. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

---

[1] *Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls*

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 advisory service specifically to help management improve the organisations 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 advisory 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 is 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 and Assurance Committee and Accountable Officer.

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

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and 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.

3.3 Whilst 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 Public Sector Internal Audit 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 and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health 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 and Assurance 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 and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit and Assurance 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 e.g. Quality & Safety Committee.

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 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.

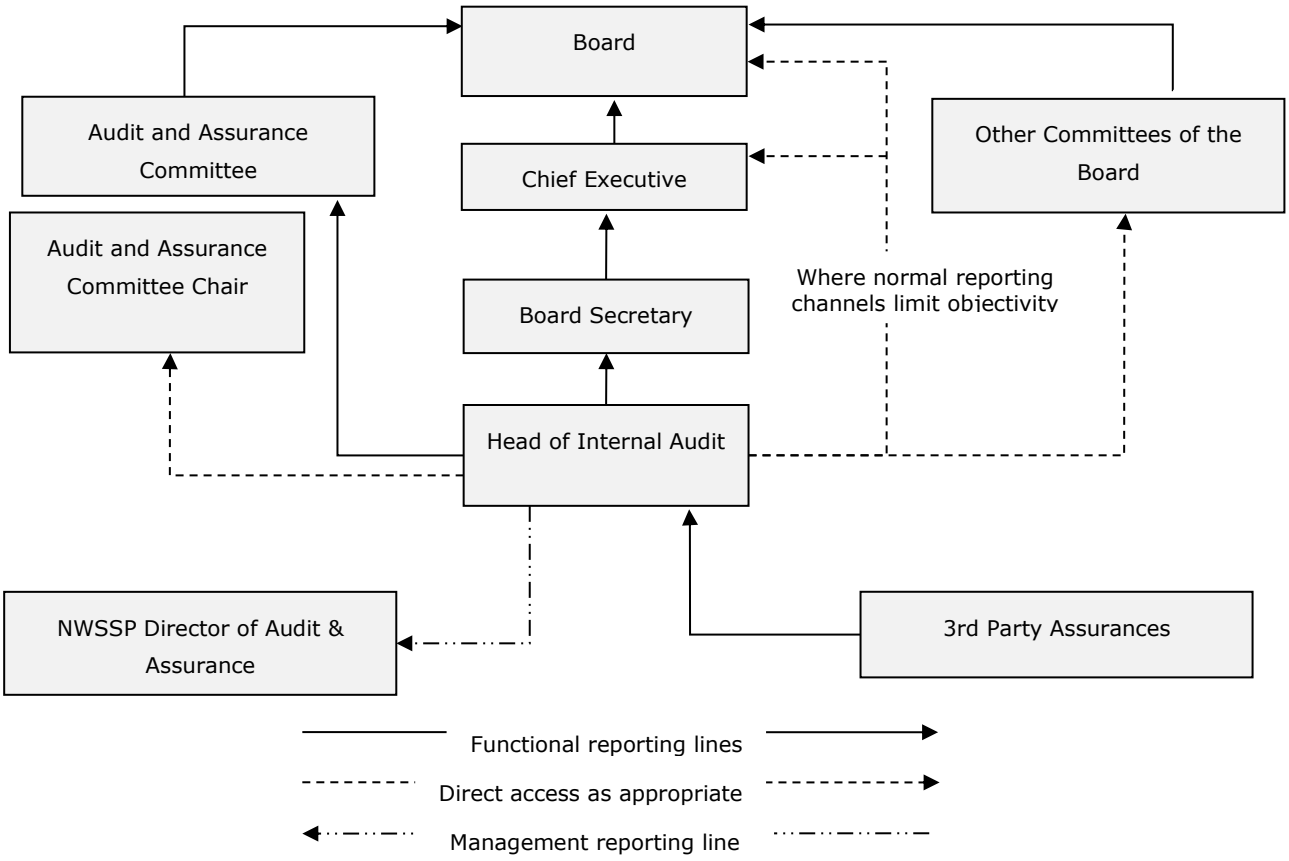
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

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, e.g. the NHS Wales Shared Services Partnership, WHSSC, EASC and NWIS (NWIS becomes a Special Health Authority called Digital Health and Care Wales from 1st April 2021).

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.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit and Assurance Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



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 2019) and associated performance standards agreed with the Audit and Assurance 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 and Assurance 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 and Assurance Committee or management, this may include areas of concern identified in the corporate risk register;
- Monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- Ensuring effective co-ordination, as appropriate, with external auditors; and
- Reviewing the Governance, Leadership & Accountability assessment and 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 and Assurance 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 services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

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 2 below:

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	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 NWSSP on behalf of NHS Wales.

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 Public sector Internal Audit Standards and facilitate:

- The provision to the Accountable Officer and the Audit and Assurance 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 and Assurance 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.

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. The key stages in this risk-based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach

9 Reporting

9.1 Internal Audit will report formally to the Audit and Assurance 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 process for arriving at the appropriate assurance level for each Head of Internal Audit opinion is subject to a review process and was last updated in 2020/21.
- 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 and Assurance 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 and Assurance Committee requirements; and
- The Audit and Assurance 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.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Annex A:

- 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 Annex A. 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 and Assurance 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 and Assurance 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 and Assurance Committee where no management response is forthcoming;

- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit and Assurance 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.

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 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 Audit and Assurance 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 and Assurance 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 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 and Assurance Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
March 2021

Charter Annex A **Audit Reporting Process**

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with operational management to check accuracy of understanding and help shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports are issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management Leads and copied to the relevant Executive Leads.
Management responses are provided on behalf of the Executive Lead within 15 working days of receipt of the draft report.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15-day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to the Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive.
Individual audit reports received by Audit and Assurance Committee.	Final reports are received by the Audit and Assurance Committee at next available meeting and discussed if applicable. In addition to the formal follow up of 'no and 'limited' assurance reports, the Audit and Assurance Committee identifies their priority areas for Internal Audit to follow up.

Charter Annex B **Audit Assurance Ratings**

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** 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.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Office details:

Audit and Assurance Services,
Woodland House,
Maes y Coed Road,
Cardiff,
CF14 4HH

Contact details:

Paul Dalton (Head of Internal Audit) – 02920 83 65 65

Dyddiad y cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.3**
Teitl yr Adroddiad	**Adroddiadau Archwilio Cymru**		
Awdur yr Adroddiad	Anne-Marie Harkin, Clare James, Helen Goddard		
Noddwr yr Adroddiad	Eifion Williams a Dafydd Bebb		
Cyflwynwyd gan	Clare James		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Adroddiadau Archwilio Cymru: • Adroddiad Cynnydd • Cynllun Archwilio Blynyddol 2021 a Ffi Archwilio • Ei Wneud yn Wahanol, Ei Wneud yn Iawn?		
Materion allweddol	Cyflwyniadau gan Archwilio Cymru: • Adroddiad Cynnydd • Cynllun Archwilio Blynyddol 2021 a Ffi Archwilio • Ei Wneud yn Wahanol, Ei Wneud yn Iawn?		

Cam Penodol i'w Gymryd *(✓un yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
			✓	

Argymhellion	Gofynnir i'r aelodau nodi'r tri adroddiad.

Archwilio Cymru
Audit Wales

Audit and Assurance Committee Update – Health Education and Improvement Wales

Date issued: March 2021

Document reference: HEIWAACU202103

This document has been prepared for the internal use of Health education and Improvement Wales as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

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).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021.

Exhibit 1 – Accounts audit work

Area of work	Current status
Annual Accounts 2020-21	**Ongoing** Quarterly meetings with the Chair, Chief Executive and Chair of the Audit and Assurance Committee have continued throughout the period. **Planning** We have completed our audit planning and risk assessment for 2020-21 annual accounts and present the final plan to you at this Committee. **Interim Audit** We have completed our interim audit testing with no significant issues to report. **Final Audit** Our final audit commences 4 May following receipt of the unaudited accounts on 30 April.

Performance audit update

3 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
Structured Assessment 2021 Executive Lead: Dafydd Bebb	Structured assessment continues to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The work is in two phases. Phase 1 - examines the effectiveness of operational planning arrangements when NHS bodies continue to respond to the pandemic and to recover and restart services. Phase 2- examines how well NHS bodies are embedding sound arrangements for corporate governance and financial management, as well as drawing on lessons learnt from the initial response to the pandemic.	Phase 1 – evidence gathering complete, report drafting underway. Phase 2 – scheduled to start in May.
2020 Local Project: Review of Commissioning	Review of the Education and Training annual commissioning cycle	Project Brief being drafted

Exhibit 3 – Planned work not yet started

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
2021 Local Project	To be confirmed	Not yet started

Good Practice events and products

4 In addition to the audit work set out above, 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.

5 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 help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

6 **Exhibit 4** outlines the Good Practice Exchange (GPX) events which have been held since the Committee last met. Materials are available via the links below. Details of future events are available on the GPX website

Exhibit 4 – Good practice events and products

Event	Details
Mental Health and Wellbeing During Covid-19	At a webinar In December 2020, public services shared how they adapted services during the pandemic, as well as successes and challenges.

NHS-related national studies and related products

7 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.

8 We have published two NHS-related or relevant national studies reports since we last provided the Committee with an update. **Exhibit 5** provides information on these reports.

Exhibit 5 – NHS-related or relevant national studies reports

Title	Publication Date
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Doing it differently; doing it right? Governance in the NHS During the COVID-19 Crisis – Key Themes, Lessons, and Opportunities	January 2021
Procurement and supply of PPE during the COVID-19 pandemic	December 2020
Web-based **data-tool** that set out NHS Wales' financial position and expenditure on COVID-19 up to the end of September 2020.	November 2020

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

2021 Audit Plan – Health Education and Improvement Wales

Audit year: 2020-21

Date issued: March 2021

Document reference: 2343A2021-22

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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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.

Contents

2021 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2021 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 continues to have an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 Audit Wales staff will continue to work pragmatically to deliver the audit work set out in this plan. In response to the government advice and subsequent restrictions, we will continue to work remotely until such time that it is safe to resume on-site activities. I remain committed to ensuring that the work of Audit Wales staff will not impede the vital activities that public bodies need to do to respond to on-going challenges presented by the COVID-19 pandemic.

4 This audit plan sets out an initial timetable for the completion of my audit work. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Audit of financial statements

5 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. 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 your Annual Governance Statement and other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

6 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.

7 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.

8 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.

9 There have been no limitations imposed on me in planning the scope of this audit. My audit planning work is now complete. This document replaces the 2021 Audit Plan (Indicative) presented to the Audit and Assurance Committee on 18 January 2021.

Audit of financial statement risks

10 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	
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.	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.
The COVID-19 national emergency continues and the pressures on staff resource and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.

Financial audit risks	Proposed audit response
Other areas of audit attention	
Under the terms of the NHS Wales, student bursary scheme students are required to commit to working in NHS Wales for two years after completing their course. Where an individual does not meet this condition, they are required to repay a proportion of the bursary. 2020-21 is the first year in which the recovery process applies. The financial amounts are not material currently, but there is a risk that the transactions could be incorrectly recorded within the financial statements.	We will discuss your processes for the recovery of the bursary and proposed accounting treatment to ensure it adheres to applicable accounting and disclosure standards and the NHS Manual for Account.

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. **Exhibit 2** sets out my current plans for performance audit work in 2021.

Exhibit 2: My planned 2021 performance audit work at the SHA

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. The plans for 2021 structured assessment work reflect the ongoing arrangements of NHS bodies in response to the

Theme	Approach/key areas of focus
	COVID-19 emergency. My 2021 work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic, and to recover and restart services. Building on last year's work, Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.
Locally focused work	Where appropriate, I will also undertake thematic performance audit work that reflects issues specific to the SHA. The precise focus of this work will be agreed with executive officers and the Audit Committee and will be reflected in the regular updates that are produced for the Audit and Assurance Committee.
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. Expectations on the implementation of previous audit recommendations will be adjusted as appropriate to take account of the impact on COVID-19.

13 Although not directly applicable to the SHA, we also intend to undertake All Wales thematic reviews of unscheduled care arrangements, and COVID-19-related output work. Our findings from these reviews will be made available on the Audit Wales website.

14 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with you, are set out in **Appendix 1**.

Fee, audit team and timetable

15 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];
- 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

16 Fee rates for 2021 are unchanged from last year. The estimated fee for 2021 is set out in **Exhibit 3** and remains unchanged from your actual 2020 fee. Please note that this proposed fee currently remains subject to final moderation by the Auditor General.

Exhibit 3: audit fee

Audit area	Proposed fee for 2021 (£)[2]	Actual fee for 2020 (£)
Audit of Financial Statements	**85,500**	**85,500**
Performance audit work:		
• Structured Assessment	49,500	49,500
• Local projects	30.500	30.500
Performance work total	**80,000**	**80,000**
Total fee	**165,500**	**165,500**

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

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

17 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 Director of Finance.

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

Audit team

19 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
Ann-Marie Harkin[3]	Audit Director (Financial Audit), and Audit Wales Engagement Director for the SHA	07967 321350	ann.marie.harkin@audit.wales
Dave Thomas	Audit Director (Performance Audit)	07798 503064	dave.thomas@audit.wales
Helen Goddard	Audit Manager (Financial Audit)	02920 320642	helen.goddard@audit.wales
Clare James	Audit Manager (Performance Audit)	07837 384617	clare.james@audit.wales
Helen Williams	Audit Lead (Financial Audit)	02920 320708	helen.williams@audit.wales

[3] Due to an internal promotion, there will a change to the Engagement Director which is yet to be confirmed

20 We can confirm that team members are all independent of you and your officers. In addition, we are not aware of any potential conflicts of interest that we need to bring to your attention.

Timetable

21 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.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2021 Audit Plan (indicative) 2021 Audit Plan	December 2020 to January 2021 February 2021	January 2021 March 2021
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum	March to June 2021	June 2021 June 2021 July 2021
Performance audit work: • Structured Assessment • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	
2021 Annual Audit Report	September to November 2021	November 2021

Appendix 1

Performance audit work in last year's audit plan still in progress

The following table summarises the status of the audit work in last year's audit plan which is still in progress.

Exhibit 6: Performance audit work still in progress.

Performance audit project	Status	Comment
Local project on HEIW's Education and Training commissioning cycle	Scoping	We have discussed proposals for this project with the SHA and will be providing a project brief shortly.

Appendix 2

Other future developments

Forthcoming key IFRS changes

This table details the key future changes to International Financial Reporting Standards.

Exhibit 7: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	1 April 2022	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2023-24 at earliest	IFRS 17 replaces IFRS 4 *Insurance Contacts*, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Good Practice Exchange

Audit Wales' Good Practice (GPX) helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. This year the work has focused on COVID-19 learning. Further information on this can be found our website.

Brexit: The United Kingdom's future outside the European Union

The United Kingdom left the European Union on 31 January 2020 under the terms of the Withdrawal Agreement. Between then and 31 December 2020, the UK entered a transition period, during which it continued to participate in EU programmes and follow EU regulations. On 31 December 2020, the transition period ended, and a new relationship between the UK and EU started, on the basis of a new free trade agreement.

The new agreement means some substantial changes in the trading relationship between the UK and the EU. There will also potentially be changes in administrative areas previously covered by EU law. In the short term, the UK has incorporated EU rules into domestic law. However, it is likely than in some key areas, such as public procurement, agricultural support and state aid, the UK will seek to diverge over time. In changing these rules, there will be some important constitutional issues around the relationship between the UK Government and devolved governments.

The wider opportunities and risks for Wales' economy, society and environment will become clearer as public services move from managing the short-term risks, especially around disruption to supply chains, to adapting to a different relationship with the EU and the wider world. We are also awaiting further details on the UK Government's plans to replace EU funding schemes for regional development and rural development.

The Auditor General will continue to keep a watching brief over developments. In November, he wrote to the Chair of the External Affairs and Additional Legislation Committee setting out some observations on the latest position with respect to preparations for the end of the transition period. His letter can be found here. His previous report on public bodies Brexit preparations can be found here with his follow up on progress here.

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Doing it Differently, Doing it Right?

Governance in the NHS During the COVID-19 Crisis – Key Themes, Lessons, and Opportunities

January 2021

This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities with their own legal functions. Audit Wales is not a legal entity. Consequently, in this Report, we make specific reference to the Auditor General or Wales Audit Office in sections where legal precision is needed.

If you require this publication in an alternative format and/or language, or have any questions about its content, please contact us using the details below. We welcome correspondence in Welsh and English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Audit Wales
24 Cathedral Road
Cardiff
CF11 9LJ

Telephone 02920 320 500
Email info@audit.wales
Website www.audit.wales
Twitter @WalesAudit

Mae'r ddogfen hon hefyd ar gael yn Gymraeg

Contents

Summary

1 In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis to:

- sustain public confidence and trust;
- support agile and effective decision making;
- provide continued assurance to all relevant stakeholders; and
- facilitate post-crisis learning and recovery.

Governing during a crisis, therefore, is about doing it differently, but still doing it right.

2 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, all NHS bodies in Wales were required to adapt their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace.

3 Our structured assessment work this year provided a unique opportunity for us to see exactly how each NHS body adapted their governance systems, processes, and structures during the crisis to enable them to respond effectively to the numerous challenges and pressures posed by the pandemic.

4 We found that all NHS bodies operated effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a clear focus on core areas of business and governance.

5 This report provides an all-Wales summary of our structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

> In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis.
>
> I have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner.
>
> The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain the sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

Adrian Crompton
Auditor General for Wales

1. Introduction

1.1 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs - the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and, the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

1.2 Our structured assessment work[1] this year was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures posed by the COVID-19 crisis.

1.3 This report is the first of two publications which summarise the findings of our structured assessment work on an all-Wales basis with the aim of highlighting key themes, identifying future opportunities, and sharing learning both within the NHS and across the public sector in Wales more widely. This report focuses on how NHS bodies have governed during the COVID-19 crisis. Our second report will focus on how NHS bodies have supported the health and wellbeing of their staff during the pandemic, with a particular emphasis on the arrangements they have put in place to safeguard staff at higher risk from COVID-19.

1.4 In this report, we discuss the importance of maintaining good governance during a crisis and describe how NHS bodies in Wales operated differently during the pandemic in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

This reports also considers the key lessons that can be drawn from the experiences of NHS bodies of governing during the COVID-19 crisis and concludes by highlighting potential opportunities for the future.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied they have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

2. Maintaining good governance during a crisis

2.1 The systems, processes, and structures in place to maintain good governance are often placed under pressure when public bodies are reacting and responding to a crisis. This is understandable, as those systems, processes, and structures are largely designed to support and maintain good governance in normal times. In times of crisis, the challenge for public bodies is to adapt their systems, processes, and structures to ensure good governance is maintained and not weakened or overlooked in any way.

2.2 Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis for the following reasons:

- **Sustaining public confidence and trust** – public scrutiny is often greater during times of crisis. The public need to be assured that public bodies are responding appropriately in the public interest to the pressures and challenges they face during a crisis, and that any disruptions or changes to service provision or quality are managed, minimised, and communicated as much as possible. A failure to act in the public interest, to communicate effectively, and to maintain openness and transparency during a crisis could significantly weaken public confidence and trust in public bodies.
- **Ensuring the right decisions are made in the right way at the right time** – due to the uncertain, complex and dynamic nature of a crisis, leaders and managers need to be empowered to react and respond at pace. Agile and rapid decision making, therefore, are critical during a time of crisis. However, decision-making authority during a time of crisis needs to be clearly defined and communicated to ensure the right decisions are made by the right people in the right way at the right time. Furthermore, in the interests of openness, transparency, and accountability, decisions made during a time of crisis need to be documented accurately, accompanied by a clear rationale, and made available for inspection and scrutiny.

- **Providing continued assurance** – maintaining, and adapting where necessary, key internal controls is more necessary than ever during a time of crisis to assure stakeholders that all relevant risks are managed; that resources continue to be used efficiently and economically; and, that service quality and safety is maintained. The challenge, however, for those responsible for providing oversight and scrutiny of public bodies – both internally and externally – is not to overburden or distract leaders and managers whilst they are dealing with a crisis. Instead, the level of oversight and scrutiny should be proportionate and targeted to ensure the relevant stakeholders receive sufficient assurance over key matters during the crisis.
- **Supporting public bodies to build back better** – maintaining good governance during a crisis can support public bodies to transition effectively from the response phase of a crisis to the recovery phase by ensuring non-essential services, processes, and systems are reinstated and reintroduced in the right way at the right time. Good governance during a crisis can also support public bodies to 'build back better' by enabling them to capitalise on the opportunities created by a crisis for them to innovate, transform, and achieve greater resilience.

In short, therefore, governing during a crisis is about doing it differently, but still doing it right.

3. How health bodies governed differently during the pandemic

3.1 All NHS bodies quickly adapted their governance arrangements at the outset of the pandemic in line with their emergency plans and Welsh Government guidance.[2] The Welsh Government guidance, which was issued in May 2020, endorsed a series of principles developed by Board Secretaries which were designed to help focus consideration of governance matters during the response phase of the pandemic. The guidance also outlined key areas for the Quality and Safety Committees and Audit Committees of each NHS body to discharge during the period.

3.2 In this section, we briefly describe how NHS bodies governed differently during the pandemic, focusing in particular on their arrangements for putting citizens first, decision making and accountability, and gaining assurance.

Putting citizens first

3.3 All NHS bodies are expected to conduct their business in an open and transparent manner and actively encourage the engagement of their local populations, partners, and other stakeholders. This is achieved in a number of ways, including actively engaging partner organisations such as Community Health Councils, conducting board meetings in public, and making board and committee papers and minutes available for public inspection. However, NHS bodies have been unable to hold their meetings in public in the normal manner during the pandemic due to the need to observe social distancing guidelines and restrict public gatherings. As a result, they have been required to embrace new ways of working to maintain openness and transparency and to ensure effective engagement with all relevant stakeholders during the crisis.

3.4 We found that all NHS bodies moved swiftly to holding virtual board and committee meetings at the start of the pandemic. Although a small number of NHS bodies encountered some challenges rolling-out the necessary technology and software required to support virtual meetings, these were overcome relatively quickly. We found that all NHS bodies adapted well to virtual meetings, with participants observing suitable etiquette and using the relevant software features appropriately to ensure online meetings were conducted effectively.

2 Guidance Note: Discharging Board Committee Responsibilities during COVID19 response phase

3.5 In order to maintain openness and transparency during the pandemic, we found that NHS bodies have been using a range of different online video platforms to either live-stream or record all relevant meetings. Several NHS bodies also increased the frequency of their board meetings to provide greater public transparency on their response to the pandemic. In terms of facilitating public involvement in virtual meetings, we found that most NHS bodies have been able to support members of the public either to submit their questions in advance of a meeting or to ask their questions directly during the relevant meeting.

3.6 In addition to holding virtual meetings, we found that all NHS bodies continued to publish board and committee papers on their websites in advance of meetings. We also found that minutes of meetings were produced in a timely manner, with some NHS bodies publishing summary versions on their websites within a matter of days to enhance openness and transparency. In addition to publishing information on their websites, we found that all NHS bodies have also been making effective use of their official social media channels to provide information to the public and other stakeholders on a range of matters, including information relating to their revised governance arrangements.

3.7 We found that all NHS bodies established mechanisms to maintain regular communication with partners during the pandemic, such as Members of Parliament, Members of the Senedd, Local Authority Leaders and Chief Executives, Police Forces, Fire and Rescue Services, Community Health Councils, third sector organisations, and other health bodies within their regional footprint. In terms of Community Health Councils (CHCs), we saw examples of effective communication and joint working between some health bodies and their respective CHCs, such as:

- inviting CHC Chief Officers to participate in virtual board and committee meetings;
- sharing details of temporary services changes introduced during the pandemic with CHCs; and
- involving CHCs in quarterly operational planning arrangements, or consulting with them on draft operational plans prior to their submission to Welsh Government for approval.

Decision making and accountability

3.8 All NHS bodies are required to operate within a robust framework for decision making and accountability, which is largely codified in a series of governing documents such as Standing Orders, Schemes of Delegation, and Standing Financial Instructions. Collectively, these documents set out the arrangements within which the boards, committees, and the executive and operational structures of NHS bodies undertake their day-to-day activities, make decisions, and ensure accountability. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements and structures in order to respond strategically, tactically, and operationally to the challenges and pressures posed by the pandemic.

3.9 We found that the majority of NHS bodies agreed temporary revisions to their Standing Orders to enable and facilitate new ways of working during the crisis; to ensure a focus on essential business and key COVID-19 related risks and matters; and, to minimise the administrative and reporting burden placed on leaders and managers during the pandemic. Whilst each body revised their Standing Orders to meet their own individual business needs and circumstances, we found some common temporary changes, including:

- standing down some board committees;
- redistributing essential committee business and postponing non-essential business;
- creating provision for streamlined agendas, including the use of a consent agenda[3] in some bodies;
- enabling focused reporting, including greater use of verbal reporting; and
- allowing Independent Members to submit questions and comments on papers in advance of board and committee meetings.

Revisions to Standing Orders were also made to enable the changes discussed previously relating to virtual meetings and public participation during the pandemic. We found that boards and committees adapted well to these new ways of working, with Independent Members continuing to provide effective scrutiny and challenge within the streamlined and virtual meeting environment.

3 A consent agenda is a technique for addressing and approving several matters in a single agenda item, such as reports, minutes, and other items that do not require discussion.

3.10 We found that all NHS bodies established formal command and control structures to enable rapid and agile decision making and ensure a coordinated response to the pandemic at a strategic, tactical, and operational level within their organisations. The command and control structures in most NHS bodies included Gold (Strategic) Groups, Silver (Tactical) Groups, and Bronze (Operational) Groups, underpinned by planning cells with responsibility for specific aspects of the response, such as securing and distributing personal protective equipment for example. All NHS bodies also had clear deputising arrangements in place to ensure resilience, responsiveness, and continuity as required.

3.11 We found that most command and control structures operated within existing frameworks for decision making. However, some NHS bodies needed to introduce temporary revisions to their Schemes of Delegation to ensure the relevant groups, managers and leaders were empowered to operate at pace during the pandemic. We found that most NHS bodies had clear arrangements in place for recording and documenting decisions, with some key decisions being published with the papers of board meetings to ensure openness and transparency.

3.12 All boards continued to meet during the pandemic, albeit virtually as noted earlier, thus allowing the corporate decision-making body of each organisation to maintain oversight of the response, hold the command structure to account, and make collective decisions on key matters during the crisis. Recognising the importance of reacting and responding at pace to the dynamic nature of the crisis, we found that each NHS body had suitable processes in place to enable Chair's actions on urgent matters. However, we found that Chair's actions were kept to a minimum and only used as a last resort in the majority of NHS bodies during the pandemic.

3.13 Some NHS bodies established temporary decision making and oversight groups involving Independent Members as part of their command and control structures. One body established a Cabinet, consisting of three Independent Members and three Executive Officers, to oversee the organisation's response and enable timely decision making and scrutiny. Another body established a Board Governance Group, which operated as a Chair's Action Group, to provide scrutiny and governance over the decision-making process as well as to provide assurance to the board that this was taking place. The membership of the Board Governance Group was restricted to the Chair, Chief Executive Officer, and two Independent Members.

Gaining assurance

3.14 All NHS bodies are required to establish and maintain a robust risk and assurance framework to ensure their boards and committees receive sufficient, timely, and reliable information that enables them to exercise good oversight of the management of risks, the quality and performance of services, and the efficient and effective use of resources. NHS bodies gain assurance from a range of internal and external sources, and report on the effectiveness of their arrangements to the public and other stakeholders via Annual Governance Statements and Annual Quality Statements. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements to ensure the flows of assurance to their boards and committees were timely, proportionate, and covered the relevant key issues during the pandemic.

3.15 We found that all NHS bodies adapted their risk management arrangements and considered their risk appetite during the pandemic. However, only some bodies decided to increase their risk appetite during the crisis. We found that some NHS bodies established stand-alone risk registers to capture, manage, and mitigate the key risks relating to COVID-19, whereas others adapted existing risk registers to incorporate COVID-19 related risks. We found that all NHS bodies had suitable processes in place to monitor and manage strategic, tactical, and operational COVID-19 risks through their command and control structures. However, we found there were variable approaches to the oversight of significant COVID-19 risks at board and committee level, with some NHS bodies not fully utilising their committees to review and scrutinise all relevant risks during the pandemic.

3.16 We found that the Quality and Safety Committee of each NHS body continued to meet during the pandemic, with some increasing the frequency of meetings to provide timely oversight and scrutiny. The majority of committees adjusted their work programmes in line with Welsh Government guidance to enable them to maintain a handle on core quality, safety, and experience issues, as well as to provide an increased focus on the impact of COVID-19 on the quality and safety of services. We saw evidence of good information flows to boards and committees to provide assurance and enable effective oversight and scrutiny on the relevant quality and safety matters during the pandemic. However, we found there was scope to strengthen these arrangements in a very small number of NHS bodies.

3.17 In addition to providing information and assurance to Independent Members via board and committee papers, we found that all NHS bodies used a range of different approaches and mechanisms to keep their Independent Members informed and engaged during the crisis, including:

- sharing daily situational reports which provided status updates across a range of COVID-19 related indicators;
- providing written and face-to-face briefings, either on a daily or weekly basis;
- using board development sessions to highlight and discuss topics relating to the pandemic;
- providing access to the papers of command and control group meetings, mostly Gold Command Groups and Silver Command Groups;
- enabling committee chairs to meet with the relevant executive leads on a regular basis; and
- establishing virtual groups for Independent Members on online and mobile communication platforms to enable them to communicate and share information with each other on an ongoing basis.

We also found that some NHS bodies created opportunities to build knowledge, understanding and resilience across its cadre of Independent Members during the pandemic by, for example, inviting them to observe committees they do not normally sit on.

4. Key lessons and opportunities for the future

4.1 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, NHS bodies were required to redefine their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace to meet their own business needs and circumstances. Indeed, the crisis demonstrated that NHS bodies are capable of operating effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a focus on core areas of business.

4.2 As they slowly move towards the full recovery phase and enter a post-pandemic world, NHS bodies should seek to reflect on their experiences of governing during the crisis by evaluating fully their revised arrangements in order to:

- consider what worked well and what did not work so well;
- identify what they would do differently during another crisis; and
- establishing which new ways of working introduced during the pandemic should be retained going forward to enhance their governance arrangements for the future.

We suggest this evaluation is undertaken as part of a wider formal programme of learning within each NHS body which enables them to reflect on all aspects of their response to the pandemic in a systematic and meaningful way. Indeed, we believe the sense of urgency and common purpose created by the crisis presents a unique opportunity for each NHS body to continue encouraging, embracing, and embedding innovation, transformation and learning in all aspects of their work going forward in order to enable them to truly become learning organisations.

4.3 In terms of governance specifically, we have identified several potential opportunities for the future:

- **Virtual meetings** – virtual meetings have proven to be an efficient and effective way of working and have also enabled boards and committees to maintain and, in some respects, enhance openness and transparency. Even when restrictions on public gatherings are lifted and social distancing rules are relaxed, we believe there is scope for NHS bodies to consider sustaining virtual meetings in some form particularly given their benefits and the level of investment that occurred during the pandemic to support and facilitate virtual working.
- **Effective and efficient meetings** – all NHS bodies adopted leaner and agile ways of working during the crisis which generated less bureaucracy and enabled more effective and efficient board and committee meetings to take place. For example, using more focused and organised agendas (such as consent agendas), keeping meetings as paper light as possible, and inviting Independent Members to submit questions in advance of meetings. The use of online video platforms also forced NHS bodies to think differently about the way they organised and structured their meetings to ensure they were run as effectively and efficiently as possible in a virtual environment.
  We believe there is scope for NHS bodies to consider retaining and refining some of these new ways of working to ensure meetings continue to be as effective and efficient as possible in a post-pandemic world.
- **Agile decision making** – one of the key features of governance during the crisis in each NHS body was the introduction of structures and processes that facilitated rapid and agile decision making. For example, clinicians were empowered to make swifter decisions about patient care within revised clinical and ethical parameters, and leaders, managers, and groups were given greater autonomy to make spending decisions. Whilst all of this was necessitated by the need to react and respond at pace to the crisis, we believe there is scope for NHS bodies to consider retaining and refining agile approaches to decision making to enable and facilitate innovation, transformation and learning on an ongoing basis in a post-pandemic world. However, to enable this, each NHS body would need to review and realign their individual risk appetites and be assured they have robust internal controls in place to minimise fraud and ensure high standards of probity.

- **Reshaping strategy** – NHS bodies have been operating within shorter planning cycles during the crisis to enable them to respond appropriately to the various operational challenges and risks posed by the pandemic. As NHS bodies slowly move towards the full recovery phase, there is both a need and an opportunity for them to review and reshape their vision and priorities to ensure they're appropriate for a post-pandemic world. Indeed, the crisis has enabled some NHS bodies to deliver their priorities in certain areas sooner than expected, such as rolling-out digital health and care. Furthermore, the crisis has also highlighted the need to ensure a greater focus in other areas, such as addressing health inequalities. Reshaping their strategies for a post-pandemic work will also enable NHS bodies to reframe their Board Assurance Frameworks and refocus their risk management arrangements.
- **Focused, targeted, and integrated assurance** – adopting more efficient and leaner ways of working has enabled NHS bodies to provide focused, targeted, and in some cases, integrated assurance to their boards and committees. This has been particularly true in the context of quality assurance, with many bodies combining operational, financial, and workforce issues with core quality, safety, and experience issues. In reshaping their vision and priorities, we feel there is scope for NHS bodies to also consider redesigning their governance structures and build upon existing arrangements to provide more integrated assurance to their boards and committees in future. However, in doing so, NHS bodies should ensure sufficient attention is given to each area of assurance embedded within an integrated framework.
- **Enhanced communication** – the crisis has undoubtedly facilitated greater communication between NHS bodies and their partners, as well as enhanced communication with and between Independent Members. The use of online video platforms and official social media channels has also enabled NHS bodies to ensure visibility, provide information, and maintain ongoing engagement with their local populations and communities. We feel there is scope for NHS bodies to maintain, and enhance where possible, new forms and ways of communication introduced during the pandemic to sustain collaboration, partnership working, and public engagement in the post-pandemic world.

4.4 In conclusion, NHS bodies have adapted well to the many challenges and pressures posed by the pandemic. We have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner. The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain that sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Dyddiad y Cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.4**
Teitl yr Adroddiad	**Ymholiadau Archwiliad Archwilio Cymru i'r rheini sy'n Gyfrifol am Lywodraethu a Rheoli**		
Awdur yr Adroddiad	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid		
Cyflwynwyd gan	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Rhyddid Gwybodaeth	Sesiwn Agored		
Pwrpas yr Adroddiad	Fel rhan o'r archwiliad o'r cyfrifon statudol, mae'n ofynnol i Archwilio Cymru (AW) adolygu'r trefniadau llywodraethu sydd ar waith yn Addysg a Gwella Iechyd Cymru (AaGIC). Er mwyn cyflawni'r cyfrifoldebau hyn, mae Archwilio Cymru wedi ysgrifennu at 'y rheini sy'n gyfrifol am lywodraethu a rheoli' yn AaGIC i ofyn am sicrwydd ynghylch nifer o feysydd penodol. Mae'r papur hwn yn nodi'r ymateb drafft i'r llythyr hwn, y mae'n rhaid ei gyflwyno i AW erbyn 30 Ebrill 2021.		
Materion allweddol	Mae AaGIC yn gallu rhoi sicrwydd priodol o ran twyll, cyfreithiau a rheoliadau a phartïon cysylltiedig ar gyfer y cyfnod rhwng 1 Ebrill 2020 a 31 Mawrth 2021.		

Cam Penodol i'w Gymryd *(✓un yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓

Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol: • Adolygu'r ymateb drafft i'r llythyr 'Ymholiadau archwiliad i'r rheini sy'n gyfrifol am lywodraethu a rheoli' ar gyfer y cyfnod rhwng 1 Ebrill 2020 a 31 Mawrth 2021, a chynnig diwygiadau yn ôl yr angen; a • Cymeradwyo cyflwyno'r llythyr i Archwilio Cymru.

YMHOLIADAU ARCHWILIAD I'R RHEINI SY'N GYFRIFOL AM LYWODRAETHU A RHEOLI

1. CYFLWYNIAD

Fel rhan o'r archwiliad o'r cyfrifon statudol, mae'n ofynnol i Archwilio Cymru (AW) adolygu'r trefniadau llywodraethu sydd ar waith yn Addysg a Gwella Iechyd Cymru (AaGIC). Er mwyn cyflawni'r cyfrifoldebau hyn, mae Archwilio Cymru wedi ysgrifennu at 'y rheini sy'n gyfrifol am lywodraethu a rheoli' yn AaGIC i ofyn am sicrwydd ynghylch nifer o feysydd penodol. Mae'r papur hwn yn nodi'r ymateb drafft i'r llythyr hwn.

2. CEFNDIR

Mae'n ofynnol i AW gynnal ei archwiliadau ariannol yn unol â'r gofynion a nodwyd yn y Safonau Rhyngwladol ar Archwilio (ISAs). Fel rhan o ofynion yr ISAs, mae AW wedi ysgrifennu at AaGIC i ofyn yn ffurfiol am brawf dogfennol o ystyriaeth a dealltwriaeth o nifer o feysydd llywodraethu sy'n effeithio ar archwilio'r datganiadau ariannol.

Yn y llythyr, dywed AW, "Mae'r rheolwyr a'r 'rheini sy'n gyfrifol am lywodraethu' fel ei gilydd yn bennaf gyfrifol am atal a chanfod twyll, sef y Pwyllgor Archwilio yng nghyswllt yr Awdurdod Iechyd Arbennig."

Y prif feysydd a adolygir yw:

- Ymholiadau i'r rheolwyr:
  - mewn perthynas â thwyll
  - mewn perthynas â chyfreithiau a rheoliadau
  - mewn perthynas â phartïon cysylltiedig
- Ymholiadau i'r rheini sy'n gyfrifol am lywodraethu:
  - mewn perthynas â thwyll
  - mewn perthynas â chyfreithiau a rheoliadau
  - mewn perthynas â phartïon cysylltiedig

3. 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.

4. GOBLYGIADAU ARIANNOL

Nid oes dim goblygiadau ariannol uniongyrchol yn sgil y papur hwn.

5. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol:

- Adolygu'r ymateb drafft i'r llythyr 'Ymholiadau archwiliad i'r rheini sy'n gyfrifol am lywodraethu a rheoli' ar gyfer y cyfnod rhwng 1 Ebrill 2020 a 31 Mawrth 2021, a chynnig diwygiadau yn ôl yr angen; a

- Cymeradwyo cyflwyno'r llythyr i Archwilio Cymru.

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig ***(nodwch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu ac ymorol am les gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni '*Cymru Iachach*'	**Nod Strategol 2:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**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'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio	**Nod Strategol 6:** Cael ein cydnabod fel partner, dylanwadwr ac arweinydd rhagorol

Ansawdd, Diogelwch a Phrofiad Cleifion
Nid oes dim effaith ar ansawdd, diogelwch na phrofiad cleifion.
Goblygiadau Ariannol
Nid oes dim goblygiadau ariannol uniongyrchol yn sgil y papur hwn.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Nid oes dim goblygiadau cyfreithiol.
Goblygiadau Staffio
Nid oes dim goblygiadau staffio uniongyrchol.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Nid oes dim goblygiadau tymor hir.

Hanes yr Adroddiad	Dim ar gyfer blwyddyn ariannol 2020/21.
Atodiadau	Atodiad 1 - YMHOLIADAU ARCHWILIAD I'R RHEINI SY'N GYFRIFOL AM LYWODRAETHU A RHEOLI 2020/21

24 Cathedral Road / 24 Heol y Gadeirlan
Cardiff / Caerdydd
CF11 9LJ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru
www.audit.wales / www.archwilio.cymru

Eifion Williams
Director of Finance
Gill Lewis
Chair of Audit and Assurance Committee
Health Education and Improvement Wales

Via e-mail

Reference: HEIW/TCWG 20-21

Date issued: 9 February 2021

Dear Eifion and Gill

Health Education and Improvement Wales – period ended 31 March 2021

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 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 2021.

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 30 April 2021. 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

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 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.

Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
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 Audit & Assurance Committee advise and assure the Board and the Chief Executive (who is the Accountable Officer) on whether effective arrangements are in place - through the design and operation of HEIW's assurance framework - to support them in their decision taking and in discharging their 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	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

Enquiries of management - in relation to fraud		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
	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 2019/20 has met on: – 13 May 2019 – 29 May 2019 – 15 July 2019 – 22 November 2019 – 27 January 2020 • A comprehensive overview of the counter fraud system and processes relevant to the organisation 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 to management teams.	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 • A comprehensive overview of the counter fraud system and processes relevant to the organisation 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.

Enquiries of management - in relation to fraud		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
	• During the year ten Financial Control Procedures (FCPs) were reviewed. Four of these required updates to reflect the requirements of the organisation and these amendments were approved by the Audit & Assurance Committee. Plans are in place to review the remaining five FCPs based on the level of risk and the timings of external reviews/support. • The organisation is subject to both internal and external audit scrutiny. The 2019/20 internal audit review of the financial systems is due to be presented to the Audit & Assurance Committee in April.	• 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.

Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
3. What arrangements are in place to report fraud issues and risks to the Audit 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 FCP is available on the organisation's intranet site. There is a Counter fraud section on the HEIW intranet site detailing various contact details for the reporting of 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. 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.

Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
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 has been provided at the organisations' induction sessions, giving all staff an understanding of fraud and how it can be reported. Further sessions have been year. Details of the International Fraud Awareness week was published on the intranet site and through social media. A newsletter is produced by the Counter Fraud team and published on the HEIW intranet. This contains details of the types of fraud that can occur in the NHS and examples of specific cases that have been dealt with. The newsletter also provides details on how to report a concern and the contact details of the counter fraud team. The latest newsletter was published in December 2019. 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 28 November 2019.	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 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 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 the responsibilities of individuals should there be a suspected case of fraud.

Enquiries of management - in relation to fraud

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body for the period ended 31 March 2020?	There is one case of suspected fraud currently under investigation. This has been discussed at the Audit & Assurance committee during the year.	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.
6. Are you aware of any fraud within the NHS Wales Shared Services Partnership (NWSSP) and NHS Wales Informatics Services (NWIS) for the period ended 31 March 2020?	The Special Health Authority 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 2020.	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.

Enquiries of those charged with governance – in relation to fraud

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
1. How does the Audit Committee, exercise oversight of management's processes for identifying 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 changes to 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.

Enquiries of those charged with governance – in relation to fraud		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
	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 2020?	There is one case of suspected fraud currently under investigation. This has been discussed at the Audit & Assurance committee during the year.	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.

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 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 determine the 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 Committee as to whether the 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.

Enquiries of management – in relation to laws and regulations		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
1. How have you gained assurance thatall 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 2020?	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.	There are no known litigations or claims that would affect the financial statements.

Enquiries of management – in relation to laws and regulations		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
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 NHS Wales Informatics Services (NWIS) for the period ended 31 March 2020?	HEIW is not aware of any non-compliance within NWSSP and NWIS.	HEIW is not aware of any non-compliance within NWSSP and NWIS.

Enquiries of those charged with governance – in relation to laws and regulations		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
1. How does the Audit 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.	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.

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.

Enquiries of management – in relation to related parties

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
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 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;	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;

Enquiries of management – in relation to related parties		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
	• 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 of interest return was issued to relevant staff on 3 March 2020.	• 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 of interest return has been issued to the members of the Board prior to year-end.

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

Question	Response for the period 1 April 2019 to 31 March 2020	Response for the period 1 April 2020 to 31 March 2021
1. How does the Audit 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 ofDirectorships, 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 Interestand Gifts, Hospitality and Sponsorship is published on the HEIW Website.

Enquiries of the those charged with governance – in relation to related parties		
Question	**Response for the period 1 April 2019 to 31 March 2020**	**Response for the period 1 April 2020 to 31 March 2021**
	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.	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.

Dyddiad y Cyfarfod	**7fed Ebrill**	**Eitem ar yr agenda**	**2.5**
Teitl yr Adroddiad	**Datganiad Llywodraethu Blynyddol Drafft 2020/21**		
Awdur yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Diben yr Adroddiad	Gofyn i'r Datganiad Llywodraethu Blynyddol drafft gael ei ystyried gan y Pwyllgor Archwilio a Sicrwydd a bod adborth yn cael ei ddarparu.		
Materion Allweddol	Mae'r Datganiad Llywodraethu Blynyddol drafft, sydd ynghlwm yn Atodiad 1, wedi'i ddatblygu yn unol â gofynion Llywodraeth Cymru.		

Camau Penodol sy'n Ofynnol *(un ✓yn* unig os gwelwch yn dda)	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
		✓		

Argymhellion	Gofynnir i'r Aelodau: drafod cynnwys y Datganiad Llywodraethu Blynyddol drafft a rhoi adborth i roi sicrwydd i'r Bwrdd bod proses lywodraethu gadarn wedi'i deddfu ar gyfer y cyfnod hyd at 31 Mawrth 2021.

DATGANIAD LLYWODRAETHU BLYNYDDOL 2020/21

1. Cyflwyniad

Diben y papur hwn yw gofyn i'r Datganiad Llywodraethu Blynyddol drafft gael ei ystyried gan y Pwyllgor Archwilio a Sicrwydd a darparu adborth.

2. Cefndir

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

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

3. Cynnig

Ceir Datganiad Llywodraethu Blynyddol drafft AaGIC, sy'n manylu ar lywodraethu'r sefydliad ar gyfer 2020/21, yn Atodiad 1.

Gofynnir i aelodau'r Pwyllgor ystyried cynnwys y Datganiad Llywodraethu Blynyddol drafft a rhoi adborth mewn perthynas â'r un peth.

4. MATERION LLYWODRAETHU A RISG

Yn ôl y Llawlyfr Cyfrifon, rhaid i'r Adroddiad Blynyddol (sy'n cynnwys y Datganiad Llywodraethu Blynyddol) a chyfrifon "yn ei gyfanrwydd fod yn deg, yn gytbwys ac yn ddealladwy ac mae'r swyddog atebol yn cymryd cyfrifoldeb personol amdano a'r dyfarniadau sydd eu hangen i benderfynu ei fod yn deg, yn gytbwys ac yn ddealladwy".

5. GOBLYGIADAU ARIANNOL

Nid oes unrhyw oblygiadau ariannol. Ystyrir bod cynhyrchu'r Datganiad Llywodraethu Blynyddol yn fater craidd i AaGIC.

6. Argymhelliad

Gofynnir i'r Aelodau:

drafod cynnwys y Datganiad Llywodraethu Blynyddol drafft a rhoi adborth er mwyn rhoi sicrwydd i'r Bwrdd bod proses lywodraethu gadarn wedi'i deddfu ar gyfer y cyfnod hyd at 31 Mawrth 2021.

Llywodraethu a Sicrwydd			
Linc i nodau strategol IMTP ***(os*** gwelwch yn ***ddau)***	**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:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau ei fod yn diwallu anghenion y dyfodol	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru drwy feithrin gallu tosturiol ac arweinyddiaeth gyfunol ar bob lefel
	✔	✔	✔
	Nod Strategol 4: Datblygu'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr enghreifftiol ac yn lle gwych i weithio	**Nod Strategol 6:** I'w gydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✔	✔	✔

Ansawdd, Diogelwch a Phrofiad Cleifion
NA.
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 Hirdymor (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Na

Hanes yr Adroddiad	
Atodiadau	Atodiad 1 – Datganiad Llywodraethu Blynyddol Drafft

Annual Governance Statement for the Period Ended 31 March 2021

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. 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 Annual Governance Statement (AGS), however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this AGS.

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. In Quarter one virtual meeting agendas become more streamlined and focussed on supporting the response to COVID-19. There have been no other material changes to HEIW's normal decision-making process.

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

The background to HEIW, its functions, the approvable Integrated Medium Term Plan 2020/23, the Quarterly Operational plans and the Annual Plan 2021/22 are set out in the Performance Report.

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

During 2020/21 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 September and HEIW's Strategic Risks approved at November Board. We will continue to evolve our BAF in 2021/22.

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 and assessments and against professional standards and regulatory frameworks.

Reporting period

The reporting period for this Annual Governance Statement is primarily focussed on the financial year from 1 April 2020 to 31 March 2021. However, it also includes reporting on material issues that have taken place between 31 March 2021 and the date that the Annual Governance Statement is finally approved by the HEIW Board on [10 June] 2021.

1.1 Our System of Governance and Assurance

HEIW's vision is "Transforming the workforce for a healthier Wales" which was developed through extensive engagement with our staff, stakeholders an partners. We are delivering this vision through our PEOPLE principles as outlined below:

P	**Planning** ahead to predict and embrace changes and build a sustainable health and social care system
E	**Educating**, training and developing staff to meet the needs of patients and citizens in line with prudent healthcare principles
O	**Offering opportunities** for development to new and existing staff from all professional and occupational groups throughout career pathways
P	**Partnership working** to increase value for our citizens, patients, learners and staff
L	**Leading** the way, through continuous learning, improvement and innovation
E	**Exciting, Enthusing**, **Engaging, Enabling** and **Empowering** staff across all professional and occupational groups

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;
- **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 2020/21 in respect of communication to further embed this to better 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).

Three of our Independent Members were recently re-appointed. Gill Lewis was re-appointed for an additional term of 4 years from 1 February 2021 taking her term to 31 January 2025. Dr Ruth Hall was re-appointed for a term of three years from 1 February 2021 taking her term of office to 31 January 2024.

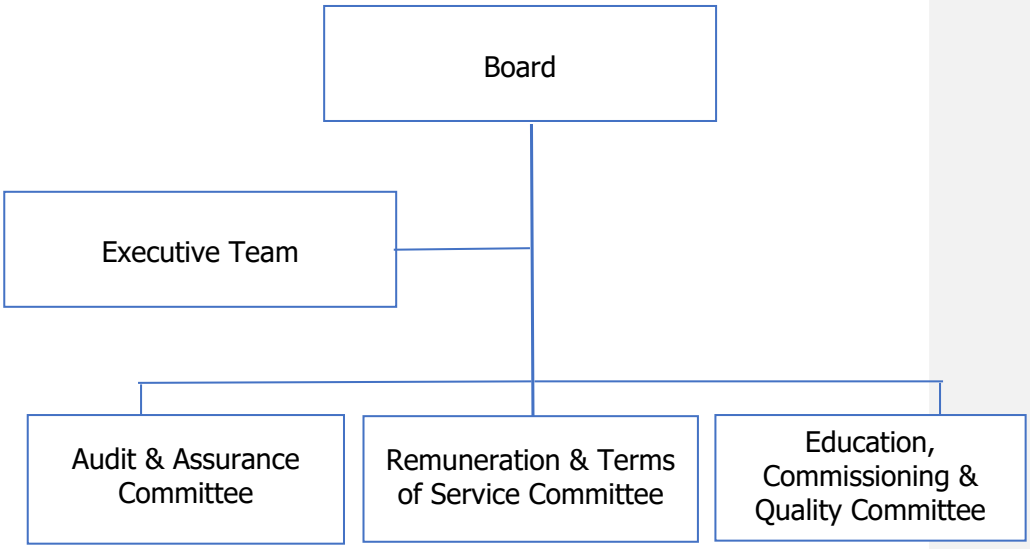
While Ceri Phillips was re-appointed for an additional term of 4 years he resigned as an Independent Member of HEIW on 31 March 2021 to take up a new role as Vice Chair of Cardiff and Vale University Health Board. The recruitment process to appoint a new Independent Member to fill this vacancy will commence after the Senedd election.

The Board is made up of Independent Members and Executive Directors. In additionto the Executive Directors appointed in accordance with the HEIW Regulations, two individuals have also been appointed to other director positions. Nicola Johnson was appointed as Director of Planning Performance and Corporate Services on 21 September and Sian Richards was appointed as Director of Digital on 1 February. Both Directors, together with the Executive Directors are members of the Executive Team. They have a standing invitation to Board meeting where they can contribute to discussions but do not have voting rights.

During 2020/21 several board development sessions were undertaken which included a focus on the following elements of governance:

- Performance Management Framework;
- Risk Appetite;
- Wellbeing and Future Generations Act;
- Socio Economic Duty;
- Board Assurance Framework;
- Board's self-assessment of its own effectiveness.

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 Committees 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 2020/21 were appropriately constituted with a quorum. The key business and risk matters considered by the Board during 2020/21 are outlined in this statement and further information can be obtained from meeting papers available on our website: [**https://heiw.nhs.wales/corporate/board-meetings-agendas-and-papers/.**]

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 the its standing orders on an annual basis. The Board will consider whether any changes are needed during 2021/2022 in line with the Board's governance framework and priorities of the Annual Plan.

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 Annual 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 2020/21, 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 2020/21 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 2020 Structured Assessment and AW's 2021 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 it will undertake a self-assessment for 2020/21 in July 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 will include representatives from AW and Internal Audit. If required, an action plan will be developed.

The Remuneration and Terms of Service Committee considers and recommends salaries, pay awards and terms and conditions of employment for the Executive Team and other key senior staff. During 2020/21 key issues considered by the Remuneration and Terms of Service Committee included:

- 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 2020/21:

- 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 2020/21 and recommended the Plan for approval at the HEIW Board in July 2020;
- Monitored 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;
- Completed the establishment of two sub committees: the Education Advisory Group and the Multi-Professional Quality and Education Group.

The Committee will undertake a self-assessment for 2020/21. An evaluation of the results of the self-assessment will be considered by the Committee at its meeting in July 2021.

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 ending 31 March 2021, along with attendance at Board and Committee meetings for this period. It also highlights the membership of the Board's committees. Members are involved in a range of other activities on behalf of the Board, such as regular board development/briefing meetings, and a range of other internal and external meetings.

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 be required to develop annual reports of their business and activities.

1.5* 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 Board or 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 HEIW Board meetings have been streamed live via a videoconference platform
- in September additional members were appointed to the Audit and Assurance Committee and the Education Commissioning and Quality Committee to increase their resilience should a member become unwell.

The decision not to hold open Board and Committee meetings in public had been regularly reviewed by the Board during 2020/21.

Table 1 - Board and Committee Membership and Attendance since 1 April 2020 to 31 March 2021:

Name	Position	Area of Expertise/ Representation Role	Board/ Committee Membership	Meeting Attendance 2020/2021	Champion Roles
Chris Jones	Chair	• Primary Care • Widening Access • Prevention	• Board (Chair) • RATS Committee (Chair)	/8 /6	• Welsh Language
John Hill-Tout	Vice Chair	• Performance • Governance • Finance	• Board • Audit and Assurance Committee • RATS Committee	/8 7/7 /6	• Primary Care • Mental Health
Tina Donnelly	Independent Member	• Leadership • Students • Workforce • Education/ Training	• Board • Education, Commissioning and Quality Committee • RATS Committee	/8 5/5 /6	• 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	/8 7/7 5/5 /6	• Rural Champion
Gill Lewis	Independent Member	• Health & Social Care Workforce	• Board • Audit and Assurance Committee • Education, Commissioning and Quality Committee (Deputy as required) • RATS Committee	/8 7/7 0/5 /6	• Health & Social Care Integration
Ceri Phillips	Independent Member	• Workforce Design • Value Agenda • Digitisation	• Board • Education, Commissioning and Quality Committee (wef 10/2020) • RATS Committee	/8 2/2* /6	• Digital

Commented [DB(1]: To be uddated to reflect attendance at the Board and RATS committee on 25 March

Heidi Phillips	*Independent Member*	• *Integrated Care* • *Improvement* • *Widening Access* • *Education/ Training*	• *Board* • *Audit and Assurance Committee (wef 10/2020)* • *RATS Committee*	*/8* *1/2** */6*	• *Quality Improvement* • *Widening Access*
Alex Howells	*Chief Executive*		• *Board*	*/8*	
Julie Rogers	*Deputy Chief Executive/ Director of Workforce and OD*		• *Board*	*/8*	
Angela Parry	*Interim Director of Nursing*		• *Board*	*/8*	
Pushpinder Mangat	*Medical Director*		• *Board*	*/8*	
Eifion Williams	*Director of Finance*		• *Board*	*/8*	

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 Nursing are the lead officers for the Education Commissioning and Quality Committee.

(*) – denotes appointment to the Committee for the first time by the Board in September. Attendance reflects the number of Committee meetings since appointment.

Table 2 - Dates of board and committee meetings held during the period 1 April 2020 to 31 March 2021**.**

The Board and its committees are fully established and operating 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 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sept 2020
Board	30/04/20	28/05/20	25/06/20	30/07/20		** 24/09/20
Audit and Assurance Committee	01/04/20	06/05/20 & 26/05/20	23/06/20	16/07/20	N/A	N/A

Education Commissioning & Quality Committee	09/04/20	N/A	N/A	02/07/20	N/A	16/09/20
Remuneration and Terms of Service Committee	30/04/20	28/05/20	N/A	30/07/20	27/08/20	N/A

	October	Novemb er	Decembe r	January	Februar y	March
Board	N/A	26/11/20	N/A	28/01/21	N/A	[25/03/21]
Audit and Assurance Committee	20/10/20	N/A	N/A	18/01/21	N/A	N/A
Education Commissioning and Quality Committee	08/10/20	N/A	N/A	N/A	O9/02/2 1	N/A
Remuneration and Terms of Services Committee	N/A	26/11/20	N/A	N/A	N/A	[25/03/21]

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 2020/21 the LPF has met bi monthly and focussed on both strategic and practical issues including culture and organisational development, employment policies, equality & diversity, staff wellbeing and welfare.

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 the 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 2021 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 September 2020. 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. Our Corporate Risk Register system and process to monitor, seek assurance and ensure shortfalls are addressed through the scrutiny 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.

Appendix 1: Methods of internal and external assurance

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
- Wales Audit Office (Structured Assessment)

- External Audits (e.g. Annual Accounts and Annual Report)
- HIW Inspections
- Regulators
- Reviews and Reports by Royal Colleges
- External visits and accreditations
- Independent Reviews

Capacity to Handle Risk

We have continued to develop and embed our approaches to risk management and emergency preparedness throughout 2020/21. Our Risk Management Policy is reviewed on an annual basis and was reviewed and approved by the Board in July.

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's 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 November the Board approved the strategic risks which will face the organisation in 2020/21. 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.
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.
3	**Cultural change required to deliver an integrated, multi professional approach.** There is a risk that HEIW could fail 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.
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 engaging with partners effectively 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 at each monthly meeting of the Senior Leadership Team. It is reviewed by the Audit and Assurance Committee on a quarterly basis and by the Board 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.

In [March] we received a substantial assurance report from internal audit following an audit of the risk management system.

HEIW's Risks arising from COVID-19 in Quarter 1

The Corporate Risk Register was updated in March/April 2020 to align it to the risk log created in response to the impact of the first wave of COVID-19. The key risks caused by COVID-19 included the impact on education and training programmes on progression and outcomes for students and trainees together with the impact on HEIW's ability to deliver the major change programmes relating to GP trainee and Pharmacy pre-registration programmes.

HEIW's Risk pre-existing risks exacerbated by COVID-19 were identified in the following areas: the shortening of the timetable for the tender process for the Strategic Review of Health and Professional Education. However, it should be noted that the commencement date of the new contracts currently remains the same. The Cybersecurity threat was also felt to be heightened as a result of the pandemic due to fraudsters increasingly targeting health organisations.

Further information can be found in the Board papers on our website: **https://heiw.nhs.wales/corporate/board-meetings-agendas-and-papers/**

During the COVID-19 crisis, the Crisis Management Team in HEIW, established in response to the pandemic, has had the role of monitoring and assessing the impact and risks arising. Also, for assessing which risks should be escalated and included within the corporate risk register.

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 Q3 and Q4 of the financial year.

Internal audit has undertaken a report assessing HEIW's systems and controls in place in relation to the organisation's risk management arrangements. The overall rating was one of substantial assurance for this area.

HEIW has a Crisis Management and Business Continuity policy which was deployed in response to the COVID-19 situation.

The Board Secretary have been attending NHS Wales SRO Brexit meetings where emergency preparedness issues have been explored and discussed.

As previously highlighted the need to plan and respond to the COVID-19 pandemic presented several challenges to the organisation. 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 HSSG COVID Planning group which has representatives from the NHS, Local Government and Welsh Government.

Our COVID-19 response has been led by the CEO and Deputy CEO. At the end of March, the CEO was asked to support Andrew Goodall as Chief Operating Officer/Deputy NHS Wales Chief Executive, dedicated to COVID 19. As such, operational responsibility for HEIW functions passed to the Deputy CEO until July. During this period the CEO has continued in her role as HEIW's Accountable Officer.

HEIW has been contributing to the national response additionally via Joint leadership via the Deputy CEO 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. Our expectation is that, after the vaccination roll out, HEIW will move to a more blended model which suits the organisation and supports the agile working of our staff.

As previously highlighted the need to plan and respond to the COVID-19 pandemic presented a number of challenges to the organisation as new and emerging risks where identified. Whilst the organisation did have a [major incident and business continuity plan] in place, the scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to support the NHS response to the pandemic. This has also involved working in partnership with the Welsh Government, Health Board and Trusts. There does remain a level of uncertainty about the overall impact this will have on the immediate and longer-term delivery of services by the organisation, although I am confident that all appropriate action is being taken.

The organisation 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.

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 in April against the main principles as they relate to NHS public sector organisations in Wales and of the Governance, Leadership and Accountability Standard] [Further detail to be inserted after the meeting].

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 Management of Risk principles 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 Care Standards relate to staff and resources. Improvements to these areas are captured in our Performance Report.

The Health Board 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.

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 (2011). Continued progress has been made in relation to our diversity, equality and inclusion agenda...

HEIW has also established its Diversity and Inclusion Group and recruited Workplace Champions. HEIW has committed to several workforce related initiatives for example the Stonewall Diversity Champion Scheme, Time to Change, Disability Confident, TUC's Dying to Work, Anti-Violence Collaboration and Communication Access Symbol.

The organisation has established a Differential Attainment Board to act as Champions in this area and ensured that all Heads of School implement strategies to support those at risk of Differential Attainment. The Board is actively exploring widening diversity of Board members and is proposing to use an Associate member opportunity to support and develop individuals from under-represented backgrounds.

HEIW's first Strategic Equality Plan 2020-2024 was published in October 2020. We have published our second Annual Equality Report 20/19 in March highlighting progress so far. Our second Gender Pay Gap Report will be published later this year.

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. HEIW does take quality and quality improvement very seriously. During 2020/21 HEIW has implemented or continued to implement the measures detailed below to secure quality improvement in relation to its functions:

- The Education Commissioning and Quality Committee's 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.
- The work of the Committee in respect of education quality has been further enhanced through the establishment of the two new sub-groups

the Education Advisory Group and the Multi-Professional Quality and Education Group.

- HEIW monitors postgraduate medical training through several means including: national GMC surveys of medical trainers and trainees, quality assurance visits and constant feedback from education leads within the NHS. Triangulation of adverse information can lead to some specialties in some sites being placed in enhanced monitoring status
- HEIW gathers information on student and trainee experiences. This information is used to inform improvements within the education and training provision.
- HEIW have clearly identified roles within the organisation which support the quality agenda.
- Continuous improvement more generally is important to HEIW, both in terms of internal sharing of good practice as well as through learning from our sister organisations in the UK.

HEIW had originally intended to engage with Welsh Government in 2020/21 to develop bespoke guidance for HEIW to complete an Annual Quality Statement as a training and education organisation. This has not been possible this year as the requirement to produce an Annual Quality Statement was suspended due to the pandemic. HEIW proposes to develop the bespoke guidance in 2021-22.

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 which was concluded in January. While the consultation received a limited number of responses all material response were positive. [The Board approved the Welsh Language Scheme for submission to the Welsh Language Commissioner in March.] HEIW looks forward to receiving confirmation from Welsh Government that it has been named under the Welsh Language Measure at the earliest opportunity.

Stakeholders and Partners - As an All-Wales organisation, with several strategic functions, the importance of 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.

During 2020/21 our face to face communications have been impacted by the coronavirus but we have still continued much of our communications and engagement activity online, continuing to embed our Board approved Communications and Engagement Strategy to build and strengthen relationships and to help shape our work and services. This has included:

- Developing all Wales internet pages with:
    - Covid-19 resources for students/ trainees and trainers across Wales;
    - Health and Wellbeing pages for NHS Wales / Social Care Wales;
    - Long Covid syndrome resources;
    - NHS Wales volunteer vaccination programme;
    - NHS Wales Covid-19 vaccination programme.
- Regular stakeholder bulletins;
- Introducing a Primary Care newsletter;
- Increasing Social media posts to inform and update;
- Regular stakeholder specific newsletters such as trainee newsletter, dental professionals, medical trainer newsletter;
- Participation in national boards and all Wales peer groups;
- Continued engagement around the Workforce Strategy for Health and Social Care, HEIW's Welsh Language consultation;
- Online all Wales conferences and events to focus on key topics including Simulation, Endoscopy, Mental Health and the Strategic Equality Plan, and to provide access to CPD and support networking;
- Introduction of blogs from a number of HEIW employees and partners highlighting projects and work – sharing them on social media and with specialist publications;
- Promotion of the NHS Wales Graduate Scheme;
- The Campaign to promote NHS Wales as a career option specifically around areas where shortage of applicants including Learning Disability Nursing, Mental Health Nursing and Healthcare sciences.

We are also working with partners across the UK, including colleagues in NHS Education for Scotland, Health Education England, NHS Improvement, Department of Health in Northern Ireland and a number of national professional bodies and regulators. The roadshows we successfully started in 2019 have been on hold whilst Health Board resources concentrate on the Coronvirus pandemic but will be reinstated as soon as it is possible. In the meantime we held several 'showcase' events where members of the NHS community and public were invited to hear of the work we are undertaking using zoom.

Working together, understanding each other's needs and how we can best support each other is critical if we are to succeed individually and as a system. To achieve this, we will continue to collaborate, communicate, engage and work closely with our partners and stakeholders.

Carbon Reduction - The organisation has not undertaken risk assessments on carbon reduction delivery plans. However, HEIW is currently developing its Biodiversity and Decarbonisation Strategy which will be finalised in 2021/22. This is considered further within the Sustainability section within the Performance Report part of the Annual Report.

Ministerial Directions

The following ministerial direction received as at year end 31 March 2021 was applicable to HEIW.

Ministerial Direction/ Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
e.g. WHC 2020 (011) – Temporary Amendments to Model Standing Orders, Reservation and Delegation of Powers	30 July 2020	Standing Orders amended and 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 2and 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 2020/21, we recorded a total of three cyber security incidents resulting in potential personal data breaches. Of these incidents, two incidents met the assessment criteria for reporting to the Information Commissioners Office (ICO). Welsh Government were notified and updated regarding the three incidents.

The two incidents reported to the ICO included an incident reported by HEIW's Pharmacy website and an incident affecting Sharepoint throughout NHS Wales which was reported to the ICO on behalf of all NHS organisations which included HEIW.

The formal ICO response on the 29th October 2020 regarding the reported incident indicated that no formal enforcement action would be taken and consider the matter to be closed.

4.2 Planning

Welsh Government planning processes were suspended in March 2020 and no IMTPs 2021-24 were formally approved due to the COVID-19 pandemic. Welsh Government has nevertheless confirmed that HEIW's IMTP was deemed approvable. HEIW's IMTP objectives were largely paused in Q1 of 2020-21, to enable the organisation to focus its resources on supporting the NHS' response to COVID-19. In line with all NHS organisations, in-year we developed and published three Quarterly Operational Plans (Q1, Q2 and Q3&4). The development of these ensured that HEIW restarted many of our Strategic Objectives from Q2 onwards, but maintained the ability to balance the needs of the immediate response to the pandemic with future strategic direction and workforce pipeline. In [March] 2021 Audit Wales reported good assurance on the development of the organisation's Operational Plan for Q3&4.

In January 2020 the Board approved HEIW's Performance Framework. This Framework describes the organisation's system for making continuous improvements to achieve our Strategic Aims and Objectives and to deliver our 'Business as Usual' activities effectively.

The Board has received regular reports in respect of the implementation of the 2021/20 Quarterly Operational plans through the structured Performance Reports. The Performance reports have shown good progress made by the organisation in the delivery of our Plans demonstrating that it is on track to deliver against the majority of its commitments. This included the publishing of the joint Workforce Strategy for Health and Social Care in partnership with Social Care Wales.

The Board has played a central role in developing the Annual Plan (2021-22) based on year two of the approvable IMTP for 2020-23. Detailed Board discussions to support the development of the Annual Plan have taken place. As a result of the uncertainties caused by the pandemic, and in line with the request of the Director General of NHS Wales, the Annual Plan was considered as a draft at March Board and approved for sharing with Welsh Government for informal feedback. The final Plan will be considered for approval by the Board in May or July 2021. Given the continued impact of COVID-19 it will be necessary to undertake a quarterly review of the Strategic Objectives to ensure that HEIW remains agile and our Plans continue to support the pandemic response and recovery.

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 a number of 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 [ ].:

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 of Executive Directors and Senior Management;
- Executive Directors and Senior Management who have responsibility for development, implementation and maintenance of the internal control framework and the continuing improving effectiveness within the organisation;
- 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 an assurance arrangements.

HEIW's May Board received the Audit and Assurance Committee's Annual Report. The Committee Chair's reflections within the Committee's Annual Report were as follows:[ ]

Commented [DB(2]: TBC – and taken from the 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:

Commented [DB(3]: TBC by the head of internal audit

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 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

Commented [DB(4]: TBC by the head of internal audit

 - + Yellow	The Board can take [ ]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 2020/21, has been reported to the Audit and Assurance Committee.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan which have been reported to the Audit and Assurance Committee throughout 2020/21. 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.

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.
- **Governance arrangements during COVID**-19 – Internal Audit issued a positive report which was Advisory only.

Strategic planning, performance management & reporting

- **Performance management** – Overall Internal Audit issued a [ ] assurance report in relation to its work in this area.

Financial governance and management

- **Financial systems** – Overall, Internal Audit issued a **reasonable** assurance report.

Information governance & security

- **Cyber Security** – Overall Internal Audit issued **reasonable** assurance for this review.

Operational service and functional management

- **Medical Commissioning Monitoring** – Overall Internal Audit issued **reasonable** assurance for this review.
- **Pharmacy – pre registration** – Overall Internal Audit issued [ ] assurance for this review.

Workforce management

- **Personal Development Process –** Overall Internal Audit issued **reasonable** assurance for this review**.**

- **Workforce Culture -** Overall Internal Audit issued **reasonable** assurance for this review**.**

Communication

Communication and engagement strategy – Overall Internal Audit issued **substantial** assurance for this review.

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 2020 was designed in the context of the ongoing response to the pandemic.

The assessment found that HEIW quickly adapted its governance, risk management and assurance arrangements to respond effectively to COVID-19. AW also stated that HEIW had continued to show strong leadership and maintained oversight of quality and staff wellbeing.

The assessment made two recommendations for the following areas:

Governance

The organisation should ensure that, unless risks are of a sensitive nature, the Corporate Risk Register should be considered at open sessions of the Audit and Assurance Committee.

Finance

That HEIW seek to identify cost and value improvement opportunities and record and report those within HEIW and more widely from its work.

The recommendations from both Internal Audit and Wales Audit together with management's response are recorded within the Audit Tracker report. This is monitored and regularly reviewed by the Audit and Assurance Committee.

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.

6. Conclusion – Corporate Governance Report

As indicated throughout this statement, the need to plan and respond to the COVID-19 pandemic has had 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 society throughout 2021/22 and beyond. I will ensure our Governance Framework considers and responds to this need.

During the period 1st April 2020 – [date of final approval] 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 2021/22 to further develop these arrangements. It will be important to communicate widely with staff to further embed these arrangements.

Signed by
Chief Executive:

Date.

Dyddiad y Cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.6**
Teitl yr Adroddiad	**Adroddiad Blynyddol DRAFFT y Pwyllgor Archwilio a Sicrwydd 2020/21**		
Awdur yr Adroddiad	Kay Barrow, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Prif bwrpas 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 prif feysydd gweithgarwch busnes a gynhaliwyd gan y Pwyllgor yn ystod 2020/21.		
Materion allweddol	Mae'r adroddiad hwn yn crynhoi'r prif feysydd gweithgarwch busnes a gynhaliwyd gan y Pwyllgor yn ystod 2020/21 ac yn tynnu sylw at rai o'r prif faterion y mae'r Pwyllgor yn bwriadu rhoi ystyriaeth bellach iddynt dros y 12 mis nesaf.		
Cam Penodol i'w Gymryd ***(✓un yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓
Argymhellion	Gofynnir i Aelodau'r Pwyllgor wneud y canlynol: • **Cymeradwyo** Adroddiad Blynyddol 2020/21 i'w gyflwyno i'r Bwrdd er sicrwydd.			

ADRODDIAD BLYNYDDOL Y PWYLLGOR ARCHWILIO A SICRWYDD 2020/21

1. CYFLWYNIAD

Prif bwrpas Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd (y 'Pwyllgor') yw sicrhau'r Bwrdd bod y system sicrwydd y mae'r Pwyllgor yn ei darparu 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 rhoi gwybod i'r Bwrdd yn rheolaidd am ganlyniadau ei adolygiadau sicrwydd, ynghyd ag unrhyw faterion eithriadol sydd wedi codi. 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 y mae'r Pwyllgor wedi'u hystyried yn ystod y flwyddyn ariannol.

Mae'r adroddiad yn rhoi sicrwydd i'r Bwrdd a'r Swyddog Atebol ynghylch pa mor ddigonol ac effeithiol yw gweithdrefnau a systemau AaGIC o ran cynnal system gadarn o reolaeth fewnol a'r casgliadau y daethpwyd iddynt yng nghyswllt blwyddyn ariannol 2020/21. Bydd hyn yn cynnwys sicrwydd ynghylch pa mor drylwyr yw'r prosesau ac ansawdd y data sydd y tu ôl i'r datganiadau a rhoi ei sicrwydd ei hun ynghylch pa mor ddibynadwy yw'r datgeliadau pan fyddant wedyn yn cael eu cyflwyno i'r Bwrdd i'w cymeradwyo.

Mae'r adroddiad pwyllgor blynyddol hwn wedi cael ei lunio'n dilyn adolygiad o gofnodion a phapurau cymeradwy'r pwyllgor, gan roi ystyriaeth briodol i gylch gwaith y Pwyllgor fel y nodir yn ei Gylch Gorchwyl.

3. ASESIAD

Mae'r adroddiad hwn yn crynhoi'r prif feysydd gweithgarwch busnes a gynhaliwyd gan y Pwyllgor yn ystod 2020/21 ac yn tynnu sylw at rai o'r prif faterion y mae'r Pwyllgor yn bwriadu rhoi ystyriaeth bellach iddynt dros y 12 mis nesaf.

4. MATERION LLYWODRAETHU A RISG

Caiff unrhyw risgiau a materion llywodraethu eu rheoli drwy gyfarfodydd y pwyllgor a bydd y cadeiryddion priodol yn darparu adroddiadau am eithriadau i'r Bwrdd.

5. GOBLYGIADAU ARIANNOL

Nid oes dim goblygiadau ariannol i'r Bwrdd eu hystyried/cymeradwyo.

6. ARGYMHELLIAD

Gofynnir i Aelodau'r Pwyllgor wneud y canlynol:

- **Cymeradwyo** Adroddiad Blynyddol 2020/21 i'w gyflwyno i'r Bwrdd er sicrwydd.

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig ***(rhowch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu ac ymorol am les gweithlu cymwys, cynaliadwy a hyblyg, i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*	**Nod Strategol 2:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**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'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio	**Nod Strategol 6:** Cael ein cydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓		✓

Ansawdd, Diogelwch a Phrofiad Cleifion
Mae sicrhau bod y Bwrdd yn cynnal ei fusnes yn briodol drwy ei Bwyllgorau ac yn unol â'i reolau sefydlog yn ffactor allweddol yn ansawdd, diogelwch a phrofiad cleifion sy'n derbyn gofal.
Goblygiadau Ariannol
Nid oes dim goblygiadau ariannol i'r Bwrdd fod yn ymwybodol ohonynt.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Mae'n hanfodol bod y Bwrdd yn cydymffurfio â'i reolau sefydlog, sy'n cynnwys derbyn diweddariadau gan ei bwyllgorau.
Goblygiadau Staffio
Nid oes dim goblygiadau staffio i'r Bwrdd fod yn ymwybodol ohonynt.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Mae'r adroddiad yn amlinellu'r gwaith a wnaed gan y Pwyllgor i adolygu cyllid a pherfformiad tymor byr AaGIC yn ogystal â chanolbwyntio ar gynaliadwyedd yn y tymor hwy. Nod y strwythur llywodraethu yw canfod problemau'n gynnar er mwyn eu hatal rhag mynd yn waeth a sicrhau bod y Pwyllgor yn rhan integredig o drefniadau cyffredinol y Bwrdd.

Hanes yr Adroddiad	Wedi'i ystyried gan y Tîm Gweithredol
Atodiadau	Atodiad 1– Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd 2020/21

AUDIT AND ASSURANCE COMMITTEE
ANNUAL REPORT 2020/21

Committee Chair's Reflection

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 therefore 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 2020/21 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;

- 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. The Committee therefore 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.

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:

- Compliance with Mandatory Training and PADR;
- 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 continues to comply with. During 2020/21, NHS Wales has been fully mobilised in support of COVID-19 and due to the escalating position during March 2020, Welsh Government agreed a number of Governance Principles for NHS Wales whilst responding to the Covid-19 pandemic.

HEIW has been and continues to be actively involved in the emergency planning response to the current COVID-19 crisis. The priority during this time for HEIW has been to mobilise the organisation to both fulfil the leadership and support requirements and to use its expertise and resources 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.

In light of the pandemic, the Committee reviewed and endorsed revisions and temporary amendments to the organisational governance arrangements and processes for approval by the HEIW Board: These are summarised below:

- Following the publication of the Welsh Health Circular "Temporary Amendments to Model Standing Orders, Reservation and Delegation of Powers", considered and recommended that the HEIW Board approve the Temporary Amendments to HEIW's Standing Orders as amendments to HEIW's Standing Orders:
    - Deadline for holding the AGM extended to 30 November 2020;
    - Maximum tenure for an Independent Member extended.

- Considered and recommended the Board approve further amendments to the HEIW Standing Orders as set out below:
    - the deadline for holding the Annual General Meeting (AGM) to revert back to 30 September for each year;
    - the Scheme of Delegation amended to reflect the appointment and responsibilities of the Director of Planning, Performance and Corporate Services and the Director of Digital;
    - to reflect the correct title for the role of Director of Finance;
    - the delegated financial limit for the Director of Planning, Performance and Corporate Services and Director of Digital be set at £50,000 for non-Education and Training Contracts.

- 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. To facilitate as much transparency and openness as possible during this extraordinary time, the Committee published on the HEIW website a synopsis of the meetings within 72 hours and the unconfirmed minutes within two weeks of a meeting.

Arising from the above scrutiny, a number of outcomes from the work of the Committee during the year have resulted in escalation of certain matters to the Board. These have included:

- The impact of COVID 19 on the delivery of the Internal and External Audit Plans for 2020-2021 and the ability of both auditing bodies to provide the required assurances to the Board.

- The increased risk of fraud during the current crisis period.

- Concerns that without the Director of Digital and an agreed Digital Strategy, caution was required in relation to decision-making around new technologies that may not suit the longer-term Information and Communications Technology (ICT) objectives.

Throughout the course of the year the Audit and Assurance Committee has also made recommendations/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 2020/21 to the Board for approval;

- Approved the amendments to the Terms of Reference for Committees which form a part of the Standing Orders as follows:
    - to reference the Vice Chair role within the membership of the Audit and Assurance Committee;
    - to reference the Vice Chair role within the membership of the Education, Commissioning and Quality Committee and, subject to the addition of the three Deans as standing 'In attendance' members.

- 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 from £2m to £3m for invoices from NWSSP relating to Single Lead Employer GP salaries.

3.3 Policies, Procedures and Plans

The Committee received and supported:

- Complaints Handling Policy;

- 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
    - FCP10 Accounts Receivable
    - FCP11 Accounts Payable
    - FCP12 Banking
    - FCP13 Counter Fraud

- Removal of the following FCPs as they had been identified as no longer

required and were either covered by a Service Level Agreement or already covered by the remaining FCPs:

- FCP14 Shared Services Functions
- FCP15 Procurement

The Committee noted the Memorandum of Understanding between HEIW and the Health Inspectorate Wales (HIW) which sets out the basis upon which HEIW and HIW will work together and exchange information to assist each party in reaching common goals.

The Committee was pleased to note the Memorandum of Understanding and Information Sharing Agreement with the General Pharmacy Council, the first agreements with a regulator that would support co-operation and information sharing between both parties. It was hoped this would be the first of many such agreements between HEIW and regulators.

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. During 2020/21, as a consequence of the COVID-19 Pandemic, the HEIW Chair supported by the Board Secretary undertook a governance review of the membership of the Board's Committees. In order to provide further resilience to the Committee, an additional Independent Member was appointed to the membership. The role of Committee Vice-Chair was also formalised.

During the financial year 2020/21, 7 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 been in attendance at 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.

The Committee also has regular attendance from representatives of:

- The Auditor General/Audit Wales;
- NWSSP Audit and Assurance Services (Internal Audit and Specialised Services Unit);
- NHS Counter Fraud Services.

5. Committee Work Programme 2020/21

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 2020/21:

- 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 2019. This assessment concluded overall that the organisation has strong leadership, and sound arrangements have supported effective business and a positive staff culture driven by excellent staff engagement. It noted that following areas require further development: risk, Board assurance, performance management and information governance.

Audit Wales concluded that HEIW has a clear vision and strategic objectives are in place for the Integrated Medium-Term Plan (IMTP) production and monitoring and that financial controls and policies are in place. Specifically, the report made a number of recommendations for the following areas:

- Governance
- Board Assurance Framework (BAF) and Risk
- Performance management framework
- Information Governance
- Digital and IT
- Monitoring objective against strategic objectives]

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.

The Committee received Audit Wales' structured assessment for 2020 which was designed in the context of the ongoing response to the COVID-19 pandemic. The assessment found that HEIW quickly adapted its governance, risk management and assurance arrangements to respond effectively to COVID-19. AW also stated that HEIW had continued to show strong leadership and maintained oversight of quality and staff wellbeing.

The assessment made two recommendations for the following areas:

- **Governance.** The organisation should ensure that, unless risks are of a sensitive nature, the Corporate Risk Register should be considered at open sessions of the Audit and Assurance Committee.

- **Finance. T**hat HEIW seek to identify cost and value improvement opportunities and record and report those within HEIW and more widely from its work.

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 2020/21. 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 Risk Management had been assessed as substantial assurance.

The Committee was pleased to receive a number of internal audit reports that had received an overall assessment of reasonable assurance. These included:

Internal audit also issued a positive assessment of Governance arrangements during COVID-19 which was an advisory report only.

Financial Systems
Cyber Security
Medical Commissioning Monitoring
Personal Development Process
Workforce Culture

[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 through the use of the Corporate Risk Register and local risk registers.

The Committee reviewed and approved amendments to the Board Assurance Framework which included HEIW's position in relation to Risk Appetite and Risk Tolerance; how it treats risks and informs wider decision making.

The Committee has reviewed the Corporate Risk Register at each quarterly meeting. It currently receives regular updates in relation to the 'red' status risk relating to Cyber Security. The Committee was pleased with the progress being made in strengthening and raising the profile of cyber security within HEIW. A work plan had been developed and would be progressed to assist in mitigating and reducing the current corporate risk level from 'red' to 'amber' status.

9. Monitoring Progress

The Committee has also monitored continuing improvement in the arrangements for:

- Compliance with Mandatory Training and PADR recorded on ESR for core staff. The Committee received assurance from the Medical Director on the targeted work within the Medical Directorate that was driving improvement in compliance.

- Information Governance and Information Management: The Committee was pleased with the overall progress with the Information Governance Work Plan.

- 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 has been completed and will be reporting to the Committee in April 2021.

- Declarations of Interest/Gifts Hospitality Sponsorship: The Committee commissioned a review of practice of Declarations of Interest/Gifts Hospitality and Sponsorship within other organisations however, this has been paused by procurement due to the impact of COVID-19. It is anticipated that this will be undertaken in the new financial year.

- Contracts & Agreements Register. The Committee reviews the Register on annual basis.

- Audit Recommendation Tracker: The Committee continues to monitor HEIW's Audit Tracker scrutinising management responses to audit reports throughout 2020/21 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.

The Committee received an update in relation to the Welsh Government Grip and Control Expectations as a result of the COVID-19 Pandemic and noted that HEIW would be reviewing its existing control arrangements in order to provide the required assurance to Welsh Government.

COVID 19 – Decision Making & Financial Guidance: The Committee received assurance that the Finance Department had a number of measures in place to ensure that work matters were conducted to the appropriate standards.

10.1 Annual Accounts

In May 2020, the Committee reviewed the draft and audited accounts for 2019-2020 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 done in June 2020.

In January 2021, the Committee received the Annual Accounts Plan and Draft Annual Report Timetable for 2020/21 and noted the changes to the submission deadline dates.

11. Counter Fraud

The Committee agreed the Counter Fraud Strategy and Work Plan and considered a number of reports relating to Counter Fraud:

- Thematic Assessment Fraud Threats to the NHS from COVID-19
- Review of NHS Counter Fraud Agency (NHSCFA) 2020 Strategic Intelligence Assessment Covering 2018-2019 and Impact on HEIW
- 'Raising our Game' Tackling Fraud in Wales – Report of the Audit General for Wales – National Report
- Effectiveness of Counter-Fraud Arrangements – HEIW specific Audit Wales report

12. 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. [ ]

13. Key Areas of Focus for the Coming Year

During 2021/22, the Committee will continue to focus on the following areas: [ ]

- Compliance with Mandatory Training and PADR
- 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

Date: April 2021

Dyddiad y cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.7**
Teitl yr Adroddiad	**Adolygu Effeithiolrwydd y Pwyllgor 2020/21**		
Awdur yr Adroddiad	Kay Barrow, 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 copi drafft o Ddogfen Adolygu Effeithiolrwydd y Pwyllgor i'r Pwyllgor Archwilio a Sicrwydd (y Pwyllgor) ac amlinellu'r dull gweithredu ar gyfer cynnal y broses adolygu.		
Materion allweddol	Mae'r Pwyllgor Archwilio a Sicrwydd yn destun proses hunanasesu flynyddol i roi sicrwydd i'r Bwrdd bod y Pwyllgor yn cyflawni ei ddyletswyddau'n effeithiol. Gofynnir i aelodau ystyried a chymeradwyo Dogfen Adolygu Effeithiolrwydd y Pwyllgor (drafft) (Atodiad 1).		
Cam Penodol i'w Gymryd ***(✓un yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
				✓
Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol: • **Cymeradwyo** cynnwys Dogfen Adolygu Effeithiolrwydd y Pwyllgor (Atodiad 1)			

ADOLYGU EFFEITHIOLRWYDD Y PWYLLGOR 2020/21

1. CYFLWYNIAD A CHEFNDIR

Bydd aelodau'r Pwyllgor Archwilio a Sicrwydd (y Pwyllgor) yn ymwybodol bod y Pwyllgor yn cynnal hunanasesiad o'i effeithiolrwydd a'i effaith bob blwyddyn drwy lenwi rhestr wirio effeithiolrwydd.

Eleni, bwriedir dosbarthu'r Rhestr Wirio i'r aelodau, a'r swyddogion hynny sy'n gweithio gyda'r Pwyllgor, i'w llenwi'n 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 cyfrannu at arfarnu Effeithiolrwydd y Pwyllgor a nodi'r themâu allweddol i'w trafod yn y Pwyllgor ar 6 Mai 2021, gofynnir i aelodau'r Pwyllgor ac ymatebwyr ehangach lenwi'r rhestr wirio hunanasesu sydd wedi dod o Restr Wirio Archwilio a Risg y Swyddfa Archwilio Genedlaethol. Hefyd, gofynnir iddynt ateb nifer o gwestiynau arfarnu, a amlinellir yn y ddogfen Adolygu Effeithiolrwydd (Atodiad 1) erbyn dydd Gwener, 16 Ebrill 2021. Bydd arfarniad o'r Adolygiad yn cael ei gyflwyno i'r Pwyllgor Archwilio a Sicrwydd ar 6 Mai 2021.

3. GOBLYGIADAU ARIANNOL

Nid oes dim goblygiadau ariannol yn gysylltiedig â'r Adolygiad o Effeithiolrwydd y Pwyllgor.

4. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol:

- **Cymeradwyo** cynnwys Dogfen Adolygu Effeithiolrwydd y Pwyllgor (Atodiad 1)

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig *(rhowch ✓)*	**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:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol yn GIG Cymru drwy ddatblygu capasiti arwain tosturiol a chydweithredol ar bob lefel
	✓	✓	✓
	Nod Strategol 4: Datblygu'r gweithlu er mwyn helpu i ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio ynddo	**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 dim goblygiadau ariannol.
Goblygiadau Cyfreithiol (gan gynnwys asesiad cydraddoldeb ac amrywiaeth)
Nid oes dim goblygiadau cyfreithiol.
Goblygiadau Staffio
Nid oes unrhyw oblygiadau staffio.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Bydd yr adolygiad o effeithiolrwydd yn cael ei gwblhau'n rheolaidd a bydd rhaglen dreigl o wella ac asesu'n cefnogi hynny. Mae'r adolygiad o effeithiolrwydd yn asesu a yw'r Pwyllgor yn cyflawni ei ddyletswyddau yn 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.

AUDIT AND ASSURANCE COMMITTEE EFFECTIVENESS REVIEW 2020/21

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 6 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 Friday, 16 April 2021** 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				

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.

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?	✓			

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)?				

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?	✓			

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.

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?				

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?				

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?				

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?	

Dyddiad y Cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.8**
Teitl yr Adroddiad	**Adroddiad Llywodraethu Gwybodaeth a Rheoli Gwybodaeth AaGIC**		
Awdur yr Adroddiad	Kay Barrow, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd am faterion sy'n ymwneud â Llywodraethu Gwybodaeth (IG) a Rheoli Gwybodaeth (IM).		
Materion allweddol	Mae'r adroddiad yn rhoi'r wybodaeth ddiweddaraf am feysydd allweddol sy'n ymwneud â Llywodraethu Gwybodaeth a Rheoli Gwybodaeth gan gynnwys: • y Cynllun Gwaith Llywodraethu Gwybodaeth; • crynodeb o Geisiadau Rhyddid Gwybodaeth a Cheisiadau am Fynediad at Ddata gan y Testun; • Seiberddiogelwch.		
Cam Gweithredu Penodol *(un ✓yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
			✓	
Argymhellion	Gofynnir i'r Aelodau nodi'r adroddiad er **sicrwydd**.		

ADRODDIAD LLYWODRAETHU GWYBODAETH A RHEOLI GWYBODAETH

1. CYFLWYNIAD

Mae Llywodraethu Gwybodaeth (IG) a Rheoli Gwybodaeth (IM) yn effeithiol yn ei gwneud yn ofynnol i AaGIC fel sefydliad ddeall ei rwymedigaethau i gydymffurfio. Mae hefyd yn golygu sicrhau bod yr holl staff yn deall pwysigrwydd sicrhau bod gwybodaeth yn cael ei rheoli'n effeithiol.

2. CEFNDIR

Pwrpas y papur hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd (A&AC) am y sefyllfa bresennol o ran y Cynllun Gwaith Llywodraethu Gwybodaeth (Atodiad 1), a'r wybodaeth ddiweddaraf mewn perthynas â Cheisiadau Rhyddid Gwybodaeth, Ceisiadau am Fynediad at Ddata gan y Testun a dderbyniwyd gan AaGIC ynghyd â Seiberddiogelwch.

Nodau sylfaenol IG ac IM o fewn AaGIC yw:

- hyrwyddo defnyddio gwybodaeth yn effeithiol ac yn briodol yn y GIG (gan gynnwys gwybodaeth bersonol gyfrinachol a data masnachol sensitif);
- darparu'r adnoddau a'r gefnogaeth briodol i staff er mwyn eu galluogi i reoli gwybodaeth mewn ffordd gyfrifol a phroffesiynol;
- sicrhau bod yr holl wybodaeth yn cael ei phrosesu'n deg ac yn effeithiol ac yn unol â'r gyfraith.

2.1 Y Cynllun Gwaith Llywodraethu Gwybodaeth

Adolygwyd y cynllun gwaith Llywodraethu Gwybodaeth cyfredol gan y Grŵp Llywodraethu Gwybodaeth a Rheoli Gwybodaeth. Mae 30 o argymhellion neu amcanion ar gyfer y cynllun gwaith ac asesir bod 24 ohonynt yn wyrdd a 6 yn felyn. Y diweddariad allweddol yw ymestyn amserlenni cysylltiedig â'r Gofrestr Asedau Gwybodaeth. Y rheswm am hyn yw bod rhywfaint o'r gwaith cwmpasu cychwynnol wedi dangos bod gwaith pellach wedi'i gwblhau er mwyn gallu cael darlun mwy cyflawn o'r wybodaeth sy'n cael ei phrosesu gan AaGIC. Bydd hyn hefyd yn cynnwys adolygiad o rannu data â byrddau iechyd eraill. Bydd cyflwyno'r Pecyn Cymorth Llywodraethu Gwybodaeth yn sail i fersiwn bellach o'r cynllun gwaith a bydd y Gofrestr Asedau Gwybodaeth yn ffocws i'r sefydliad yn ystod y flwyddyn nesaf.

2.2 Rhyddid Gwybodaeth

Derbyniodd AaGIC 7 cais Rhyddid Gwybodaeth ar gyfer y cyfnod 1 Ionawr 2021 i 28 Chwefror 2021. Ymatebwyd i bob cais o fewn yr amserlenni a nodir yn Neddf Rhyddid Gwybodaeth 2000. Roedd y gyfradd gydymffurfio (ymateb o fewn 20 diwrnod gwaith) i dderbyn y ceisiadau yn **100%**. Ni dderbyniwyd unrhyw geisiadau am adolygiad na chwynion gan Swyddfa'r Comisiynydd Gwybodaeth.

- **Ffynhonnell Ceisiadau**

Unigolyn Preifat	5
Ymchwilydd/Dadansoddwr	0
Cwmni Preifat	0
Y Cyfryngau	0
Grŵp, Cymdeithas, Cymdeithas Siartredig	1
Ymgyrchydd (Whatdotheyknow.com)	1
Llywodraeth Cymru	0
Cyflogeion GIG Cymru	0
Ymddiriedolaeth/Bwrdd Iechyd	0
AS/Aelod Cynulliad	0
Llywodraeth Leol/Awdurdod Lleol/Trydydd Sector	0
Myfyriwr/Hyfforddai	0
Cyfreithiol	0
Coleg Brenhinol/RCN	0
CYFANSWM	**7**

- **Testun Ceisiadau**

Cais Testun am Wybodaeth	**Nifer**
Corfforaethol	4
Staff/Cyflogaeth	1
Contractau/Comisiynu	0
Hyfforddiant/Addysg	1
Ariannol	1
Ystadegol	0
Llywodraethu Gwybodaeth	0
CYFANSWM	**7**

- **Eithriadau a Ddefnyddiwyd**

Mae'r Ddeddf Rhyddid Gwybodaeth yn cynnwys nifer o eithriadau sy'n caniatáu i sefydliadau gadw gwybodaeth yn ôl oddi wrth rywun sy'n gwneud cais. Mewn rhai achosion, bydd y rhain hefyd yn caniatáu i AaGIC wrthod cadarnhau na gwadu a yw'r wybodaeth gan y sefydliad.

Mae rhai eithriadau yn ymwneud â math arbennig o wybodaeth, tra bo eraill yn seiliedig ar y niwed a fyddai'n cael ei achosi neu a fyddai'n debygol o gael ei

achosi o'i datgelu, er enghraifft, pe bai datgelu'n debygol o niweidio ymchwiliad troseddol neu niweidio buddiannau masnachol rhywun. Mae eithriad hefyd yng nghyswllt data personol pe bai rhyddhau'r data yn mynd yn groes i'r Rheoliad Cyffredinol ar Ddiogelu Data. Darparodd AaGIC ddatgeliad llawn ar gyfer 4 o'r 7 ymateb a gaewyd. Cymhwyswyd 2 eithriad fel a nodir isod:

Eithriad	**Nifer o Weithiau y'i Defnyddiwyd**
Adran 16: Cynghori a Chynorthwyo	1
Adran 40(2): Gwybodaeth Bersonol	3
CYFANSWM	**4**

Mae AaGIC yn rhoi gwybod i Lywodraeth Cymru am geisiadau sy'n dod i law sy'n cael eu hystyried yn sensitif neu'n gynhennus fel rhan o broses adrodd wythnosol Cymru Gyfan. Mae copïau o'r ymatebion hynny hefyd yn cael eu hanfon ymlaen at Lywodraeth Cymru er gwybodaeth.

2.3 Ceisiadau am Fynediad at Ddata gan y Testun (DSARS)

Nid yw AaGIC wedi cael ceisiadau am fynediad at ddata gan y testun yn ystod y cyfnod hwn.

2.4 Seiberddiogelwch

Mae Cynllun Gweithredu Gwaith a Rhaglen Seiberddiogelwch AaGIC wedi cael eu diffinio'n benodol i leihau proffil risg seiberddiogelwch AaGIC a gwella ei gyflwr o ran seiberddiogelwch. Mae'r Cynllun yn parhau i gael ei wreiddio ac mae'n canolbwyntio ar dri amcan strategol, sef Amddiffyn, Ymateb a Datblygu, a phum blaenoriaeth strategol allweddol:

Amcanion	**Blaenoriaethau Strategol**
Amddiffyn	• Deall cyflwr presennol seiberddiogelwch. • Sicrhewch fod glendid seiber yn iawn ac adeiladu sylfaen ddiogel.
Ymateb	• Ymateb yn gyflym ac yn effeithiol i ddigwyddiadau seiberddiogelwch.
Datblygu	• Ymgysylltu â swyddogaethau AaGIC a thu hwnt. • Hyrwyddo diwylliant o fod yn ymwybodol o seiber.

3. Y CYNNIG

Nodi'r adroddiad er sicrwydd.

4. MATERION LLYWODRAETHU A RISG

Mae diffyg cydymffurfio â Llywodraethu Gwybodaeth yn gallu arwain at ymchwiliad ffurfiol, cyhoeddusrwydd gwael ac, o bosibl, cosb ariannol gan Swyddfa'r Comisiynydd Gwybodaeth.

5. GOBLYGIADAU ARIANNOL

Nid oes unrhyw oblygiadau ariannol.

6. ARGYMHELLIAD

Gofynnir i'r Aelodau **nodi'r** adroddiad er sicrwydd.

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig *(rhowch ✓)*	**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:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**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'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio	**Nod Strategol 6:** Cael ei gydnabod fel partner, dylanwadwr ac arweinydd rhagorol
	✓	✓	✓

Ansawdd, Diogelwch a Phrofiad Cleifion
Mae'n bwysig bod AaGIC yn sicrhau defnyddwyr gwasanaeth y bydd IG ac IM yn cael eu hystyried a'u cynnal mewn diwylliant o gyfrinachedd effeithiol.
Goblygiadau Ariannol
Does dim goblygiadau ariannol i'w hystyried.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Os nad ydynt yn cael eu hystyried, gallai goblygiadau cyfreithiol diffyg cydymffurfio ag IG ac IM wneud y sefydliad yn agored i'r posibilrwydd o weithdrefnau ymchwiliad ffurfiol a chosb ariannol gan Swyddfa'r Comisiynydd Gwybodaeth.
Goblygiadau Staffio
Dim goblygiadau staffio.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Dim wedi'u nodi.

Hanes yr Adroddiad	Mae Adroddiad Llywodraethu Gwybodaeth a Rheoli Gwybodaeth yn cael ei gyflwyno i'r Pwyllgor Archwilio a Sicrwydd bob chwarter.
Atodiadau	Atodiad 1 – Y Cynllun Gwaith Llywodraethu Gwybodaeth

Atodiad 1 – Crynodeb o Gynllun Gwaith Llywodraethu Gwybodaeth AaGIC (Tachwedd 2020 – Mawrth 2021)

Y Cynllun Gwaith Llywodraethu Gwybodaeth

Allwedd

Mae Gwyrdd yn dynodi 'wedi cwblhau' neu fod camau gweithredu sydd â sail dreigl wedi cael eu hystyried yn y cynllun gwaith hwn
Mae Melyn yn dynodi bod peth gweithredu yn angenrheidiol i gwblhau a'i fod wedi cael ei ystyried
Mae coch yn dynodi bod y weithred yn disgwyl sylw, ond mae wedi cael ystyriaeth ond nid oes dim wedi'i gwblhau hyd yma

Amcan / Argymhelliad	Camau Rheoli	Arweinydd Cyfrifol	Statws RAG/ Cwblhau erbyn	Cynnydd	Manteision
1. Adolygu ac asesu Rheoliad Cyffredinol ar Diogelu Data (GDPR) yr UE ar gyfer AaGIC	1.1 Sicrhau bod y GDPR yn cael ei adlewyrchu yn y dogfennau ac ym mhrosesau AaGIC	Ysgrifennydd Bwrdd/Swyddog Gwybodaeth Llywodraethu	Y broses adolygu bresennol i'w chwblhau erbyn diwedd Rhagfyr 2020	Mae'r rhan fwyaf o feysydd wedi'u cwblhau. Prif flaenoriaeth y gwaith sydd i'w gwblhau yw'r Gofrestr Asedau Gwybodaeth. **Diweddariad 04/03/2020** – Mae'r holl gamau adolygu wedi'u cwblhau.	Yn rhoi sicrwydd bod y sefydliad yn cydymffurfio â'r ddeddfwriaeth ddiweddaraf
2. Datblygu dogfennau sy'n canolbwyntio ar IG.	2.1 Datblygu protocolau a chanllawiau Llywodraethu Gwybodaeth i sicrhau bod gan y sefydliad y rhestr gywir o ddogfennau, sy'n cynnwys cyfeiriadau at ddeddfwriaeth GDPR (gan gynnwys dogfennau cychwyn Prosiect) a	Ysgrifennydd Bwrdd/Swyddog Gwybodaeth Llywodraethu	Cwblhawyd	Mae swyddogaeth Llywodraethu Gwybodaeth AaGIC wedi datblygu protocolau, ffurflenni a dogfennau sy'n canolbwyntio ar AaGIC ar gyfer y swyddogaeth Llywodraethu Gwybodaeth. Mae hyn wedi cynnwys datblygu Hysbysiadau Preifatrwydd ar gyfer Staff.	Yn rhoi sicrwydd bod y sefydliad yn cydymffurfio â'r ddeddfwriaeth ddiweddaraf

	Hysbysiadau Preifatrwydd.				
3. Cysylltiad llywodraethu gwybodaeth â cheisiadau am rannu data	3.1 Sicrhau bod y swyddogaeth IG yn cael ei gwneud yn ymwybodol o brosesau sy'n gofyn am ddatblygu cytundebau a dogfennau proses gan nodi lle nad oes rhai	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae cytundeb mynediad safonol a chytundeb peidio â datgelu wedi'u datblygu i'w defnyddio gyda cheisiadau am ddata ac at ddibenion prosesu.	Yn dogfennu cyfrifoldebau pob parti o ran yr hyn sy'n ofynnol ar gyfer ei dderbyn
4. Cysylltiad llywodraethu gwybodaeth o ran creu, defnyddio a chyflwyno gwaith newydd gan ddefnyddio prosesau Preifatrwydd drwy Ddylunio	4.1 Sicrhau bod y swyddogaeth IG yn cael gwybod am wasanaethau newydd sy'n cael eu trosglwyddo o sefydliadau eraill (nid dim ond GIG Cymru) i AaGIC ac unrhyw brosiectau newydd sy'n cynnwys gwybodaeth adnabyddadwy	Perchennog y Prosiect/Swyddog Llywodraethu Gwybodaeth	Mae gwaith wedi dechrau ar hyn. Proses i gael ei sefydlu'n gadarn a'i defnyddio erbyn diwedd mis Chwefror. **Diweddariad 04/03/2020 – mae'r gwaith o integreiddio prosesau i'r prosesau ymuno wedi dechrau a bydd wedi'i gwblhau erbyn diwedd mis Ebrill.**	Bydd IG yn ymwneud â gofynion penodol pob gwasanaeth ac a yw newidiadau neu ddefnydd o gyfrinachedd yn cael eu mesur a'u Arfarnu.	Ystyrir cyfrinachedd ac IG ar gyfer pob prosiect/system newydd a newidiadau presennol i waith/neu gynigion/newidiadau
	4.2 Cyfathrebu a chodi ymwybyddiaeth o ofynion yr Asesiad o'r Effaith ar Ddiogelu Data	Swyddog Cyfathrebu a Llywodraethu Gwybodaeth	Parhaus	Cafodd cyfathrebiad ei ddatblygu a'i anfon at yr holl staff ynglŷn â'r gofynion ar gyfer cwblhau Asesiad o'r Effaith ar Ddiogelu Data a phan fydd angen cwblhau	Ystyrir cyfrinachedd ac IG ar gyfer pob prosiect/system newydd a newidiadau presennol i

				un ddiwedd mis Mehefin 2020.	waith/neu gynigion/newidiadau
5. Sicrhau bod systemau Teledu Cylch Cyfyng wedi'u lleoli'n gywir a bod yr asesiadau priodol wedi'u cynnal	5.1 Sicrhau bod y Swyddog Llywodraethu Gwybodaeth yn cael gwybod am gynigion i osod systemau diogelwch Teledu Cylch Cyfyng	Perchennog/arweinydd Prosiect/Swyddog Llywodraethu Gwybodaeth	Parhaus	Mae gan AaGIC brotocol Teledu Cylch Cyfyng sy'n cynnwys gwybodaeth am leoli, cydymffurfio ac arwyddion cywir, cadw ac ati.	Mae Teledu Cylch Cyfyng yn monitro gan gydymffurfio'n gywir ac nid yw'n torri unrhyw un o'r cyfreithiau'r SCC na phrotocol AaGIC.
6. Sicrhau bod digwyddiadau o dorri neu golli cyfrinachedd sy'n cael eu hamau, eu honni neu eu cadarnhau yn cael eu hadrodd a'u hymchwilio'n adweithiol/rhagweithiol	6.1 Mae staff yn ymwybodol o'r broses o roi gwybod am dorri cyfrinachedd ac yn gwybod sut i ganfod digwyddiad lle mae amheuaeth o dorri a ble i roi gwybod amdano.	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae protocol adrodd ar dorri cyfrinachedd cyfredol AaGIC ar waith i adlewyrchu'r newidiadau a wnaed dan y Rheoliadau newydd. Mae hwn wedi cael ei gymeradwyo gan y Tîm Gweithredol ac mae wedi cael ei roi ar y fewnrwyd	Hyrwyddo diwylliant o gyfrinachedd, gan reoli risgiau i'r sefydliad o ran torri rheolau gwybodaeth ac atal y rhain.

7. Sicrhau bod proses yr Asesiad o'r Effaith ar Ddiogelu Data (DPIA) yn cael ei defnyddio i sicrhau bod yr holl brosesau, gwasanaethau, systemau gwybodaeth ac asedau gwybodaeth perthnasol eraill yn cael eu datblygu, eu gweithredu a'u defnyddio mewn ffordd ddiogel a strwythuredig, tra'n cydymffurfio â gofynion achredu Diogelwch IG, Ansawdd Gwybodaeth, Cyfrinachedd a Diogelu Data	7.1 Gweithdrefnau wedi'u dogfennu wedi'u sefydlu i sicrhau bod pob proses newydd yn cael asesiad effaith ar Ddiogelu Data er mwyn sicrhau eu bod yn cydymffurfio â gofynion cyfrinachedd a Diogelu Data	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd Mae gan staff ymwybyddiaeth a dealltwriaeth fod proses DPIA lle bydd prosiectau neu ffyrdd newydd o ddefnyddio PII sydd eisoes yn bodoli o bosib angen asesiad o dan yr egwyddorion pan fo'n cael ei ystyried neu ei weithredu	Mae'r ddogfen DPIA wedi'i chymeradwyo ac yn cael ei defnyddio lle bo angen. Mae'r holl staff yn cael gwybod am y broses Asesiad o'r Effaith ar Ddiogelu Data mewn sesiynau hyfforddi ac ymwybyddiaeth i sicrhau bod y swyddogaeth IG yn cael ei defnyddio pan fydd prosiectau neu wasanaethau newydd yn cael eu cynnig yn y sefydliad. Mae bwletin sy'n cynnwys gwybodaeth ynghylch pryd mae angen DPIA a beth i'w wneud nesaf wedi cael ei ddatblygu a'i ryddhau ddiwedd mis Mehefin 2020.	Mae materion sy'n ymwneud â chyfrinachedd bob amser yn cael eu nodi, eu hateb a'u datrys yn unol â gofynion Diogelu Data ar gyfer pob system/proses/ llif gwaith newydd
	7.2 Mae pob Asesiad Effaith Preifatrwydd terfynol yn cael ei gymeradwyo a'i gymeradwyo gan grŵp lefel uwch pan fydd yr argymhellion wedi'u cwblhau gan Berchennog y Prosiect a'u cytuno gan y Swyddog Llywodraethu Gwybodaeth	Swyddog Llywodraethu Gwybodaeth	Proses yn ei lle	Mae templedi DPIA newydd sy'n adlewyrchu newidiadau o dan y Rheoliadau newydd. Mae'r rhain bellach wedi cael eu cymeradwyo i'w defnyddio. Ar ôl eu cwblhau, bydd y Swyddog Llywodraethu Gwybodaeth yn eu cymeradwyo ac yn eu cyflwyno er gwybodaeth a thrafodaeth yn y Tîm Gweithredol.	

8. Mae hyfforddiant ac ymwybyddiaeth o lywodraethu gwybodaeth ar waith ac mae'r holl staff priodol yn cael hyfforddiant (ystafell ddosbarth ac e-Ddysgu)	8.1 Ymgyrch weithredol i hyrwyddo hyfforddiant IG a'r gofyniad bod rhaid i staff sydd wedi cael eu nodi fel staff sy'n trin data adnabyddadwy gwblhau hyfforddiant wyneb yn wyneb ddwywaith y flwyddyn.	Swyddog Llywodraethu Gwybodaeth	Mae angen ystyried hyfforddiant parhaus. Bydd amserlen hyfforddiant yn cael ei chreu ar gyfer y flwyddyn 21-22. **Diweddariad 4/3/2020 – mae anghenion hyfforddi wedi'u nodi ac mae cynllun yn cael ei ddatblygu ar gyfer 21-22. Mae angen cynllun mwy cynhwysfawr sy'n cynnwys amrywiaeth o bynciau llywodraethu gwybodaeth**	Mae hyfforddiant Llywodraethu Gwybodaeth yn cael ei hyrwyddo a'i gyflwyno ar draws y sefydliad. Dechreuodd hyfforddiant IG ym mis Awst 2019. Ceir cofrestr o'r niferoedd, yr adran a chyfanswm y staff sydd wedi'u hyfforddi hyd yma Oherwydd ymrwymiadau'r Swyddog Llywodraethu Gwybodaeth a nifer y staff sy'n defnyddio'r sesiynau a drefnwyd (yr awydd amdanynt), ni threfnwyd sesiynau pellach yn yr ystafell ddosbarth yn 2020 hyd yma.	
	8.2 Sicrhau bod yr holl staff yn ymwybodol o'u cydymffurfiad blynyddol ac yn ei gwblhau gan ddefnyddio'r modiwl sgiliau craidd eDdysgu	Swyddog Llywodraethu Gwybodaeth	Mae angen cwblhau eDdysgu bob blwyddyn ar gyfer yr holl staff ac mae hyn yn gysylltiedig â'r broses PADR.	Anfonir nodiadau atgoffa o fewn y Cofnod Staff Electronig ar y modiwlau eDdysgu Llywodraethu Gwybodaeth. Bydd y rhain yn rhan o unrhyw adroddiadau hyfforddiant IG ar gyfer adran orfodol unrhyw ddiweddariadau a roddir i'r Tîm Gweithredol. Mae angen gweithredu ar hyn o bryd i gynyddu lefel cydymffurfiad staff yn AaGIC.	

	8.3 Datblygu tudalennau mewnrwyd AaGIC i gynnwys Llywodraethu Gwybodaeth	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae'r rhain wedi cael eu cyhoeddi erbyn hyn. Nodwyd ei fod wedi'i gwblhau, ond bydd angen ei adolygu'n flynyddol a'i ddiweddaru yn ôl yr angen	Bydd canllawiau clir yn helpu staff.
	8.4 Datblygu cyflwyniad Llywodraethu Gwybodaeth ar gyfer tudalen we AaGIC	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae'r rhain wedi cael eu cyhoeddi erbyn hyn. Nodwyd ei fod wedi'i gwblhau, ond bydd angen ei adolygu'n flynyddol. Mae rhagor o wybodaeth wedi cael ei hychwanegu at y safle i gynnwys adran IG gyda pholisïau a gweithdrefnau.	
	8.5 Datblygu taflenni a chanllawiau Llywodraethu Gwybodaeth ar arferion da	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae taflenni sy'n ymwneud ag IG, GDPR ac e-bost wedi cael eu creu ac yn cael eu defnyddio ac wedi cael eu cyhoeddi ar fewnrwyd AaGIC	

9. Cynhaliwyd adolygiad llawn o sut mae gwybodaeth yn cael ei defnyddio ledled y sefydliad drwy'r swyddogaeth Cofrestr Asedau Gwybodaeth	9.1 Rheoli'r broses ar gyfer cofnodi Asedau Gwybodaeth neu "Mapio" sy'n cynnwys: • Testun gwybodaeth • Mathau o wybodaeth • sail gyfreithiol dros brosesu • atebolrwydd y wybodaeth a gedwir	Swyddog Llywodraethu Gwybodaeth	Mae angen gwneud gwaith parhaus i gynnal y Gofrestr Asedau Gwybodaeth (IAR). Peth ymwybyddiaeth bod gwaith pellach i'w wneud ar hyn i adlewyrchu'r data sydd gan AaGIC. Bydd yr IAR wedi'i chwblhau erbyn diwedd Chwefror 2021. **Diweddariad 04/03/21 – Nodwyd bod angen gwaith pellach ar y Gofrestr Asedau Gwybodaeth. Bydd cynllun pellach yn cael ei gwmpasu pan geir adborth ar ôl cwblhau'r Pecyn Cymorth Llywodraethu Gwybodaeth.**	Fel rhan o gydymffurfio â'r Rheoliadau Diogelu Data Cyffredinol (GDPR), mae perchnogaeth asedau gwybodaeth yn ofyniad. Dim ond yn rhannol y mae hyn wedi'i gwblhau ar hyn o bryd. Cafodd cofrestr o asedau sy'n ymwneud â safle SharePoint AaGIC ei chwblhau ym mis Mai 2019 ac mae'n aros i gael ei hadolygu gan adrannau unigol. Mae hwn yn ymarfer i asesu pa mor addas yw'r dogfennau etifeddol a'r dogfennau hŷn a gedwir yn SharePoint ar hyn o bryd. Mae e-bost wedi cael ei anfon at yr holl staff i ofyn am wybodaeth am brosesu data adnabyddadwy unigol yn y sefydliad ac mae e-bost arall a anfonwyd at yr holl staff ym mis Mai 2020 wedi arwain at dros 160 o staff sydd wedi darparu ymateb i gadarnhau neu wadu defnyddio data adnabyddadwy ac sydd wedi darparu ymateb unigol neu gyfunol i restru eu defnydd.	

	9.2 Sicrhau, wrth adnabod a chofnodi Asedau Gwybodaeth, bod risgiau'n cael eu nodi i'r asedau sy'n cael eu dal a'u cofnodi ar gofrestr risg a bod gwaith yn cael ei wneud i leihau unrhyw broblemau	Swyddog Llywodraethu Gwybodaeth/ Perchnogion Asedau Gwybodaeth	Angen gwaith parhaus. Bydd yr IAR wedi'i chwblhau erbyn diwedd Chwefror 2021. **Diweddariad 04/03/21 – Nodwyd bod angen gwaith pellach ar y Gofrestr Asedau Gwybodaeth. Bydd cynllun pellach yn cael ei gwmpasu pan geir adborth ar ôl cwblhau'r Pecyn Cymorth Llywodraethu Gwybodaeth.**	Mae'r broses o gasglu Asedau Gwybodaeth yn mynd rhagddi ar hyn o bryd ac mae staff yn cadarnhau (neu'n gwadu) yn unigol eu bod yn defnyddio data personol ac yn llenwi ffurflen os yw'n berthnasol iddynt hwy. Fodd bynnag, ni nodwyd unrhyw waith prosesu risg uchel hyd yma.	
	9.3 Sicrhau bod proses barhaus ar waith i gofnodi'r holl asedau Gwybodaeth yn y dyfodol a dileu gwybodaeth nad yw o werth mwyach er mwyn sicrhau bod y gofrestr yn gywir	Swyddog Llywodraethu Gwybodaeth	Mae gwaith angen ei wneud i sicrhau bod y broses yn casglu gwybodaeth bersonol. Bydd y gwaith hwn yn cael ei gwblhau erbyn diwedd mis Chwefror 2021, yn unol â gofynion eraill y Gofrestr Asedau Gwybodaeth. **Diweddariad 04/03/21 – Nodwyd bod angen gwaith pellach ar y Gofrestr Asedau Gwybodaeth. Bydd cynllun pellach yn cael ei gwmpasu pan geir adborth ar ôl cwblhau'r Pecyn**	Rhoddir sylw i'r broses hon yn flynyddol ac atgyfnerthir yr arferion diweddaru. Bydd angen adolygu gwybodaeth a gedwir ar SharePoint yn drylwyr er mwyn cael gwared ar hen ddogfennau a dogfennau etifeddol nad ydynt yn cael eu defnyddio.	

			Cymorth Llywodraethu Gwybodaeth.		
10. Adrodd yn effeithiol ar fonitro a rheoli Risgiau Llywodraethu Gwybodaeth mewn datganiadau o reolaethau mewnol. Hyn i gynnwys manylion am achosion o golli data a thorri cyfrinachedd yn AaGIC	10.1 Rhoi'r wybodaeth ddiweddaraf i Dîm Gweithredol AaGIC yn rheolaidd a sicrhau bod pynciau, pryderon a/neu risgiau Llywodraethu Gwybodaeth yn weladwy	Swyddog Llywodraethu Gwybodaeth	Mae'r gofrestr risg ddrafft wedi'i chwblhau	Mae cofrestr risg ddrafft ar gyfer IG yn ei lle	
	10.2 Canfod rhagor o risgiau yn dilyn prosesau'r Gofrestr Asedau Gwybodaeth	Swyddog Llywodraethu Gwybodaeth	Angen proses adolygu barhaus ar gyfer IAR. Proses adolygu i'w sefydlu yn unol â gofynion eraill IAR erbyn diwedd mis Chwefror 2021. **Diweddariad 04/03/21 – Nodwyd bod angen gwaith pellach ar y Gofrestr Asedau Gwybodaeth. Bydd cynllun pellach yn cael ei gwmpasu pan geir adborth ar ôl cwblhau'r Pecyn Cymorth**	Mae'r Gofrestr Asedau Gwybodaeth yn casglu gwybodaeth am y sefydliad ac yn nodi unrhyw risgiau posibl a allai achosi tor-cyfrinachedd. Mae gwaith yn mynd rhagddo ar hyn o bryd i gasglu ac adolygu asedau gwybodaeth o fewn y sefydliad er mwyn gwneud y penderfyniadau hynny ynghylch risgiau.	

			Llywodraethu Gwybodaeth.		
11. Sicrhau bod y sefydliad yn parhau i gydymffurfio â'r holl asesiadau Llywodraethu Gwybodaeth gan gynnwys ymarferion hunanasesu	11.1 Sicrhau bod yr holl ymarferion i gydymffurfio â'r holl ddeddfau a moeseg perthnasol yn cael eu cwblhau er mwyn rhoi sicrwydd bod gwybodaeth bersonol adnabyddadwy yn cael ei thrin a'i rheoli'n effeithiol	Swyddog Llywodraethu Gwybodaeth	Angen cynnal asesiadau bob blwyddyn.	Bydd y Pecyn Cymorth IG yn rhan o asesiad IG wrth symud ymlaen yn 2020. Oherwydd cynnydd IG o fewn AaGIC ym mis Ebrill 2019, ni chafodd yr ymarfer cychwynnol ei gwblhau nes bod rhagor o gynnydd wedi cael ei wneud. Oherwydd Covid-19, nid oes pecyn cymorth 2020/21 wedi cael ei gyhoeddi hyd yma. Caiff y broses o gofrestru ar gyfer Diogelu Data ei chwblhau'n flynyddol ym mis Hydref. Bydd archwiliadau mewnol ac ymarferion y Comisiynydd Gwybodaeth yn cael eu cwblhau ar sail ad hoc.	

	11.2 Sicrhau bod y gwaith o adrodd yn effeithiol ar weithgareddau Llywodraethu Gwybodaeth yn cael ei gwblhau'n amserol i'r Tîm Gweithredol. Bydd hyn yn cynnwys datblygiadau yn y swyddogaeth Llywodraethu Gwybodaeth, cydymffurfio â hyfforddiant ac adroddiadau torri cyfrinachedd	Swyddog Llywodraethu Gwybodaeth	Proses wedi'i sefydlu. Bydd y Swyddog Llywodraethu Gwybodaeth yn ysgrifennu ac yn cyflwyno papurau pan fydd angen.	Dylid rhoi gwybod i'r Tîm Gweithredol am weithgarwch Llywodraethu Gwybodaeth pan fydd gofyniad. Dylai'r gweithgaredd hwn hefyd helpu i lywio meysydd fel adroddiadau blynyddol a datganiadau Llywodraethu. Cyflwynir papurau yn y grŵp IGIM bob chwarter.	
12. Cynhwysiant ac ymwybyddiaeth o ddigwyddiadau diogelwch TG a allai effeithio'n uniongyrchol neu'n anuniongyrchol ar Lywodraethu Gwybodaeth	12.1 Cynnwys TG a Seiberddiogelwch o fewn gwaith Llywodraethu Gwybodaeth	Swyddog Llywodraethu Gwybodaeth	Mae'r cysylltiad hwn wedi'i sefydlu ac mae'r Swyddog Llywodraethu Gwybodaeth yn cael gwybod am ddigwyddiadau lle bo angen.	Hysbysiad IG i gael ei gynnwys yn y broses hysbysu am ddigwyddiadau Seiber.	
13. Cydweithredu ag awdurdodau goruchwylio ynghylch adrodd ar ddigwyddiadau a sicrhau bod yr holl bartïon yn ymwybodol o ddigwyddiadau sy'n gysylltiedig ag IG	13.1 Sicrwydd bod y swyddogaeth Llywodraethu Gwybodaeth yn ymwneud ag unrhyw adroddiadau torri cyfrinachedd a'r camau i'w cymryd yn dilyn digwyddiad	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae gan AaGIC weithdrefn Adrodd ar Dorri Amodau Cyfrinachedd ar waith a bydd yn cysylltu â'r Tîm Gweithredol mewn achosion o ddigwyddiadau lefel uchel.	

14. Cynrychioli AaGIC mewn unrhyw fforymau Llywodraethu Gwybodaeth Cymru gyfan ac ymrwymiadau ffurfiol sy'n berthnasol i'r rôl	14.1 Sicrhau bod Llywodraethu Gwybodaeth yn cael ei gynnwys mewn cyfarfodydd lle mae angen cyngor ynghylch cyfrinachedd	Swyddog Llywodraethu Gwybodaeth	Wedi'i gwblhau ar hyn o bryd, gofyniad parhaus i'w ystyried	Bydd cysylltiad â chyfarfodydd a phwyllgorau ar ran AaGIC yn cael ei benderfynu yn ôl yr angen	Sicrhau cynrychiolaeth briodol i'r sefydliad
15. Mae archwiliadau Rheoli Cofnodion yn cael eu cwblhau i fesur lefelau'r wybodaeth wedi'i harchifo a'i storio sy'n cael ei chadw yn AaGIC	15.1 Gan ddilyn GDPR, sicrhau nad yw AaGIC ond yn cadw cofnodion a ffeiliau sy'n ofynnol a bod cofnodion wedi'u harchifo'n cael eu dinistrio yn unol â'r amserlen cydymffurfio	Swyddog Llywodraethu Gwybodaeth	Mae hyn yn mynd rhagddo.	Mae angen egluro'r trefniadau Rheoli Cofnodion a'r archwiliadau arfaethedig o hyd a bydd hyn yn rhan o'r broses Asedau Gwybodaeth sy'n mynd rhagddi yn y sefydliad. Bydd unrhyw waith rheoli cofnodion yn cael ei ystyried ar sail yr adroddiadau a ddarperir gan staff AaGIC ac a oes pryder ynghylch y papur sydd wedi cael ei storio.	
16. Mae ceisiadau am Fynediad at Ddata gan y Testun yn cael eu cwblhau'n effeithiol ac yn drylwyr	16.1 Datblygu protocol Cais am Fynediad at Ddata gan y Testun	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae Tîm Gweithredol AaGIC wedi cymeradwyo hyn fel rhan o'r gyfres o brotocolau IG sydd ar waith	
	16.2 Datblygu gweithdrefn unioni er mwyn i Destunau Data ofyn am newid/golygu neu ddileu gwybodaeth o'u cofnodion eu hunain	Swyddog Llywodraethu Gwybodaeth	Cwblhawyd	Mae Tîm Gweithredol AaGIC wedi cymeradwyo hyn fel rhan o'r gyfres o brotocolau IG sydd ar waith	
17. Gwaith sy'n gysylltiedig â Grŵp Llywio Llywodraethu Gwybodaeth AaGIC	17.1 Llunio Cylch Gorchwyl	Aelodau IGIM	Parhaus	Y Cyfarwyddwr Datblygu Digidol i gadarnhau'r cylch gorchwyl.	

18. Cyfathrebu'n rheolaidd â staff ar bynciau penodol sy'n ymwneud â Llywodraethu Gwybodaeth	18.1 Cyfathrebiadau rheolaidd yn Gymraeg ac yn Saesneg i staff drwy gyfrwng y Tîm Cyfathrebu ac Ymgysylltu	Swyddog Llywodraethu Gwybodaeth	Angen gwaith parhaus.	Amserlen i'w sefydlu ar gyfer y cyfathrebiadau hyn.	
19. Llywodraethu Gwybodaeth i ymwneud â chyflwyno gwasanaethau newydd drwy ymarferion caffael safonol	19.1 Sicrhau bod y Swyddog Llywodraethu Gwybodaeth yn cael gwybod am wasanaethau newydd sy'n cael eu prynu a allai gynnwys a bod angen defnyddio gwybodaeth gyfrinachol	Swyddog Llywodraethu Gwybodaeth	Bydd hyn yn cael ei ymgorffori yn y prosesau presennol.	Gwaith i ymgorffori hyn yn y prosesau presennol.	

Dyddiad y Cyfarfod	**7fed Ebrill 2021**	**Eitem ar yr Agenda**	**2.6**
Teitl yr Adroddiad	**Adroddiad Cydymffurfio - Caffael AaGIC**		
Awdur yr Adroddiad	Christine Thorne, Pennaeth Caffael, Partneriaeth Cydwasanaethau GIG Cymru		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Cyflwynwyd gan	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Pwrpas yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd ynghylch gweithgarwch caffael yn ystod y cyfnod rhwng 1af Ionawr 2021 a 19eg Mawrth 2021, ac yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheirianneg) y Cyfarwyddiadau Ariannol Sefydlog.		
Materion allweddol	Mae eglurhad o'r rhesymau, yr amgylchiadau a manylion unrhyw gamau pellach a gymerwyd hefyd wedi eu cynnwys yn yr atodiadau i'r adroddiad.		

Cam Penodol i'w Gymryd *(✓un yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyaeth**
			√	

Argymhellion	Gofynnir i aelodau: • **Nodi**'r adroddiad er sicrwydd

ADRODDIAD CYDYMFFURFIO - CAFFAEL AaGIC

1. CYFLWYNIAD

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

2. CEFNDIR

Pwrpas yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio ynghylch gweithgarwch caffael yn ystod y cyfnod rhwng 1af Ionawr 2021 a 19eg Mawrth 2021, ac yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheirianneg) y Cyfarwyddiadau Ariannol Sefydlog.

Mae eglurhad o'r rhesymau, yr amgylchiadau a manylion unrhyw gamau pellach a gymerwyd hefyd wedi eu cynnwys yn yr atodiadau i'r adroddiad.

Cyfeirnod Cyfarwyddiadau Ariannol Sefydlog (SFI)	Disgrifiad	Eitemau
3.5	Gweithredu Un Dyfynbris	4
4.2	Gweithredu Tendr Sengl	0
5.3	Tendrau Sengl i'w hystyried yn dilyn galwad am Gystadleuaeth OJEU	0
14.2	Dyfarnu cyllid ychwanegol y tu allan i delerau'r contract (a weithredir drwy Nodyn Newid Contract (CCN) neu Amrywio'r Telerau)	4

3. GOBLYGIADAU LLYWODRAETHU AC 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 Un Dyfynbris. Y canllawiau cyffredinol ar wario arian cyhoeddus yw y dylid ei gyflawni mewn ffordd deg, dryloyw ac agored, gan sicrhau y ceisir cystadleuaeth lle bynnag y bo modd. Felly, dylid cael cyn lleied â phosib o geisiadau am weithredu sengl.

4. ARGYMHELLIAD

Gofynnir i'r Pwyllgor:

- **Nodi**'r adroddiad er sicrwydd

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig *(rhowch ✓)*	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu ac ymorol am les gweithlu cymwys, cynaliadwy a hyblyg, i gefnogi'r gwaith o gyflawni *'Cymru Iachach'*	**Nod Strategol 2:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**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'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio	**Nod Strategol 6:** Cael ein cydnabod fel partner, dylanwadwr ac arweinydd rhagorol

Ansawdd, Diogelwch a Phrofiad Cleifion
Nid oes dim goblygiadau penodol o ran ansawdd a diogelwch yn gysylltiedig â'r gweithgarwch a nodwyd yn yr adroddiad hwn.
Goblygiadau Ariannol
Mae Cyfarwyddiadau Ariannol Sefydlog, Gorchmynion Sefydlog (SO), rheolyddion ariannol a phrosesau a systemau cyfrifo yn sail i lawer o reolaethau sefydliadol sy'n rhan o gyflawni targedau ariannol a llywodraethu da. Y canllawiau cyffredinol ar wario arian cyhoeddus yw y dylid ei gyflawni mewn ffordd deg, dryloyw ac agored, gan 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 asesiad cydraddoldeb ac amrywiaeth)
Nid oes dim goblygiadau cyfreithiol penodol yn gysylltiedig â'r gweithgarwch a nodwyd yn yr adroddiad hwn.
Goblygiadau Staffio
Nid oes dim goblygiadau staffio penodol yn gysylltiedig â'r gweithgarwch 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	
Atodiadau	Atodiad 1 Gwybodaeth Gryno Atodiad 2 Materion Pellach

Health Education Improvement Wales - Audit Committee Report – March 2021

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	Dental	HEIW-SQA-547	February 2021 – July 2021	Single Quotation	Maxinity Software	Maxinity Software Ltd	£15,480.00	Single quotation required as an interim solution whilst procuring the Learning Management System (LMS).	Endorsed	Support operational colleagues to ensure new contract is delivered on time	First Submission
HEIW	Medical	HEIW-SQA-564	March 2021	Single Quotation	Practical Skills for Education and Leadership for Healthcare Scientists (PSEL)	Academy of Healthcare Science	£17,400	Bespoke leadership course critical for the healthcare science profession.	Endorsed	No action required.	First Submission.
HEIW	Workforce	CCN-HEIW-040	January 2021	Change Control Notice	Workforce Planning Training	Skills for Health	£3,900	Change to online training due to Covid-19.	Endorsed	No action required.	First Submission
HEIW	Workforce	CCN-HEIW-041	January 2021 – July 2021	Change Control Notice	Thinqii LMS Platform	CDSM	£3,000	Change to virtual class rooms due to Covid-19.	Endorsed.	No further action required.	First Submission.

HEIW	Medical - SAS	CCN-HEIW-042	January 2021	Change Control Notice	SAS Courses	Attrainability	£1,700	Increase in scope to cover additional technical content.	Endorsed.	Advised service to ensure all requirements are captured within the specification	First Submission.
HEIW	Dental	CCN-HEIW-043	January 2021	Change Control Notice	Providers of Postgraduate Dental Education	Glennys Bridges	£3,000	Additional accreditation requirement to support course delivery.	Endorsed	No action required.	First Submission.

Health Education Improvement Wales - Audit Committee Report – March 2021

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-087	N/A	File Note	Provision of a bespoke programme within Inclusion and Organisational Development at HEIW.	Insight HRC	£13,000	Required to support the establishment of a new directorate to build a high performing team.	Endorsed.	Meeting held with service to affirm competition requirements	First Submission.
HEIW	Medical	HEIW-FN-088	October 2020 – August 2021	File Note	Public Health Masters	Cardiff University	£9,700	PHW trainee transitioned to HEIW; misunderstanding of	Endorsed.	Procurement process outlined and Procurement Manual	First submission

								process competition requirements.		highlighted.	

Dyddiad y Cyfarfod	**7fed Ebrill 2021**	**Eitem ar yr agenda**	**2.10**
Teitl yr Adroddiad	**Cofrestr Risg Gorfforaethol (CRG)**		
Awdur yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Diben yr Adroddiad	Rhoi trosolwg o'r risgiau a nodir ar hyn o bryd ar y Gofrestr Risg Gorfforaethol.		
Materion Allweddol	• Mae'r adroddiad yn rhoi'r wybodaeth ddiweddaraf am y Gofrestr Risg Gorfforaethol(CRG), sydd i'w gweld yn Atodiad 1. • Mae'r CRG yn cadarnhau: - **un** risg statws 'coch' - **wyth** risg statws 'ambr'		

Camau Penodol sy'n Ofynnol ***(un ✓yn*** unig os gwelwch yn dda)	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
			✓	

Argymhellion	Gofynnir i'r Pwyllgor: • **Sylwi** ar gynnwys yr adroddiad.

COFRESTR RISG GORFFORAETHOL

1. Cyflwyniad

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd nodi'r sefyllfa bresennol o ran y Gofrestr Risg Gorfforaethol **(Atodiad 1**) fel yr amlinellir yn yr adroddiad hwn.

2. Asesiad

Ers y cyfnod adrodd diwethaf, mae **9 risg ar y Gofrestr Risg** Gorfforaethol ar hyn o bryd. Aseswyd y risgiau hyn fel a ganlyn: un statws 'coch' ac **wyth** statws 'ambr'. Ac eithrio paragraff 2.1, mae'r sylwebaeth isod yn tynnu sylw at y newidiadau i'r GRG dros y mis diwethaf.

2.1 Risg Goch

- **Risg 8** - Os nad yw AaGIC yn sicrhau bod pob cam rhesymol yn cael ei gymryd mewn perthynas â seiberddiogelwch, gall fod yn agored i dorri data, dirwyon posibl gan Swyddfa'r Comisiynydd Gwybodaeth a chyhoeddusrwydd gwael cysylltiedig.

  Lliniaru: Mae hyn yn gofyn am weithredu argymhellion a amlygwyd yn adroddiad asesiad Seiberddiogelwch AaGIC. Cynllun gweithredu Seiberddiogelwch i'w ddrafftio a'i weithredu.

  Cynnydd: Mae'r argymhellion yn adroddiad asesu Seiberddiogelwch AaGIC wedi'u gweithredu neu'n cael eu gweithredu. Mae gweithgareddau i gefnogi'r gwaith o gyflawni'r cynllun seiberddiogelwch ar y gweill.

  - Datblygiadau diweddar:
    - Rhoddwyd mynediad i wasanaeth Gwybodaeth Diogelwch a Rheoli Digwyddiadau GIG Cymru (SIEM).
    - Mae cynllun caffael lefel uchel wedi'i gyflwyno i gaffael gwasanaeth e-ddysgu ac efelychu seiberddiogelwch.
    - Mae gwaith yn mynd rhagddo i edrych ar adnodd seiberddiogelwch ychwanegol.
    - Mae gwaith ar y gweill i osod y gweinydd eilaidd (cynnes) i gefnogi gwefan Fferylliaeth.
    - Mae'r Polisi Ymateb i Ddigwyddiadau Seiber wedi'i ailddrafftio ac mae'n barod i'w adolygu gan y Bwrdd Gweithredol.
    - Mae'r Cynllun Adfer Trychineb yn cael ei adolygu ar hyn o bryd ac yn cael ei ailddrafftio.
  - Datblygiadau eraill:
    - Mae'r archwiliad mewnol seiberddiogelwch wedi dod i gasgliad ac asesiad o sicrwydd rhesymol a ddarparwyd.

2.2 Risg gyda Sgôr Uwch

Bu dwy risg gyda sgoriau uwch ers yr adroddiad diwethaf.

- **Risg 19:** Os byddwn yn parhau i gomisiynu addysg ôl-gofrestru ac ôl-raddedig gan Sefydliadau Addysg Uwch yng Nghymru a Lloegr heb gontract, yna gall Sefydliadau Addysg Uwch dynnu darpariaeth addysg yn ôl neu fethu â darparu addysg o ansawdd uchel y gellir rheoli perfformiad yn y ffordd arferol sy'n cael ei llywodraethu gan gontract.

  Lliniaru: Adolygiad strategol o gam 2 Addysg Iechyd i fod yn eitem sefydlog mewn cyfarfodydd contract gyda Sefydliadau Addysg Uwch. Parhau i ymgysylltu â thrafodaethau rheolaidd â chyfarfodydd yr Ysgol Genedlaethol (4 gwlad a gynhelir bob chwarter) Dull graddol gyda'r rhaglenni hynny sydd fwyaf mewn perygl yn y don gyntaf. Rheidrwydd i gadw at amserlen y cytunwyd arni a sicrhau bod digon o adnoddau ar gyfer y prosiect e.e. penodi rheolwr prosiect

  Cynnydd: Achos busnes yn cael ei ddrafftio i gyflwyno i Lywodraeth Cymru i ddangos yr angen am adnoddau ychwanegol i gefnogi cam 2.

  Asesiad: mae'r risg hon wedi cynyddu dros y cyfnod o 6 i 8 ac ar hyn o bryd asesir bod ganddi statws 'Ambr'.

2.3 Risg gyda Sgôr Is

- **Risg 15**-. Os nad oes digon o gyfleoedd cyflogaeth ar gael ar gyfer graddio Gweithwyr Proffesiynol Perthynol i Iechyd a myfyrwyr Gweithwyr Cymorth Gofal Iechyd sydd wedi dewis y fwrsariaeth, gellir colli'r buddsoddiad mewn addysg i'r myfyrwyr hyn.

  Lliniaru: Mae rhaniad dwfn wedi'i wneud i archwilio'r rhesymau sylfaenol dros brinder cyflogaeth a'r broses apeliadau bwrsariaeth sy'n rhyddhau/gorfodi myfyrwyr o'u cyfrifoldebau bwrsariaeth. Y canlyniad yw'r camau lliniaru canlynol:
  1. Monitro'n well y swyddi sydd ar gael ac apeliadau bwrsariaeth
  2. Ymgysylltu â WoDs a DoFs i dynnu sylw at y bwlch rhwng ceisiadau comisiynu a chyfleoedd cyflogaeth.

  Disodlwyd y Grŵp Monitro Manylach gan y Grŵp Cymorth wedi'i Dargedu. Mae hyn wedi amlygu bod angen mireinio'r broses olrhain fel bod lleoliad myfyrwyr yn hysbys i AaGIC

  Mae'r broses bwrsariaeth wedi'i hystyried o Gymorth wedi'i Thargedu oherwydd y cynnydd a wnaed. Mae graddedigion eithriadol 2020 yn cael eu dilyn a rhoddir adroddiad i'r Bwrdd Gweithredol yn fisol. Mae cynllun symleiddio i fyfyrwyr yn cael ei gyflwyno ar gyfer yr holl fyfyrwyr sy'n graddio yn 2021 ac mae'r protocolau i gefnogi hyn yn cael eu cwblhau.

  Cynnydd: Blwyddyn olaf mae myfyrwyr Gweithwyr Proffesiynol Perthynol i Iechyd wedi cael eu cyhoeddi ar broses cynllun symleiddio i fyfyrwyr 2021. Risg wedi'i leihau i ambr. Rhai pryderon gan Benaethiaid Bydwreigiaeth ynghylch effaith recriwtio Band 5 ar gynlluniau'r gweithlu. Mae trafodaethau'n parhau. Mae cyfarfodydd wythnosol bellach ar waith rhwng AaGIC a Phartneriaeth Cydwasanaethau GIG Cymru. AaGIC a Phartneriaeth Cydwasanaethau GIG Cymru yn mynychu sesiynau briffio

gwybodaeth gyda holl grwpiau rhaglenni'r flwyddyn olaf ar draws yr holl ddarparwyr addysg. Ystyriaeth yn cael ei rhoi i reoli'r trefniadau diwedd blwyddyn ar gyfer y garfan hon.

Asesiad: aseswyd y sgôr risg hon yn wreiddiol fel 15 a statws 'coch'. Fodd bynnag, ailaseswyd y risg ac mae wedi arwain at leihau'r sgôr i 12 a'i hasesu fel statws 'Ambr'

- **Risg 17** – Os oes diffyg diddordeb gan Ddarparwyr Addysg mewn lotiau fel y nodir yn HCA, yna gallai hyn arwain at dorri ar draws y biblinell gweithlu a risg o ran enw da i AaGIC. Er bod ymgynghori helaeth wedi'i gynnal wrth ddatblygu'r HCA, mae'r dirwedd ar gyfer darparwyr addysg wedi newid yn 2020 oherwydd pandemig ac atgyfodiad COVID.

  Lliniaru: Bu ymgynghori manwl â'r holl randdeiliaid wrth ddatblygu'r HCA a datblygu 'Lotiau' wedi'u saernïo'n ofalus.

  Mae addysg y bu'n anodd recriwtio ynddi o'r blaen wedi'i hymgorffori mewn 'Lotiau' mwy gan sicrhau y bydd cynigwyr - er enghraifft, mae Ymarferwyr Cynorthwyol Radiograffeg wedi'u hymgorffori yn y 'Lot' Radiograffeg Ddiagnostig fwyaf.

  Mae'r holl PTPau Gwyddoniaeth Gofal Iechyd wedi'u hymgorffori mewn un 'Lot' – felly niferoedd cynyddol a chyllid ar gyfer y 'Lot', a ddylai arwain at gomisiynu pob PTPs Gweithiwr Cymorth Gofal Iechyd.

  Cynnydd: Digwyddiad olaf y cynigydd wedi'i gynnal. Ni chodwyd unrhyw bryderon ynghylch cynigwyr posibl drwy'r mecanweithiau caffael a nodwyd neu drwy unrhyw gyfathrebu uniongyrchol ag AaGIC.

  Mae'r holl ddeiliaid contract presennol wedi defnyddio'r dogfennau tendro ar sell2Wales.

  Mae un brifysgol wedi rhoi rhybudd nad ydynt yn bwriadu gwneud cais am un o'u rhaglenni presennol, ond mae sicrwydd wedi'i wneud i Gyfarwyddwr Addysg yr Adran Addysg y bydd Prifysgolion eraill yn gwneud cais amdano.

  Derbyniwyd ceisiadau gan Brifysgolion ar gyfer pob 'Lot' a gynigiwyd. Mae'r gwerthusiad o'r ceisiadau wedi dechrau. Mae angen i bob gwerthuswr gyfrannu eu hymatebion i'r safon a'r amserlenni gofynnol er mwyn cadw'r broses ar y trywydd cywir.

  Asesiad: Aseswyd y i sgôr risg yn wreiddiol fel 12 a statws 'Ambr'. Fodd bynnag, ailaseswyd y risg ac mae wedi arwain at leihau'r sgôr i 8 a'r statws 'Ambr' sy'n weddill.

2.4 Tynnu Risg

Dilëwyd risgiau 4 a 18 o'r GRG ers yr adroddiad diwethaf.

2.5 Risg Newydd

Nid oes unrhyw risgiau newydd wedi'u hychwanegu at y GRG ers yr adroddiad diwethaf.

3. MATERION LLYWODRAETHU A RISG

Mae rheoli risg drwy'r Gofrestr Risg Gorfforaethol yn offeryn craidd ar gyfer llywodraethu risg o fewn AaGIC.

4. GOBLYGIADAU ARIANNOL

Mae rheoli risg drwy'r Gofrestr Risg Gorfforaethol yn un o swyddogaethau craidd AaGIC fel Awdurdod Iechyd Arbennig. Ni ragwelir unrhyw oblygiadau cost ychwanegol.

5. Argymhelliad

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd:

- **Sylwi** ar gynnwys yr adroddiad.

Llywodraethu a Sicrwydd			
Linc i nodau strategol IMTP ***(os*** gwelwch yn ***ddau)***	**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:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau ei fod yn diwallu anghenion y dyfodol	**Nod Strategol 3:** Gweithio gyda phartneriaid i ddylanwadu ar newid diwylliannol o fewn GIG Cymru drwy feithrin gallu tosturiol ac arweinyddiaeth gyfunol ar bob lefel
		✓	
	Nod Strategol 4: Datblygu'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr enghreifftiol ac yn lle gwych i weithio	**Nod Strategol 6:** I'w gydnabod fel partner, dylanwadwr ac arweinydd rhagorol
Ansawdd, Diogelwch a Phrofiad Cleifion			
Y Gofrestr Risg Gorfforaethol yw'r offeryn craidd i sicrhau rheolaeth risg 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 Arbennig. Ni ragwelir unrhyw gostau ychwanegol.			
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)			
AMHERTHNASOL			
Goblygiadau Staffio			
Nid oes unrhyw oblygiadau staffio ychwanegol.			
Goblygiadau Hirdymor (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)			

Y Gofrestr Risg Gorfforaethol yw offeryn craidd AaGIC i reoli risg wrth symud ymlaen.	
Hanes yr Adroddiad	Cyflwynir y Gofrestr Risg i'r Pwyllgor Archwilio a Sicrwydd bob mis.
Atodiadau	Atodiad 1 – Cofrestr Risg Gorfforaethol

HEIW CORPORATE RISK REGISTER (MARCH 2021)

te Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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. Apr 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 has commenced working on a new Cyber Security Implementation Plan. Update 04/03/2021 Activities to support the delivery of the cyber security plan are underway. Recent developments: • Access has been granted to the NHS Wales Security Information and Event Management (SIEM) service. • A high-level procurement plan has been submitted to procure a cyber security eLearning and simulation service. • Work is underway to look at additional cyber security resource. • Work is underway to setup the secondary (warm) server to support the Pharmacy website. • The Cyber Incident Response Policy has been redrafted and is ready for Executive review. • Disaster Recovery Plan is currently under review and being redrafted. Other developments: The cyber security internal audit has drawn to a conclusion. A draft copy of the audit report has been distributed for internal review.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
10. May 2020	**1.**	If the suspension of routine dentistry and the suspension of aerosol producing procedures in response to COVID-19 is affecting dental training processes both in undergraduate and postgraduate arenas is not mitigated this will affect when, and, how dental students and foundation dentists gain the relevant level of experience in order to qualify and may impact on the NHS workforce and service delivery. **Medical Director**	**4**	**4**	**16**	LOW	The matter is being considered at a 4 nations level to ensure a co-ordinated response. Changes to the training programmes will be developed. This will include: • Mandatory clinical skills test before starting on patients • Redirection of training programme based on contract reform principles • Front loading of Simulation and classroom elements of training from Sept 2020- Jan 2021 • Practical clinical elements of training to be undertaken in later in the training programmes.	**3**	**3**	**9**		Undergraduates were not prevented from qualifying in 2020. They have progressed to Foundation across the UK. The majority of Foundation trainees had gained sufficient competencies to progress. All of our Core Training and Specialist Training posts have been filled The risk for next year remains though Dentistry has recommenced with appropriate protection. Update 7.10.2010 - No change Update 2.11.2020 There are National discussions ongoing regarding Final Year Dental Students who were due to graduate in the Summer of 2021. It is looking likely that their graduation will be delayed as late as December 2021 which will have implications for Foundation programmes in 2021 and onward progression after that. Update10.01.2020 The current position in Wales is that Graduation may be delayed slightly in Cardiff, but Foundation year could start almost on time. 12.02.2021 - No Change 04.03.2021 There is a specific problem emerging in relation to the filling of Foundation posts in Wales in Autumn of 2021 due to predicted late graduation in England. There are ongoing National discussions regarding this and local discussions with Cardiff Dental School to anticipate how this will develop.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
11. July 2020	**1.**	If there is a second or multiple peaks of COVID-19 and HEIW does not re-assess its Quarterly Plan then it will not be able to re-allocate resources to provide the necessary support to the NHS workforce during the crisis and fail to manage expectations in the delivery of its objectives. **Director of Performance, Planning and Corporate Services**	**4**	**4**	**16**	LOW	HEIW undertook a review and pause of its IMTP objectives in Q2 and lessons learnt from this process have been captured and utilised. Our Q3 and Q4 Operational Plan has been agreed by the Board and submitted to WG. Our capacity to deliver our Q3&4 Plan remains under review but objectives have not been paused. Progress at the end of Q3 has been reviewed by the Executive Team and the majority of Objectives are on-track.	**4**	**2**	**8**		

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
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**		Discussions with Welsh Government and NWSSP to take place to understand the remit and responsibilities for each organisation. Data access discussions with NWSSP in progress

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
13. July 2020	**1**	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 and costing of workforce requirements made as part of the development of the Quarterly/Annual plans	**4**	**2**	**8**		Plans actively reviewed and monitored to assess delivery trajectories and inform revisions/mitigation. 'Reset' under consideration in context of draft 2021-22 annual plan to ensure that capacity and resources are aligned to priority areas

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
15. **Aug 2020**	**2**	If there are insufficient employment opportunities available for graduating AHPs and HCS students who have opted into the bursary tie in the investment in education for these students may be lost. **Interim Director of Nursing**	**3**	**5**	**15**	LOW	A deep dive has been undertaken to examine underlying reasons for employment shortages and the bursary appeals process that releases/enforces students from their bursary responsibilities. The outcome of which are the following mitigating actions: 1. Enhanced monitoring of available posts and bursary appeals 2. Engagement with WoDs and DoFs to highlight the gap between commissioning requests and employment opportunities. The Enhanced Monitoring Group has been replaced by the Targeted Support Group. This has highlighted that there is a need to refine the tracking process so that the whereabouts of students are known to HEIW The bursary process has been stood down from Targeted Support due to the progress made. The outstanding 2020 graduates are being followed up and a report is given to the Executive on a monthly basis. Streamlining is being introduced for all students graduating in 2021 and the protocols to support this are being finalised'.	**4**	**3**	**12**		Enhanced monitoring and conversations with service proceeding AHP graduates will be included in the summer 2021 streamlining process to facilitate transition to NHS Wales posts. Agreement made in Dec/ Jan 20-21. 03/02/2021 – Final year AHP students have been issued comms on the 2021 streamlining process. Risk reduced to amber. Some concerns from Heads of Midwifery regarding the impact of Band 5 recruitment on workforce plans. Discussions ongoing. Weekly meetings now in place between HEIW and NWSSP. HEIW and NWSSP attending information briefing sessions with all final year programme groups across all education providers. Consideration being given to managing the year end arrangements for this cohort.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
16. Aug 2020		If there is an increase in cases of COVID 19 that impacts on 'usual' service delivery there may be disruptions to placement opportunities for trainees and students thereby impacting their ability to progress, graduate or complete training in their field . This in turn will impact the workforce with shortages that may have a long-term effect on service delivery. **Interim Director of Nursing & Medical Director**	**4**	**3**	**12**	LOW	• Continuation of the mapping of cohort/programme delays • Supporting EPs and service to implement HEIWs placement recovery principles • Continuous engagement with regulators, EPs CoDs medical Colleges and other statutory educational bodies (4 nation approach) to ensure continuity of education. • Placement recovery principles. • Revised processes for ARCPs and curriculum derogations for medical trainees to continue until September 2021 to support progression • Established communication channels with LEPs for medical trainees to ensure time limited approach to any redeployment in context of second wave • Data gathering at individual medical and dental trainee level • The UK approval of a Covid 19 vaccine on 2/12/20, with NHS staff prioritised, followed by the wider UK population provides assurance that programmes will be able to revert to pre Covid approaches by spring 2021.	**4**	**3**	**12**		<u>Nursing and AHP</u> The Directorate is in continuous conversations with regulators, EPs, CoDs and Government. Following a resurgence of the Covid pandemic in October 2020 a review as to whether students should be deployed again has been under review by the 4 nations and key stakeholders. It is not the intention of Wales to deploy students at this point thereby enabling the students to complete their learning and enter the workforce as planned. 350+ nursing student are due to enter the workforce in March 2021. Additionally, a number of e-resources have been made available to students to reduce any concerns they may have of entering placement / travelling to placement during the pandemic situation. Instigation of emergency standards is again under review. Engagement with WG has ensured that students on placement have parity of access to Covid vaccinations as paid staff. Update10.01.2020 <u>Medicine</u> The second wave has resulted in the potential for further redeployment of trainees. This activity is being carefully monitored and more effective management and communication plans are in place. 4 nation agreed revised ARCP processes and derogations to curricula to continue until September 2021 to enable progression of trainees as far as possible but further disruption will have a cumulative impact on trainee progression and potential There are ongoing discussions at UK level in Medicine and Dentistry to ensure that the beneficial changes across the UK are maintained.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
16. *Continued*												Update 3/2/21 <u>Nursing</u> WG has confirmed there are no plans to redeploy students to support the workforce during the second wave of COVID. The current fall in infection rates across Wales provides greater certainty that this position will remain. ECQT led placement recovery group continues to support the safe reopening and expansion of placements. <u>Medicine</u> Redeployment has happened when needed at a local level and with the agreement and involvement of the Appropriate Deanery. February rotations have proceeded as planned. There are ongoing concerns about experience for Craft specialties with the reduction of planned surgery. 04.03.2021 <u>Medicine</u> Ongoing concerns about craft specialties. This may become clearer with new planned care programmes.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
17 Oct 2020		If there is a lack of interest from Education Providers in lots as detailed in ITT. Then this may result in an interruption to the workforce pipeline and a reputational risk to HEIW. Whilst extensive consultation has been undertaken in developing the ITT, the landscape for education providers has shifted in 2020 due to the COVID pandemic and resurgence. **Director of Finance/Interim Director of Nursing**	**5**	**4**	**20**	LOW	• Detailed consultation with all stakeholders in developing the ITT. Development of carefully crafted lots. • Education which has previously been difficult to recruit to has been incorporated in larger lots ensuring that there will be bidders – for example Radiography Assistant Practitioners has been incorporated into the largest Diagnostic Radiography lot • All Healthcare Science PTP's have been incorporated into one lot – therefore increasing numbers and funding for the lot which should result in all small HCS PTPs being commissioned	**4**	**2**	**8**		2/10/20 Final bidder event undertaken. No concerns around have been raised by possible bidders through the procurement mechanisms set out or through any direct communication with HEIW. 3/12/20 – All current contract holders have accessed the tender documents on sell2Wales. Jan 21 – One university has provided notice that they do not intend to bid for one of their current programmes, however assurances have been made to the Dept Dir of Ed that other Unis will bid. Feb 21 - Bids have been received from Universities for all Lots that were offered. Evaluation of the bids has commenced. There is a need for all evaluators to contribute their responses to the required standard and timescales to keep the process on track.

Date Added	Ref (Risk Area)	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Action	Residual Risk			RAG Status	Progress
		Details of risk If…then… impact…	Impact	Probability	Overall Score	None Low Moderate High V. 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	
19 Dec 2020		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. **Interim Director of Nursing**	**3**	**6**	**18**	High	Strategic review phase 2 to be a standing item in contract meetings with HEI's. Continue to engage with regular discussions with the National School (4 countries meetings held quarterly) Phased approach with those programmes most at risk in first wave. Imperative to keep to agreed timeline and ensure project is sufficiently resourced e.g. appointing a project manager	**2**	**4**	**8**		3/2/21 – Business case being drafted to present to WG to illustrate need for additional resource to support phase 2.

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

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.

Dyddiad y Cyfarfod	**7 Ebrill 2021**	**Eitem ar yr Agenda**	**2.12**
Teitl yr Adroddiad	**Adnodd Tracio Argymhellion Archwiliad**		
Awdur yr Adroddiad	Kay Barrow, Rheolwr Llywodraethu Corfforaethol		
Noddwr yr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	At ddibenion cydymffurfio a sicrwydd, cyflwyno i'r Pwyllgor Archwilio a Sicrwydd yr Adnodd Tracio Argymhellion Archwiliad (yr Adnodd Tracio) sy'n cynnwys y camau gweithredu presennol y cytunwyd arnynt mewn ymateb i'r argymhellion a'r ystyriaethau cynghorol o fewn adroddiadau Archwilio a dderbyniwyd gan ffynonellau fel Archwilio Mewnol a Swyddfa Archwilio Cymru. Rhoi diweddariad ynghylch statws Coch Melyn Gwyrdd nifer o argymhellion ar ôl i'r Tîm Gweithredol adolygu cynnydd y camau gweithredu yn yr Adnodd Tracio.		
Materion allweddol	Mae'r Adnodd Tracio, y mae ei statws yn cael ei gynrychioli gan ddefnyddio proses sgorio Coch; Melyn; Gwyrdd (RAG), yn cwmpasu **40** o argymhellion ac ystyriaethau cynghorol ar hyn o bryd. Mae'r Adnodd Tracio wedi'i atodi yn Atodiad 1.		

Cam Penodol i'w Gymryd *(un ✓yn unig)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
				✓

Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol: • **Nodi'r** adroddiad; • **Ystyried** y cynnydd; • **Cymeradwyo** bod yr argymhellion gwyrdd yr aseswyd eu bod wedi'u cwblhau, neu sydd wedi'u cwblhau yn llwyr, yn cael eu tynnu o'r Adnodd Tracio.

ADNODD TRACIO ARGYMHELLION ARCHWILIAD

1. CYFLWYNIAD

Yn unol ag arfer da, dylai'r Pwyllgor Archwilio a Sicrwydd fonitro cynnydd yn fanwl gan ddefnyddio'r rhaglen o adroddiadau archwilio mewnol ac allanol a gynhelir yn Addysg a Gwella Iechyd Cymru (AaGIC). Sefydlwyd Adnodd Tracio Argymhellion Archwiliad (Adnodd Tracio) i nodi cynnydd holl argymhellion yr adroddiadau Archwilio Mewnol ac Allanol ers sefydlu AaGIC.

Bydd yr Adnodd Tracio yn rhoi sicrwydd i'r Pwyllgor Archwilio a Sicrwydd bod yr argymhellion hynny yn cael eu datblygu, eu monitro a'u cwblhau.

2. CEFNDIR

Dylai'r Pwyllgor chwarae rôl allweddol yn cefnogi llywodraethiant effeithiol AaGIC. Dylai'r Pwyllgor chwarae rôl allweddol yn sicrhau bod AaGIC yn gweithio yn unol ag arferion llywodraethu da, drwy osod safonau cyfrifyddu ac archwilio priodol a thrwy fabwysiadu trefniadau rheoli risg priodol.

3. MATERION LLYWODRAETHU A RISG

Yn unol ag arferion llywodraethu da, mae cydlynu ac adrodd ar gamau gweithredu sefydliadau ar gyfer gweithgareddau archwilio yn rhai o brif elfennau trefniadau sicrwydd cyffredinol AaGIC.

Mae'r Adnodd Tracio'n monitro statws argymhellion ac ystyriaethau cynghorol yr Archwilwyr Mewnol ac Allanol yn agos. Mae hyn yn darparu adnodd ymarferol i AaGIC sy'n golygu bod modd craffu'n fanylach ar argymhellion archwilio. Mae wedi'i ddylunio er mwyn canolbwyntio'n fanylach ar y rhesymau pam mae argymhellion yn hwyr neu pam does dim cynnydd wedi'i wneud yn unol â'r amserlenni y cytunwyd arnynt. Bydd hyn yn amlygu meysydd mae'n bosib bod angen cymorth ychwanegol arnynt ac yn sicrhau bod mecanweithiau clir ar waith i godi unrhyw faterion.

Taenlen Excel yw'r Adnodd Tracio, ac mae wedi'i rhannu'n chwe tab:

- 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

Caiff argymhellion archwilio eu rhoi mewn categorïau yn ôl eu lefel blaenoriaeth ac, fel canllaw, dylent gael eu cwblhau o fewn yr amserlenni canlynol oni bai y cytunir ar amserlen fwy priodol yn ystod yr archwiliad.

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**

Adeg cyhoeddi'r adroddiad, roedd **29** o argymhellion archwilio mewnol cyfredol ar yr adnodd tracio.

Mae'r Adnodd Tracio yn dangos yr argymhellion sydd wedi cael eu cwblhau a'r rhai y bwriedir eu tynnu o'r Adnodd Tracio, y rheini sydd wedi gwneud cynnydd sylweddol ond sydd yn dal heb gael eu cwblhau'n llawn, a'r rheini lle mae cynnydd wedi'i wneud ond mae llawer o ffactorau yn parhau, sy'n atal y camau gweithredu rhag cael eu cwblhau'n llawn.

Mae'r **29** argymhelliad yn y tab archwiliad mewnol wedi'u rhoi mewn categorïau yn y tabl isod:

Coch	**0**	Dim cynnydd a'r tu allan i'r dyddiad targed gwreiddiol. Mae dyddiadau cau diwygiedig wedi cael eu pennu.
Gwyrdd	**17**	Aseswyd bod y cam gweithredu wedi'i gwblhau neu wedi'i gwblhau'n llwyr.
Melyn	**12**	Cynnydd sylweddol ond yn dal heb ei gwblhau'n llwyr, neu dydy'r Cam Gweithredu heb gyrraedd y dyddiad cau ar hyn o bryd.

Bwriedir tynnu'r **17** cam gweithredu 'Gwyrdd' yr aseswyd eu bod wedi'u cwblhau neu sydd wedi'u cwblhau'n llwyr o'r Adnodd Tracio os bydd y Pwyllgor Archwilio a Sicrwydd yn cytuno i wneud hynny.

Cyfanswm Argymhellion Archwiliad Mewnol Hwyr

Mae **8** argymhelliad yn hwyr ar yr adnodd tracio sy'n cael eu rhoi yn eu cyd-destun isod.

Gofynnir i aelodau'r pwyllgor nodi bod COVID 19 wedi achosi oedi o ran rhoi nifer o'r argymhellion ar waith oherwydd bod pwyslais AaGIC wedi symud i gefnogi ymateb GIG Cymru i'r pandemig.

Mae rhai o'r argymhellion hwyr yn ymwneud â meysydd lle mai dim ond yn gymharol ddiweddar y mae AaGIC wedi penodi aelodau allweddol o staff, fel y Cyfarwyddwr Cynllunio, Perfformiad a Gwasanaethau Corfforaethol a'r Cyfarwyddwr Digidol. Yn dilyn penodi'r Cyfarwyddwr Cynllunio, Perfformiad a Gwasanaethau Corfforaethol, gwelwyd cynnydd amlwg yn y ffocws mewn meysydd fel y Fframwaith Perfformiad a'r Dangosfwrdd Perfformiad.

Mae nifer o'r argymhellion yn yr archwiliad mewnol yn ymwneud â'r un meysydd, megis y Dangosfwrdd Perfformiad.

Mae'r cyd-destun uchod (ac eithrio'r pwynt am y Dangosfwrdd Perfformiad) hefyd yn berthnasol i argymhellion hwyr yr archwiliad allanol sy'n cael eu hystyried isod.

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	1
Canolig	5
Isel	2
Cyfanswm	**8**

Nodir isod nifer yr argymhellion hwyr yn ôl y sgoriau sicrwydd:

Sgôr Sicrwydd	Nifer yr Argymhellion Hwyr
Cyfyngedig	0
Rhesymol	7
Sylweddol	1
Heb ei Raddio	0
Cyfanswm	**8**

Mae rhagor o waith yn cael ei wneud i sicrhau bod gweddill y camau gweithredu ar y gronfa ddata yn cael eu cwblhau fel y cytunwyd.

- **Tab 2 – Crynodeb o Adroddiadau Archwilio Mewnol**

Mae Tab 2 yn disgrifio'r argymhellion a wnaed yn dilyn Asesiadau Strwythuredig Archwilio Cymru ac unrhyw adroddiadau archwilio allanol eraill. Adeg cyhoeddi'r adroddiad, roedd **10** o argymhellion archwilio mewnol cyfredol ar yr adnodd tracio. Amlinellwyd cefndir a chyd-destun ychwanegol yr argymhelliad allanol hwyr uchod yn yr adran ar argymhellion archwilio mewnol hwyr.

Mae'r tabl isod yn disgrifio statws argymhellion archwilio allanol cyfredol:

Statws	Nifer yr Argymhellion
Yn hwyr	3
Nid yw i fod yn barod eto	1
Wedi'i gwblhau yn y cyfnod hwn	6
Parhaus	0
Cyfanswm	**10**

Bwriedir tynnu'r **7** cam gweithredu 'Gwyrdd' yr aseswyd eu bod wedi'u cwblhau neu sydd wedi'u cwblhau'n llwyr o'r Adnodd Tracio os bydd y Pwyllgor Archwilio a Sicrwydd yn cytuno i wneud hynny.

Mae rhagor o waith yn cael ei wneud i sicrhau bod gweddill y camau gweithredu ar y gronfa ddata yn cael eu cwblhau fel y cytunwyd.

- **Tab 3 – Crynodeb o Adolygiadau Cynghorol Archwilio Mewnol**

Mae Tab 3 yn disgrifio statws yr 1 ystyriaeth ymgynghorol sydd ar ôl yn dilyn y Trefniadau Llywodraethu Archwilio Mewnol yn ystod Adroddiad Cynghorol Pandemig COVID-19. Mae'r tabl isod yn disgrifio statws argymhellion archwilio mewnol cyfredol:

Statws	Nifer yr Argymhellion
Yn hwyr	0
Nid yw i fod yn barod eto	1
Wedi'i gwblhau yn y cyfnod hwn	0
Parhaus	0
Cyfanswm	**1**

Mae rhagor o waith yn cael ei wneud i sicrhau bod gweddill y camau gweithredu ar y gronfa ddata yn cael eu cwblhau fel y cytunwyd.

4. GOBLYGIADAU ARIANNOL

Efallai y bydd sgil effeithiau ariannol i gamau gweithredu unigol ond, nid oes effaith ariannol uniongyrchol sy'n gysylltiedig â'r adroddiad yma ar hyn o bryd.

5. ARGYMHELLIAD

Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol:

- **Nodi'r** adroddiad;
- **Ystyried** y cynnydd;
- **Cymeradwyo** bod yr argymhellion gwyrdd yr aseswyd eu bod wedi'u cwblhau, neu sydd wedi'u cwblhau yn llwyr, yn cael eu tynnu o'r Adnodd Tracio.

Llywodraethu a Sicrwydd			
Cyswllt â nodau strategol y Cynllun Tymor Canolig Integredig ***(rhowch ✓)***	**Nod Strategol 1:** Arwain y gwaith o gynllunio, datblygu ac ymorol am les gweithlu cymwys, cynaliadwy a hyblyg i gefnogi'r gwaith o gyflawni '*Cymru Iachach*'	**Nod Strategol 2:** Gwella ansawdd a hygyrchedd addysg a hyfforddiant i'r holl staff gofal iechyd gan sicrhau eu bod yn diwallu anghenion y dyfodol	**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'r gweithlu i gefnogi'r gwaith o ddarparu diogelwch ac ansawdd	**Nod Strategol 5:** Bod yn gyflogwr rhagorol ac yn lle gwych i weithio	**Nod Strategol 6:** Cael eich cydnabod fel partner, dylanwadwr ac arweinydd rhagorol

Ansawdd, Diogelwch a Phrofiad Cleifion
Bydd yr effaith ar ansawdd, diogelwch a phrofiad cleifion yn cael ei hamlygu yn y camau gweithredu unigol ac yn y gofynion sicrwydd, lle bo'n briodol.
Goblygiadau Ariannol
Efallai bydd canlyniadau ariannol i gamau gweithredu unigol, ond nid oes effaith ariannol uniongyrchol cysylltiedig ar hyn o bryd.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Nid oes unrhyw oblygiadau cyfreithiol.
Goblygiadau Staffio
Nid oes unrhyw oblygiadau staffio.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Bydd ystyriaethau Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) yn cael eu cynnwys wrth ystyried camau gweithredu unigol lle bo'n briodol.

Hanes yr Adroddiad	Wedi cael ei adolygu gan y Tîm Gweithredol
Atodiadau	• Atodiad 1 - Adnodd Tracio Argymhellion Archwiliad.

Internal Audit Open Recommendations

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
61	19/20	Board and Committee Governance Arrangements November 2019	Substantial	Board Secretary	Board Secretary	Medium	The Board should undertake a self-assessment of their effectiveness, within an appropriate timeframe, and thereafter on an annual basis. While we acknowledge that the Education, Commissioning and Quality Committee has been in existence for less than 12 months, the Board should consider when it would be appropriate for the Education, Commissioning and Quality Committee and Remuneration and Terms of Service Committee to undertake a self-assessment, and plan accordingly.	• Self-assessment for the **Board** scheduled for Q4 of 2019/20.	mar-20	Complete	Complete	Decision made to undertake self-assessment during September/ October 2020	**Progress as at January 2020:** All self-assessments are scheduled into the appropriate Forward Work Programme. **Progress as at July 2020:** The Board planned to undertake its self-assessment as part of a Board Development Session in Q4. However, it has been agreed that the Board will undertake its self-assessment during September/October 2020 at its 2-year anniversary at the HEIW Chair's request. **Progress as at October 2020:** The Board will consider the process for undertaking the self assessment at its Development Session in October 2020. The outcome of the self-assessment will be considered at the November Board. **Progress as at January 2021:** Self Assessment has been completed by Board Members and evaluation report drafted. To be considered by the Board at its February Development Session. **Current Progress: COMPLETE**. Board Evaluation of the Self-Assessment to be considered by the Board on 25 March 2021.	mar-21	12				
61	19/20	Board and Committee Governance Arrangements November 2019	Substantial	Board Secretary	Board Secretary	Medium	The Board should undertake a self-assessment of their effectiveness, within an appropriate timeframe, and thereafter on an annual basis. While we acknowledge that the Education, Commissioning and Quality Committee has been in existence for less than 12 months, the Board should consider when it would be appropriate for the Education, Commissioning and Quality Committee and Remuneration and Terms of Service Committee to undertake a self-assessment, and plan accordingly.	• Self-assessment for the **Remuneration and Terms of Service Committee** scheduled for Q4 of 2019/20	mar-20	Partially complete	Overdue	Due to the increasing priority of Coronavirus, the self-assessment has been delayed until further notice.	**Progress as at January 2020:** All self-assessments are scheduled into the appropriate Forward Work Programme. **Progress as at July 2020:** It was planned for the Committee to undertake its self-assessment in Q4. However, due to the increased priority of Coronavirus, the draft Self Assessment Checklist will be considered at the July RATS Committee. **Progress as at October 2020:** Consideration of the self assessment took place at November RATS Committee. The checklist has been issued for completion by 4 January 2021 with the evaluation to be presented to the RATS Committee at the end of January 2021 **Progress as at January 2021:** The RATS Committee considered the draft self assessment checklist at its meeting in November. Completion of the checklist expected by early January 2021 with evaluation anticipated to be presented to the RATS Committee at the end of January 2021. **Current Progress:** The RATS Committee began the process of completing the self assessment and it has been determined that the self-assessment checklist requires further development. The self assessment process be postponed until the Summer 2021.	sep-21	18				
75	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Corporate Services	Director of Planning, Performance & Corporate Services	High	HEIW should continue to establish a formal Performance Management Framework that incorporates the objectives the organisation is trying to achieve from such a framework, reporting lines, responsible officers and executive leads. In doing so, similar organisations, including stakeholders that are furtheradvanced in developing a Performance Management Framework could be contacted.	A request has been made to Internal Audit for examples of best practice to help develop the Performance Management Framework. Whilst we have an indicative structure of the framework we need to articulate expectations, responsibilities and timings to support the development of the Performance Report and Performance Management Framework.	apr-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** A review of examples has supported the development of a draft framework. This provides details of expectations to oversee and manage the development of performance reports including responsibilites and reporting lines. The impact of COVID-19 has restricted further development and once an understanding and appreciation of the new normal is in place we intend to finalise the framework for implementation. **Progress as at October 2020:** A review of Frameworks from other organisations supported the development of a draft framework. Following the appointment of the new Director of PPCS the work has been taken forward and engagement on the draft Framework is underway, including with the Executive Team, SLT and Board. **Progress as at January 2021:** The draft Framework has been engaged upon and the final Framework will be presented to the Board for approval in January 2021. **Current Progress: COMPLETE.** Reviewed at Performance Dashboard Steering Group in January 2021 and approved by the Board on 28 January 2021.	jan-21	9				
77	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Corporate Services	Director of Planning, Performance & Corporate Services	Medium	An assessment should be undertaken to identify the link between KPIs and projects and work programmes aimed at achieving the strategic objectives. Where no existing KPIs are identified in relation to a strategic objective, consideration should be given to developing relevant KPIs that will allow monitoring of progress to achieve the strategic objective.	Following approval of our IMTP, where feasible and through iterations of the report and dashboard, we will look to incorporate this recommendation where possible.	jun-20	Partially complete	Overdue	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** This has been delayed given the impact of COVID-19 on normal activites. Following revision to the IMTP moving forward we will aim to consider KPI's that can feasibly measure progress of objectives. **Progress as at October 2020:** The drafting of the performance framework has provided an opportunity look at the data that we report on as well as the data that we had planned to commence reporting on pre-COVID. Work to ensure validated data is available to enhance performance reporting continues. In parallel, with the additional capacity provided by the new Director, and the impetus of the draft PM framework, we are commencing a review of the data we hold and our KPIs to ensure that we have the information and KPIs we need to measure and assure progress of our strategic aims on a sustainable basis. **Progress as at January 2021:** Following the appointment of the new Director of PPCS a Performance Dashboard Steering Group has been esablished to drive the development of KPIs and the Dashboard, framing it around the Six Stratgic 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. **Current Progress:** The Performance Dashboard Steering Group are making steady progress with the development of the priority KPIs for Strategic Aims 2 and 4.	jan-21	7				
78	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Corporate Services	Director of Planning, Performance & Corporate Services	Medium	Consideration should be given to include a wider range of KPIs within the performance management dashboard, that fall in line with the aims of performance reporting as outlined in performance management framework. The performance management dashboard should be further developed to include targets against each KPI and comparisons against previous quarters.	Work is ongoing with respective teams to consider data and information options that will enable monitoring and analysis of the value work being undertaken has on education, training and quality. A range of qualitative and quantitative options have been identified following meetings with teams to increase the range of metrics available to be reported and will be included over a period of report iterations.	jun-20	Partially complete	Overdue	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** This has been delayed given the impact of COVID and the restricted data currently available. **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. **Progress as at January 2021:** Following the appointment of the new Director of PPCS a Performance Dashboard Steering Group has been esablished to drive the development of KPIs and the Dashboard, framing it around the Six Stratgic 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. **Current Progress:** The Performance Dashboard Steering Group are making steady progress with the development of the priority KPIs for Strategic Aims 2 and 4.	jan-21	7				
79	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Corporate Services	Director of Planning, Performance & Corporate Services	Medium	The 2018/19 Consolidated Plan should be reviewed to ensure that all relevant KPIs or performance metrics are captured in the Performance Management dashboard and Data Glossary.	A review will be undertaken and as indicated we will ensure that the dashboard encapsulates the range of metrics required to support managing our performance including reviewing the 18/19 consolidated plan. All measures in the dashboard will now have a 'Data Owner' (responsible officer) that will have overall responsible for the accuracy and validity of the data. This will be detailed in the data Glossary.	jun-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** This has been delayed given the impact of COVID and the restricted data currently available. **Progress as at October 2020:** This will be articulated in the performance framework when finalised. **Progress as at January 2021:** See the entries above for development of the Dashboard. The Glossary has been developed to include all measures currently included in the Dashboard and to identify Exec Leads and Responsible Owners and will continue to be updated as the KPIs are agreed and the Dashboard is developed. **Current Progress: COMPLETE.** Reviewed at Performance Dashboard Steering Group in January 2021.	jan-21	7				
80	19/20	Performance Management March 2020	Reasonable	Deputy 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	Partially complete	Overdue	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 requiremetns for additional infomration. 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. **Current Progress:** A Performance Dashboard Steering Group has been esablished to drive the development of KPIs and the Dashboard, framing it around the Six Stratgic 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 4.	jan-21	7				
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	Partially complete	Overdue	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Head of Cyber Security commenced in post on 29 June 2020. Work has commenced on the Disaster Recovery Plan and was anticipted to e completed by the agreed deadline. **Progress as at October 2020:** Draft Disaster Recovery Plan is currently under review. In addition to this, other contributing elements including the re-drafting of the Business Continuity and Crisis Management Plan are in progress. The Cyber Incident Response Plan was considered by the IGIM Group on 29 September 2020 and recommended for approval by the Executive Team. **Progress as at January 2021:** Draft Disaster Recovery Plan prepared and consulted upon in autumn 2020. Sign off held back to ensure final draft was consistent with the revised HEIW Crisis and Business Continuity Plan and learning from COVID-19, as well as the recently approved Cyber Incident Response Plan and Policy. Executive sign off expected by end January 2021. **Current Progress:** The draft Disaster Recovery Plan is currently under review and work on the final draft is underway. Given that HEIW outsource a considerable proportion of its technical infrastructure, network, services and systems it has been agreed that the plan should be service orientated and aligned to service deliverables and prioritisation of incidents. The draft Plan is expected to be completed by the end of March 2021 and will be submitted to the Executive Team for approval by the end of April 2021.	apr-21	7				
102	19/20	Service Review - Medical Commissioning Monitoring September 2020	Reasonable	Medical Director/Post Graduate Medical Dean	Medical Director	Medium	The purpose and necessity of the HEIW Education Contract should be reviewed and either removed, or if deemed applicable should be updated to reflect curriculum changes ensuring a consistency in approach for all trainees.	We accept this recommendation. We will review the need for these contracts and update the website accordingly.	jun-21	Complete	Complete		**Progress as at January 2021:** Review of website to be undertaken in January 2021. **Current Progress: COMPLETE.** The purpose and future role of educational contract has been reviewed and it will be amalgamated into the expectations agreement. Once complete the website will be updated to reflect the alignment of process and change	mar-21	1				
112	20/21	Personal Development Review Process December 2020	Reasonable	Leadership & OD Practitioner/ Senior HR Business Partners	Director of Workforce & OD	Medium	1. The errors identified during the audit testing should be investigated to establish their cause and their potential impact on compliance rates. 2. Line Managers should be reminded that all completed performance appraisals should be promptly and accurately recorded on the ESR system.	The errors appear to be a lack of manual updating of the PADR report in the ESR system. To improve this, HEIW will take the following action: 1. Reminder for staff and managers on their responsibilities to ensure this is completed as part of the PADR process.	jan-21	Partially complete	Partially complete	On target for the new review cycle	**Current Progress:** The errors that were identified during the audit have been investigated. Objective setting for 2020/21 coincided with the start of the lockdown where there were some initial issues identified around holding appraisal conversations via Skype and lack of access to ESR without a token. Other errors (ie. dates and line of sight to the IMTP) have been corrected by making changes to the PADR form and comments . A reminder has been drafted for staff and managers to remind them of their obligations. Additional dates will be made available for full and partical (refresher training) on the completion of the PADR. The Leadership and OD Practitioner has been working with Senior HR Business Partners to improve compliance rates particularly for sessional staff throught the PADR Lite scheme.	apr-21	3				
112	20/21	Personal Development Review Process December 2020	Reasonable	Head of People Inclusion & OD/ Senior Leadership Team	Director of Workforce & OD	Medium	1. The errors identified during the audit testing should be investigated to establish their cause and their potential impact on compliance rates. 2. Line Managers should be reminded that all completed performance appraisals should be promptly and accurately recorded on the ESR system.	The errors appear to be a lack of manual updating of the PADR report in the ESR system. To improve this, HEIW will take the following action: 2. Manager responsibility to ensure compliance is over 85% as reported on ESR (linked to pay progression). 'how to guides' to be reviewed and reminders issued to ensure staff are aware of the help available	feb-21	Complete	Complete	On target for the new review cycle	**Current Progress: COMPLETE.** The Analytics team have prepared detailed guides for managers which are available via the intranet. All new managers will be invited to a full PADR session. Current and existing manage rs will be invited to refresher training on the scheme, the documentation and how to record the dates on to the ESR system	feb-21					
112	20/21	Personal Development Review Process December 2020	Reasonable	Senior Leadership Team	Director of Workforce & OD	Medium	1. The errors identified during the audit testing should be investigated to establish their cause and their potential impact on compliance rates. 2. Line Managers should be reminded that all completed performance appraisals should be promptly and accurately recorded on the ESR system.	The errors appear to be a lack of manual updating of the PADR report in the ESR system. To improve this, HEIW will take the following action: 3. Regular reporting at team and directorate level as part of the performance metrics	apr-21	Complete	Complete	On target for the new review cycle	**Current Progress: COMPLETE.** PADR Compliance rates is a Key Performance Indicator of the Corporate Dashboard Performance Metrics. These are shared and discussed at both Executive and Directorate Senior Management Team Level.	mar-21					

Internal Audit Open Recommendations

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
112	20/21	Personal Development Review Process December 2020	Reasonable	Head of People Inclusion & OD/Senior Leadership Team	Director of Workforce & OD	Medium	1. The errors identified during the audit testing should be investigated to establish their cause and their potential impact on compliance rates. 2. Line Managers should be reminded that all completed performance appraisals should be promptly and accurately recorded on the ESR system.	The errors appear to be a lack of manual updating of the PADR report in the ESR system. To improve this, HEIW will take the following action: 4. Active intervention to support non-compliant to ensure capability of undertaking PADR and uploading into ESR	Ongoing	Partially complete	Partially complete		**Current Progress:** Responsibilities are clear and align across to NHS Wales. All managers are required to have PADR discussions with their staff in April 2021 with a suggested deadline of mid-May. HEIW has put in place timely and regular reminders for Line Managers and the Executive Team. To support the process where required, help is available through ESR and in supporting documentation and also on request from the analytics team. Regular 'clinics' will be established during March 2021 and ongoing to support staff where required in entering a range of data within ESR, which includes PADR data.	Ongoing					
112	20/21	Personal Development Review Process December 2020	Reasonable	People & Analytics Team	Director of Workforce & OD	Medium	1. The errors identified during the audit testing should be investigated to establish their cause and their potential impact on compliance rates. 2. Line Managers should be reminded that all completed performance appraisals should be promptly and accurately recorded on the ESR system.	The errors appear to be a lack of manual updating of the PADR report in the ESR system. To improve this, HEIW will take the following action: 5. Clarify the responsibilities to ensure accurate entry on ESR - whether directly or indirectly	mar-21	Complete	Complete		**Current Progress: COMPLETE.** Responsibility for updating the ESR system is directly with people managers across all teams. A communications update is due to be sent shortly reminding managers of their responsibilities under the scheme together with information signposting them to additional support through training, support guides and possible workshops).	mar-21					
113	20/21	Personal Development Review Process December 2020	Reasonable	Senior Leadership Team	Director of Workforce & OD	Medium	Performance appraisals should be undertaken annually for all staff in accordance with the values based performance appraisal and development policy. Management should decide whether consultants should continue to be required to undertake a full PADR for HEIW, or if the more concise form used for sessional staff would be more appropriate.	We have decided that consultants who are employed on 0.3 wte or less (defined as sessional workers and agency staff) should continue to use the more concise form (PADR Lite). For staff working less than 0.3 wte the lite version is to be used. Staff 0.31wte and above will complete the full PADR version. Regardless of the version of PADR utilised, the information must be entered in ESR.	Immediate & Ongoing	Partially complete	Partially complete		**Current Progress:** A commnications update is due soon which will remind all staff and managers of their oligations under the scheme, particularly the procedure for sessional staff. Presentations and training will be delivered to all Directorates who engage sessional staff who work 0.3 wte or less.	Immediate & Ongoing					
114	20/21	Personal Development Review Process December 2020	Reasonable	Head of People Inclusion & OD/ Leadership & OD Practitioner	Director of Workforce & OD	Medium	1. Staff should be reminded that a six-monthly review should be held for all staff between each annual end of year assessment, and that appraisal forms should be fully completed. 2. Consideration should be given to monitoring outstanding appraisals and sending out targeted reminders as appropriate.	1. Managers and staff will be reminded of their responsibility under the PADR policy and Procedure.	feb-21	Partially complete	Overdue		**Current Progress:** A communications update is due to be sent early March to remind all managers and staff of their responsibilities underthe PADR scheme.	mar-21					
114	20/21	Personal Development Review Process December 2020	Reasonable	Leadership & OD Practitioner	Director of Workforce & OD	Medium	1. Staff should be reminded that a six-monthly review should be held for all staff between each annual end of year assessment, and that appraisal forms should be fully completed. 2. Consideration should be given to monitoring outstanding appraisals and sending out targeted reminders as appropriate.	2. A system will be established for managers / staff to confirm their participation in the six monthly review.	apr-21	Partially complete	Not yet due		**Current Progress:** HEIW are encouraging managers to complete the PADR dates on ESR every six months (April / May, and September / October). The People and OD Team are currently exploring the use of additional ESR modules to assist with reporting and tracking.	apr-21					
115	20/21	Personal Development Review Process December 2020	Reasonable	Leadership & OD Practitioner	Director of Workforce & OD	Medium	1.The standard appraisal form should be reviewed and amended to make clear the link between personal objectives, team / departmental objectives and organisational objectives recorded in the IMTP. 2. Line managers carrying out annual appraisals should ensure that employees record these links on their appraisal forms.	1. The documentation will be reviewed to incorporate a clear line of sight between individual, team and annual plan objectives.	mar-21	Complete	Complete		**Current Progress: COMPLETE.** A new draft of the PADR form has been reduced to reflect the audit recommendations and operational best practice.	mar-21					
115	20/21	Personal Development Review Process December 2020	Reasonable	Leadership & OD Practitioner	Director of Workforce & OD	Medium	1.The standard appraisal form should be reviewed and amended to make clear the link between personal objectives, team / departmental objectives and organisational objectives recorded in the IMTP. 2. Line managers carrying out annual appraisals should ensure that employees record these links on their appraisal forms.	2. These findings will be actioned and communicated in preparation for the end of year review and establishment of new objectives.	mar-21	Complete	Complete		**Current Progress: COMPLETE** Subject to final approval and sign off.	mar-21					
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 assetregister. 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		**Current Progress:** 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 indentified and recorded and any discrepancies will be dealt with as part of the accounts closure process during April.	mar-21					
116	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	High	1. Inventory lists should be prepared to support all grouped assets on the assetregister. 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.	2. Agree - Asset managers to be identified and recorded for all assets on the register.	mar-21	Complete	Complete		**Current Progress: COMPLETE.** All assets have been allocated to a manager	jan-21					
117	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Medium	1. A set of standard reminder letters should be developed and issued within predetermined timescales to chase outstanding debts. 2. Recovery action should be escalated for debts that remain outstanding after standard reminders have been issued. This could involve referral to a debt collection agency or the commencement of legal proceedings. Due to the relatively low number and value of debts at present, we would suggest that HEIW make enquiries with Shared Services with a view to referring any future unpaid debts for recovery via the Shared Services debt recovery contract.	1. Agree - As part of the FCP update in November 2020 reminder letters and timescales were produced for the salary overpayments process, but this was not replicated for 'standard' debt recovery. These documents will be prepared.	jan-21	Complete	Complete		**Current Progress: COMPLETE.** Templates have been prepared for the various stages of debt recovery	jan-21					
117	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Medium	1. A set of standard reminder letters should be developed and issued within predetermined timescales to chase outstanding debts. 2. Recovery action should be escalated for debts that remain outstanding after standard reminders have been issued. This could involve referral to a debt collection agency or the commencement of legal proceedings. Due to the relatively low number and value of debts at present, we would suggest that HEIW make enquiries with Shared Services with a view to referring any future unpaid debts for recovery via the Shared Services debt recovery contract.	2. Agree - Following discussion with the NWSSP procurement team a framework debt recovery contract has been identified and is available to HEIW.	des-20	Complete	Complete		**COMPLETE**	des-20					

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
118	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Medium	All assets recorded on the asset register should be verified annually in line with the Asset Register Financial Control Procedure.	Agree - A plan for the verification of assets will be prepared for the 2020/21 financial year taking into account the following; • A 100% verification may not be possible due to the nature of the assets capitalised. As a significant element of capital costs were incurred for the initial equipping of HEIW many of the individual lines in the asset register relate to 'grouped assets'. As an example, this will include keyboards and mice, which are low-value high-quantity items that would be difficult and time-consuming to verify with any degree of accuracy. • Any access constraints as a result of building closures will need to be considered for 2020/21. It should be noted that whilst only 30 assets were marked as having been verified in 2019/20, further assets had been checked but these had not been included on the register in error. The total Net Book Value of assets verified during the year was £1.85m out of the total of £2.60m. The asset register will be fully updated for all verified assets for the 2020/21 financial year.	mar-21	Partially complete	Overdue		**Current Progress:** 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 verified, although this cannot be finalised until the balance sheet date (31/03/21). Any discrepancies will be dealt with as part of the accounts closure process during April.	mar-21					
119	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Medium	Desk notes should be prepared to cover the following Asset Register processes in accordance with the Asset Register Financial Control Procedure: • Additions; • Disposals; • Transfers; • Depreciation; • Indexation; and • Revaluation.	Agree - The asset register was developed towards the end of 2019/20 and appropriate desk notes were not able to be prepared at that point due to the year-end deadlines. During 2020/21 it has been possible to review and revise the processes for the completion of the register and these will now be documented.	jan-21	Complete	Complete		**Current Progress: COMPLETE.** Desk notes have been prepared.	jan-21					
120	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Low	Users should be reminded to ensure that they fully complete all fields of the journal tracker when posting journals. Alternatively, the need to record the upload and posting references on the journal tracker should be reviewed.	The upload and posting references are not used to identify the journal as this is done through the journal name that is provided for all lines on the tracker. Therefore, there is no risk that the journal cannot be identified and crossreferenced to the backing documents. However, a standard process will be implemented for the recording of journal posting references to ensure that they are recorded consistently.	jan-21	Complete	Complete		**Current Progress: COMPLETE.** Standard process adopted for journals	jan-21					
121	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Low	1. Finance staff responsible for completing month-end reconciliations should ensure there is an appropriate division of duties between preparation and sign-off of month end reconciliation activities. 2. Staff should also ensure that the month-end reconciliation front sheet is updated to reflect the month that is being reviewed.	1. The issues identified above were administration errors on the cover of the overall reconciliation review only. There was appropriate segregation of duties as the reconciliation and reviews had been completed by different people, and this was recorded on each individual reconciliation.	des-20	Complete	Complete		**COMPLETE**	des-20					
121	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Low	1. Finance staff responsible for completing month-end reconciliations should ensure there is an appropriate division of duties between preparation and sign-off of month end reconciliation activities. 2. Staff should also ensure that the month-end reconciliation front sheet is updated to reflect the month that is being reviewed.	2. A final check will be carried out on future reviews to ensure that the information is correct.	des-20	Complete	Complete		**COMPLETE**	des-20					
122	20/21	Financial Systems January 2021	Reasonable	Head of Financial Accounting	Director of Finance	Low	1. The reason why a manual payment has been requested should be recorded on the payment request form and bank payments log. 2. The officer approving each manual payment should be recorded on the bank payments log by name. 3. Finance staff should ensure the invoice date is correctly recorded on the bank payments log.	Agreed - The process note for manual payments will be updated and re-issued to the financial accounting team to ensure the log provides the required information. The date format in the payments log had been set to the American version (MMDD-YY), resulting in errors for some entries. This has now been amended.	des-20	Complete	Complete		**COMPLETE**	des-20					

Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

External Audit Open Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
63	2019	Structured Assessment 2019 January 2020	Board Secretary	**Conducting Business Effectively** **R1** Given the fast pace of change within HEIW's operational and governance arrangements, HEIW should review Board and committee oversight to ensure the breadth of its work is covered and there are no gaps in scrutiny arrangements.	HEIW has recently completed a review of its Board and Committee structure – entitled Future Ways of Working. The focus of the work included consideration of any gaps between Board and its committees. HEIW's Standing Orders were amended in November to reflect the findings of the Future ways of Working. HEIW will undertake a review of the group structure which underpins the Board and its committees	jul-20	Complete	Complete	Complete	Progress as at July 2020: A review of the reporting structures within Directorates is being undertaken. This wok has been postponed due to the impact of COVID 19. This work will recommence during the Summer. Progress as at October 2020: The mapping of the directorate meeting structure is progressing and anticipated to be completed by the end of October 2020. Progress as at January 2021: Anticipated completion by end of February 2021 in preparation for consideration by the Audit & Assurance Committee in April 2021. Current Progress: The review of HEIW's group structures was completed in February 2021. The Executive Team is now categorising HEIW's groups into 5 categories. The Executive Team are currently focussed on category A groups which are defined as those groups that are required to be in place to support Executive Directors to discharge their individual responsibilities and accountabilities.	feb-21	6		
64	2019	Structured Assessment 2019 January 2020	Board Secertary	**Managing risk to achieve strategic priorities:** **R2** HEIW's Board Assurance Framework (BAF) sets out clearly what a BAF should do and the processes involved. HEIW should now create the assurance map required by undertaking a process to identify and map the controls and key sources of assurance against the principle risks to achieving its strategic objectives.	HEIW to work towards a form for the assurance map which is proportionate and relevant to HEIW's remit. Assurance map to be completed following the completion of the new corporate register which will be aligned to the IMTP.	mai-20	Partially complete	Overdue	Overdue	Progress as at July 2020: This work has been paused due to the focus on responding to COVID 19. A review of the IMTP has been undertaken and work is due to recommence in Q2. Progress as at October 2020: An update on the BAF will be presented to the Audit & Assurance Committee in October 2020. Progress as at January 2021: Audit & Assurance Committee recommended revisions to the BAF to the Board for approval. BAF was approved by the Board at its November meeting. BAF Assurance Mapping to be presented to the Audit & Assurance Committee in April 2021. Current Progress: COMPLETE. The Assurance Map is being drafted to reflect HEIW's position as a provider of education and training. BAF Assurance Mapping to be presented to the Audit & Assurance Committee in May 2021.	mai-21	11		
66	2019	Structured Assessment 2019 January 2020	Director of Planning, Performance & Corporate Services	**Embedding a sound system of assurance:** **R4** HEIW should document its performance management framework, setting out: a) operational performance management arrangements and lines of accountability; and b) what is reported to whom and by when, and Board / Committee oversight for performance management.	Agreed	mar-20	Complete	Complete	Complete	**Progress as at July 2020:** A review of examples has supported the development of a draft framework. This provides details of expectations to oversee and manage the development of performance reports including responsibilites and reporting lines. The impact of COVID-19 has restricted further development and once an understanding and appreciation of the new normal is in place we intend to finalise the framework for implementation. We have continued to build a data glossary and produce bi-monthly performance reports and dashboards to document performance to Board. **Progress as at October 2020:** We are in the process of finalising our overarching performance framework whilst maintaining bi-monthly performance reporting to the Board. We hope to finalise the framework now that the newly appointed Director of Planning, Performance & Corporate Services is in post. **Progress as at January 2021:** The Performance Framework will be presented to the Board for approval in January 2021. **Current Progress: COMPLETE**. The Board approved the Performance Framework at its meeting on 28 Januuary 2021	jan-21	10		
67	2019	Structured Assessment 2019 January 2020	Board Secretary/ Director of Digital	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: c) achieving certification in cyber security arrangements;	c) Work is underway to gain cyber essential plus certification. A provider has been contacted & HEIW is working through a set of pre-qualifying questions.	mar-20	Complete	Complete	Complete	**Progress as at July 2020:** Appointment of agency staff or consultant by March 2020 was unsuccessful. The Head of Cyber Security commenced in post on 29 June 2020 and will be looking at a range of actions tot be taken forward. A meeting is scheduled for the week commencing 6 July 2020 with NWIS to discuss this work. **Progress as at October 2020:** The Head of Cyber Security has investigated approaches to achieving cyber essentials / cyber essentials plus certification. Following discussion of the options at the IGIM Group on 29 September 2020, it has been agreed that the Head of Cyber Security work with NWIS to obtain the cyber essentials plus certification. **Progress as at January 2021:** We are currently focussing on strengthening alignment with the requirements of Cyber Essentials. The approach will include working closely with Cyber Essentials questionnaire in conjunction with NWIS and relevant stakeholders, an assessment of HEIW's technical environment and review of critical service providers. **Current Progress: COMPLETE.** Following a review of cyber essentials and given recent developments surrounding the established project to implement the UK-wide Network and Information Security (NIS) Regulations in the health sector in Wales, it is recommended that HEIW utilise the Cyber Assessment Framework (CAF) instead of cyber essentials. The CAF collection and developed in-depth guidance is aimed at helping organisations understand their essential services in more detail, assess their level of cyber security & resilience and provide a framework to support organisations in responding to cyber incidents which affect critical services. This decision would be in line with other Trusts and Health Boards in Wales who have been identified as Operators of Essential Services (OES). The assessment against the CAF will be completed by the end of March 2021. The outcome of the assessment of compliance against the CAF will be provided to the IGIM Group.	mar-21	12		
68	2019	Structured Assessment 2019 January 2020	Director of Digital	**Developing Strategic Plans:** **R6** HEIW should strengthen its strategic approach to digital and IT by: a) developing and approving a Digital and IT strategy;	Recommendation to be amended in line with discussions. a) Following our first operational year, we are to consider the appropriateness of a digital and IT strategy given changes proposed to NWIS and NHS Executive function.	Summer 2020	Partially complete	Overdue	Overdue	**Progress as at July 2020:** The appointment to Director of Digital has yet to be made. As such we anticpate following recruitment processes being undertaken this to commence in Q4. **Progress at October 2020:** The Digital and IT Strategy is in early development and will be completed following the recruitment of the Director of Digital.It is expected that recruitment into the post of Director of Digital will be completed in Q4 2020/21. It is anticipated that the development of the Digital Strategy should be concluded by the end of Q1 2021/22.**Progress:** Director of Digital has been appointed and is due to commence in February 2021. **Current Progress:** Director of Digital commenced in post February 2021. Digital delivery plans will be developed by the end of Q2 2021/22 and will inform the strategic direction for digital and the development of the Digital and IT Strategy.	sep-21	12		

External Audit Open Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
68	2019	Structured Assessment 2019 January 2020	Director of Digital	**Developing Strategic Plans:** **R6** HEIW should strengthen its strategic approach to digital and IT by: c) developing and reporting IT KPIs for challenge and scrutiny.	IT KPI's will be considered within the iterative development of the Performance report. It would be helpful to understand examples from other heath boards to ascertain applicability to HEIW.	Ongoing	Partially complete	Not yet due	Not yet due	**Progress as at October 2020:** The overarching performance framework will be finalised now that the Director of Performance, Planning & Corporate Services has commenced in post. However, the further development to include IT KPI's within the performance reporting will be undertaken once the Director of Digital is recruited. It is expected that recruitment into the post of Director of Digital will be completed in Q4 2020/21. **Progress as at January 2021:** The Director of Digital has been appointed and is due to commence in February 2021. **Current Progress:** Work is in progress to develop plans with Directorates and Departments to inform the measures and Digital and IT KPIs aligned to the Digital and IT Strategy.	sep-21	18		
69	2019	Structured Assessment 2019 January 2020	Director of Planning, Performance & Corporate Services	**Monitoring delivery:** **R7** HEIW has not set out a framework for monitoring performance against its strategic objectives and IMTP and should: a) formally document arrangements for the oversight and scrutiny of performance against strategic objectives	A performance dashboard and accompanying narrative has been developed and shared with the HEIW, WG JET meetings and Quality & Delivery meetings. This formally documents evidence of HEIW across a wide range of functional areas with a key focus on progress updates against strategic objectives and Remit letter actions.	Feb - April 2020	Complete	Complete	Complete	**Progress as at July 2020:** A draft framework has been developed. Following finalisation, further interaction will be held with teams/sections to confirm expectations. This will be reflective of the impact of COVID-19 on future performance arrangements. **Progress as at October 2020:** Framework as indicated above is in final stages of development. **Progress as at January 2021:** The Performance Framework will be presented to the Board for approval in January 2021. **Current Progress: COMPLETE**. The Board approved the Performance Framework at its meeting on 28 January 2021.	jan-21	9		
69	2019	Structured Assessment 2019 January 2020	Director of Planning, Performance & Corporate Services	**Monitoring delivery:** **R7** HEIW has not set out a framework for monitoring performance against its strategic objectives and IMTP and should: b) work with pace to develop KPIs and targets which are clearly linked to strategic objectives, against which the Board can scrutinise performance.	The performance data development is an iterative process and as further data is generated it is anticipated that KPI's and targets will be identified and developed with the Board.	Feb - April 2020	Complete	Complete	Complete	**Progress as at July 2020:** KPIs aligned to the IMTP will be developed in line with the timescales for implementation and taking note of the changes as a result of COVID-19. **Progress as at October 2020:** Areas have been identifed to develop and enhance our performance reporting and work is ongoing with departments to identify appropriate monitoring mechansisms. **Progress as at January 2021:** The Performance Framework will be presented to the Board for approval in January 2021. **Current Progress: COMPLETE.** The Board approved the Performance Framework at its meeting on 28 January 2021.	jan-21	7		
107	2020	Effectiveness of Counter Fraud Arrangements - HEIW September 2020	Director of Finance/ Director of Workforce & OD/ Head of Counter Fraud	**Counter-Fraud Training:** Implement mandatory counter-fraud training for some or all staff groups. **Intended Outcome Benefit:** To improve staff understanding of fraud and how to prevent it.	As part of the Compliance & Competency section within the Heath Body's Electronic Staffing Record (ESR) Database, any such training, which is deemed as being mandatory, has to be agreed and by the Health Body's Workforce Department in conjunction with Staff Side Representation before it can be implemented.	Ongoing with review date of 31 March 2021	Complete	Complete	Complete	**Progress as at January 2021:** Counter Fraud Training is a core component of Induction Training for new staff. However, refresher training is undertaken by the Counter Fraud Team being invited to Directorate and Departmental meetings. A number of refresher awareness sessions have been undertaken over the past few months during virtual Directorate and Departmental Team meetings. The People and OD Team and Counter Fraud Team are exploring the requirement for Counter Fraud training to form part of the ESR statutory and mandatory training online learning components. **Current Progress: COMPLETE.** There is a continuing process to provide fraud awareness sessions which are part of the corporate induction programme. Virtual Counter Fraud awareness sessions have been booked monthly up to December 2021.	mar-21			
109	2020	Effectiveness of Counter Fraud Arrangements - HEIW September 2020	Head of Counter Fraud/ Board Secretary	**Recording and Monitoring of Economic Fraud Risk:** Implement consistency in the recording and monitoring of economic fraud risk in line with the HEIW's risk management policy and strategy. **Intended Outcome Benefit:** To ensure prevention of fraud features prominently within the organisation's risk management framework.	As part of the Health Body's ongoing review of its risk management framework, fraud risk assessments relating to fraud will also be integrated within the wider risk management framework. This will ensure that wider corporate ownership and active management of risks can be implemented.	mar-21	Partially complete	Overdue	Overdue	**Progress as at January 2021:** Fraud to be added as a standard risk on the Directorate Risk Registers to ensure it has a sufficient profile and that steps to mitigate the risk are considered and implemented. **Current Progress:** Acting Head of Counter Fraud and Board Secretary have agreed that fraud should only appear on a risk register when identified as a risk. The Risk Management Policy will be amended to reflect this at its next annual review and will include narrative regarding the notification of any identified fraud risk to the Local Counter Fraud Service. The revised pollicy will be presented to the Audit & Assurance Committee in July 2021.	jul-21	4		

Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

Internal Audit Advisory Open Considerations

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
105	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Finance	**FINANCIAL GOVERNANCE: Budget and Savings** Our review identified the following: • There is a budget in place for 2020/21 to support financial reporting. • At the time of our review it was unclear whether the 2020/21 budget and financial reporting would require differentiation between Covid-19 and non-Covid-19 expenditure. • HEIWs' small capital allocation has not been impacted by Covid-19.	We suggest the following considerations as the organisation looks forward: • Management should consider the impact of Covid-19 on the financial statements for 2020/21 so that if any adjustments are necessary, these can be identified and made in a timely manner.	We will consider the impact of COVID-19 in preparing the financial statements for 2020-21.	apr-21	Partially complete	Not yet due	Not yet due	**Current Progress:** Due for review in April 2021	apr-21			

Key
Less than 3 months
Between 3 and 6 months
Between 6 and 12 months
Over 12 months

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
1	18/19	Core Financials - Budgetary Control February 2019	Reasonable	Director of Finance and Corporate Services	Director of Finance and Corporate Services	Medium	To ensure clear responsibility and acceptance of ownership of a budget, L1 budget forms should be in place for all key delegated budgets and should be appropriately completed and authorised.	A review of L1 budget delegation forms will be undertaken to ensure that they are complete and appropriately authorised in accordance with the scheme of delegation.	mar-19	Complete	Complete		All L1 forms have been reviewed and are complete and correctly authorised.	mai-19	2	Yes		Yes	No
2	18/19	Core Financials - Budgetary Control February 2019	Reasonable	Director of Finance and Corporate Services	Director of Finance and Corporate Services	Low	Consideration should be given requesting budget holders to formally sign to accept their budget at the start of the financial year.	Agreed that this will be an important aspect of the budget setting process for 2019/20. It will be key to ensuring that budget holders have authority to commit to expenditure within their delegated budgetary level but also confirm their responsibility managing within it.	mar-19	Complete	Complete		**Progress as at May 2019:** Discussion undertaken at Executive Team on 15 May 2019. Budget allocation letters have been drafted for Executive Directors signed by the Chief Executive and distributed. It is anticipated that they will all be signed and returned by 31st May 2019. Progress as at July 2019: A signed Budget Holder letter has been returned by every Executive Director.	jul-19	4	Yes		Yes	No
3	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Medium	Now that HEIW has been operating for a number of months, FCPs should be reviewed to ensure they are complete and reflect the process being carried out within the organisation, whilst ensuring the expected controls remain. The department should create desktop procedures that outline to staff the process to be followed when performing tasks. This will facilitate a standardised approach to work and can act as guide for new or less experienced staff to use.	There is a journal register within Oracle so there is no need for a duplicate hard copy. However, the FCP can be clarified for this point. The manual (ad hoc) payments of £9.1m were processed using the same documentation as required by Accounts Payable. The method of payment is different i.e. direct payments rather than BACS but remaining information is the same. Whilst the FCPs were approved by audit committee in October 2018 with a yearly review process it is agreed that some will be reviewed before the start of the financial year and where necessary updated in light of the audit findings. Shared services subsequently changed their approach to miscellaneous payments in November 2018 which meant that the payments are now made via Accounts Payable using the same backing documentation. No clarification is therefore required in the FCP as this approach has been used by precursor organisations, in particular, Shared Services, and presumably has been dealt with satisfactorily in the past. Since the audit fieldwork was undertaken, desk top procedures have been written.	mar-19	Complete	Complete		**Progress as at May 2019** On-going – Processes are still being reviewed and refined to reflect best practice identified from other organisations and from discussions as part of the year-end audit. Working papers and desktop notes are being prepared to reflect the operational procedures. It is anticipated this will be complete by the end of July 2019. **Progress as at July 2019:** Completion of the internal review is expected to be complete by the end of July 2019. The Head of Financial Accounting is a member of the All-Wales Technical Accounting Group (TAG) task and finish group reviewing Financial Control Procedures (FCPs), which is due to meet shortly. Feedback from the group will be used to review and update FCPs as appropriate. **Progress at November 2019** Complete - A suite of desktop notes has been prepared for the main tasks carried out within the financial accounting team. These wil be reviewed and updated on an on-going basis. The annual review of the FCPs is included as a separate agenda item for the Audit and Assurance Committee in November 2019.	nov-19	8	Yes		Yes	No
4	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Medium	Backing documentation provided to support a payment request should be more robust, ideally be in the form of an invoice and include key information including the service that has been provided, the date of service delivery and a breakdown of the costs. All payment request forms should be completed in full with the amount the authorising officer is signing for written clearly on the form.	As has been noted the process has firmed up over the period since the start of HEIW. Reassurance is obtained in that the payments can be traced back to the correct suppliers and the coding is correct. It should be noted that all the payments are supported by backing documents and therefore any risk is very low. Indeed it is reassuring that no mis-payments have been identified in this audit. However, controls can always be improved and the payment request form will be completed in full going forward but the payments can be traced back to the backing documentation.	feb-19	Complete	Complete		A revised manual payment request form has been issued requiring additional information and all payments are logged. The majority of all payments are now made through the Accounts Payable system.	mai-19	3	Yes		Yes	No
5	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Low	A sample review of the balance sheet codes reconciliations should take place once the responsibility of completing the reconciliations has been given to the Assistant Financial Accountant. This will ensure that the department are following the formal month end process as outlined in the FCP. In the mean-time consideration should be given to a peer review of the reconciliations to confirm accuracy.	The balance sheet code reconciliations are being undertaken and reviewed. In addition, there is a sample review undertaken by interim Head of Financial Accounting but earlier in the review process than required by the FCP. As regards the banking and other reconciliations being completed by senior staff, this is referring effectively to a Financial Accountant completing but the interim Head of Financial Accounting was reviewing and authorising the reconciliations. The key point is that there is segregation of duty between the person completing and the person authorising the reconciliation – in line with good accounting practice. A sample check is being undertaken on the other reconciliations. The FCP's will be reviewed on an annual basis as there is currently no significant inherent control weakness.	feb-19	Complete	Complete		A revised timetable has been prepared and all reconciliations are reviewed in line with the agreed timescales. For year-end detailed balance sheet reconciliations were prepared for all codes and this process will continue monthly. From July 2019 a monthly 'Corporate Control Meeting' will be held to review balance sheet transactions with service teams on a rotational basis. This will introduce an additional level of challenge and scrutiny to the overall financial position.	mai-19	3	Yes		Yes	No
6	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Low	The department should ensure that two members of staff are aware of the access code to the safe to allow access to be granted during times of absence. The current location of the safe should be considered.	There has been nothing of value in the safe until the middle of January 2019, when some petty cash has been stored. However, all Financial Accounting staff are now aware of the code to the safe. The location of the safe will be moved to the second floor, where the financial accounts team moved on 26 January 2019.	feb-19	Complete	Complete		All Financial Accounting staff are now aware of the code to the safe.	mai-19	3	Yes		Yes	No
7	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Low	All purchasing card transaction summary forms should be approved by the budget holder or line manager as per the Purchasing Card FCP. Where card holders are of a senior position within the organisation, forms should be countersigned by staff member of similar authority.	This is a very low risk as the level of spend by senior directors is minimal. However, this will be amended going forward.	feb-19	Complete	Complete		Approvals are made through the service desk requests.	mai-19	3	Yes		Yes	No
8	18/19	Core Financials - Financial Accounting February 2019	Reasonable	Head of Financial Accounting	Director of Finance and Corporate Services	Low	Purchasing card holders should be reminded that cards should only be used in circumstances where existing purchasing agreements or contracts are not in place.	This is a very low risk but this should be dealt with on a case by case basis. For example, stationery may be required if someone is travelling on business. Such purchases would not be on the framework but could still provide value for money overall.	feb-19	Complete	Complete		Update sent 24/05/2019. From 1/4/19 quarterly summaries of purchasing card transactions will be sent to NWSSP procurement to review expenditure and procurement routes.	mai-19	3	Yes		Yes	No
9	18/19	Governance Arrangements March 2019	Substantial	Board Secretary	Board Secretary	Low	To help both existing and new staff the organisation should consider mapping its committee structure to pictorially show the flow of information between committees, other key groups and external parties.	A pictorial representation of the committee structure will be created.	jun-19	Complete	Complete		This is now included in the Corporate Governance Reporting as part of the .Accountability Report 2018/19.	mai-19		Yes		Yes	No

Internal Audit Completed Recommendations

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
10	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD/ Head of Financial Accounting	Director of Workforce and OD	High	A) Management should ensure an effective audit trail is maintained that justifies employment status.	A) A) HEIW Finance & People teams provided recruiting managers with training in this area in November 2018: this covered effective audit trails, how to undertake and complete the employment status checks, etc. to support the roll out of the toolkits, flow charts and employment status letters to the recruiting managers. Finance & People Teams felt satisfied at the time the recruiting managers had sufficient information to complete the checks appropriately and issue employment letters. An email reminder was sent to those staff that engage casual workers on 12/04/2019, reminding them of the importance of doing checks and that letters need to be sent. The findings of this objective & the management response to it will be shared with the Senior Leadership Team and expectations cascaded.	jun-19	Complete	Complete		Further reminders have been sent out by the People Team to recruiting managers who engage casual workers, detailing the requirement for ESS checks, employment status letters. The People Team are also conducting spot checks to ensure the processes are being followed.	jul-19	1	Yes		Yes	No
10	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD	Director of Workforce and OD	High	B) Management should review the employment status of individuals for appropriateness.	B) B) Given the findings of this objective, the People team will be asking recruiting managers to submit copies of the ESS checks and employment status letters to the People Team at the same time as submitting the casual worker engagement forms. That way we can centrally monitor compliance and ensure an audit trail is maintained.	jun-19	Complete	Complete		All recruiting managers are now sending copies of completed letters and ESS checks to the People Team at the same time as submitting casual worker or IR35 enrolment forms. In the event that the incorrect/incomplete information is submitted, the People Team are returning all paperwork to the recruiting manager, requesting the full set of required documents prior to processing.	jul-19	1	Yes		Yes	No
10	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD/ Head of Financial Accounting	Director of Workforce and OD	High	C) Management should remind staff of the need to issue employment status letters and to retain copies.	C) Further training will be offered to recruiting managers on the importance of the need to issue the employment status letters and to retain copies.	sep-19	Complete	Complete		Follow up of the recommendations during September/October 2019 highlilghted that a reminder email had been issued in May 2019 however, no follow up training has been provided as per the management response. The follow-up audit report published in November 2019 did not pick this up the requirement for training. Action completed.	nov-19	2	Yes			
11	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD	Director of Workforce and OD	High	A) Staff should be reminded of the need to ensure engagement forms and timesheets are appropriately completed.	A) A) The People Team will send a reminder to the recruiting managers to let them know that all sections of the casual worker engagement forms and timesheets need to be completed otherwise they will be returned and won't be processed until fully complete. To ensure timely completion of timesheets, we will amend the form to include that claims MUST be submitted within 3 months of work being carried out in order to be paid.	jun-19	Complete	Complete		A reminder was sent about the importance of all sections of engagement forms and timesheets being completed. If any get submitted with blank sections, the People Team return them and ask for all sections to be completed prior to processing. The timesheet states that claims must be submitted within 3 months of the work being completed.	jul-19	1	Yes		Yes	No
11	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD	Director of Workforce and OD	High	B) The organisation should review existing arrangements to ensure that current casual workers have been appropriately assessed.	B) As per response to Recommendation 1, going forward recruiting managers will be expected to send the completed ESS checks to the People Team so we can check they have been done and the correct process has been followed depending on the outcome.	jun-19	Complete	Complete		B) This is now happening for all engaged workers. In the event that documents come through without a copy of the completed ESS check, we return the documents to sender and request the full set of required documents before processing.	jul-19	1	Yes		Yes	No
12	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD/ Head of Financial Accounting	Director of Workforce and OD	High	Management should consider implementing a programme of spot checks or peer reviews to ensure the correct application of HEIW processes. Having a range of these measures would enhance the control environment for the assessment and treatment of casual workers.	All engagement forms and timesheets already come to the People Team, and we will check these forms to ensure they have been completed correctly. Although more training for the recruiting managers is currently being sourced, HEIW will also create a peer group/network for the recruiting managers to enable them to support each other in the correct completion of the treatment of casual workers, ESS checks and employment status letters. The People Team and Finance would oversee this group and undertake spot checks to ensure the documentation and audit trail complies with legislation.	jul-19	Complete	Complete		**Progress as at July 2019:** The People Team currently check all paperwork that gets submitted to ensure it has been completed correctly. A peer group is currently being set up. Progress at November 2019 The People team review all paperwork submitted by recruiting managers and has modified some of its processes; such as date the ESS checks are being completed, to ensure the tighter tracking of documents being submitted. However, some recruiting managers are not sending out the employment status letters in a timely manner. The People team will be sending a further communication to the recruiting managers in November to advise them that the letter must be sent out promptly after the ESS check has been completed, ideally before the casual worker undertakes any work for us. The Peer Group is an adhoc arrangement between the recruiting managers, but they generally seek additional support from the People team rather than their Peer Group. The People team anticipate this will change once the Ernst Young training is completed.	nov-19	4	Yes		Yes	No
13	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD/ Head of Financial Accounting	Director of Workforce and OD	Medium	Management should consider establishing a documented operational procurement procedure (Procurement Manual) to ensure a standard approach is used across HEIW.	HEIW is in discussion with NWSSP Procurement Team regarding further training and support for staff undertaking procurement within HEIW. We will consider the inclusion of specific training and guidance for on the engagement of casual workers in HEIW within that context.	jul-19	Complete	Complete		Follow up of the recommendations during September/October 2019 highlilghted that an operational procedure (Procurement Manual) had not been established. This recommendation is included in the follow up audit report published in November 2019. This actions is therefore not completed but will be picked up under recommendation reference number 54.	feb-20	7		See comments in column N	Yes	No
14	18/19	Workforce Review: Casual Workers – Employment status May 2019	Limited	Head of People & OD/ Head of Financial Accounting	Director of Workforce and OD	Medium	A) Guidance on completing and rechecking the HMRC online tool should be produced for all required areas. B) Management should consider assessing the training requirement and provide updates accordingly.	As outlined earlier, training and guidance was made available to all recruiting managers in HEIW in November 2018. However the audit shows that there are clearly further training requirements around ESS checks and processes for engaging casuals. The People Team are currently scoping further training, which will be made available to all staff.	July 2019 & September 2019	Complete	Complete		Follow up of the recommendations during September/October 2019 highlighted that the guidance had been been developed nor training arranged for staff. This recommendations is included in the follow up audit report published in November 2019. This action is therefore not completed but will be picked up under recommendation reference number 55. This matter has now been completed under recommendation reference number 55.	feb-20	5	Yes	See comments in column N	Yes	No
15	18/19	Risk Management May 2019	Reasonable	Board Secretary	Board Secretary	High	Management should ensure that they develop and approve an appropriate risk management policy and accompanying risk management procedure as soon as practically possible. The policy and procedure should then be communicated to staff within the organisation as appropriate.	Risk Management Policy to be completed and presented to the Executive Team in May. May Board to be provided with an update in respect of the policy. The policy will be considered at June SLT and communicated to staff immediately following SLT.	May 2019 & June 2019	Complete	Complete		**Progress as at July 2019:** There has been slippage on the original timescales due to the requirement for the policy to be presented to the Audit & Assurance Committee for endorsement prior to the Board for approval. The Policy is to be presented to the Audit and Assurance Committee on 15 July 2019; HEIW Board on 18 July and SLT on 15 August 2019. Communication to staff within the organisation will take place after SLT in August. **Progress at November 2019** Completed. The Risk Management policy was adopted at July Board and has subsequently been presented to SLT.	nov-19	5	Yes		Yes	No
16	18/19	Risk Management May 2019	Reasonable	Board Secretary	Board Secretary	High	Management should continue to develop its risk management plan, which includes key actions, responsibilities and timeframes for its implementation. The plan should be appropriately monitored to ensure that all milestones are delivered on target and remedial action taken where issues are identified.	(As above) Risk Management Policy to be completed and presented to the Executive Team in May. May Board to be provided with an update in respect of the policy. The policy will be considered at June SLT and communicated to staff immediately following SLT.	May 2019 & June 2019	Complete	Complete		**Progress as at July 2019:** There has been slippage on the original timescales due to the requirement for the policy to be presented to the Audit & Assurance Committee for endorsement prior to the Board for approval. The Policy is to be presented to the Audit and Assurance Committee on 15 July 2019; HEIW Board on 18 July and SLT on 15 August 2019. Communication to staff within the organisation will take place after SLT in August. The Executive Team regularly review the risk register which is presented to the Audit and Assurance Committee at each meeting and to the Board 6-monthly. Progress at November 2019 Completed - see response to 15 above	nov-19	5	Yes		Yes	No

Internal Audit Completed Recommendations

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
17	18/19	Risk Management May 2019	Reasonable	Board Secretary	Board Secretary	Medium	The organisation's risk policy and procedure should clearly set out its expectations with regards to risk registers. For example, it may be appropriate to develop directorate level risk registers that 'feed' into the risk register that is reported to committees of the Board. The organisation's risk policy and procedure should be communicated to staff so that the approach to risk is clearly accessible.	The risk policy, which is to be completed in May, will set out HEIW's expectations in respect of the risk register will include reference to the creation of directorate level risk registers. HEIW risk policy will be presented at June SLT and communicated to staff thereafter.	May 2019 & June 2019	Complete	Complete		**Progress as at July 2019:** There has been slippage on the original timescales due to the requirement for the policy to be presented to the Audit & Assurance Committee for endorsement prior to the Board for approval. The Policy is to be presented to the Audit and Assurance Committee on 15 July 2019; HEIW Board on 18 July and SLT on 15 August 2019. Communication to staff within the organisation will take place after SLT in August. **Progress at November 2019** Completed - see response to 15 above	nov-19	5	Yes		Yes	No
18	18/19	Risk Management May 2019	Reasonable	Board Secretary	Board Secretary	Low	The BAF should be developed with consideration to the organisation's risk management policy and procedure.	The BAF will be developed to take account of the risk management policy. Risk Management policy to be completed in May and will be taken into consideration in respect of the BAF thereafter.	jun-19	Complete	Complete		**Progress as at July 2019:** Timescales for the approval of the Risk Management Policy have slipped. However, the Draft BAF is to be presented to the Audit and Assurance Committee on 15 July 2019. **Progress at November 2019** Completed. The BAF, which references the Risk policy, was approved at September Board.	nov-19	5	Yes		Yes	No
19	18/19	Performance Management May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	High	A high-level summary performance monitoring report should be prepared at objective level for each organisation of the legacy organisations. This should be reported to the Board for the year ended 31 March 2019, and if necessary, quarterly until the new Integrated Performance Framework is fully implemented.	A Board update is scheduled for May Board which will incorporate the recommendations above for the period to end of March 2019. An integrated reporting utilising the performance dashboard is scheduled for its first iteration for the period to end of June 2019.	mai-19	Complete	Complete		The May Board Report was presented in line with recommendations.	jul-19	2	Yes		Yes	No
20	18/19	Performance Management May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	Medium	Management should ensure that the Board are engaged in the development of the new Integrated Performance Framework and dashboard to ensure the proposed format and content meets their performance monitoring requirements. A planned timescale should be developed for the roll out of ESR to all staff, and for the implementation of the new Integrated Performance Framework	To date, the development has involved an Independent Member (JH-T) reviewing progress at a meeting alongside CEO on 9 April 2019. The draft dashboard was also discussed at a Board Development Session at the end of April 2019. Response have been positive and Board is aware of the iterative nature of the development over the course of the next 6-12 months. All Staff who are employed and paid by HEIW now have access to ESR and its self-service functionality. First live data report to be presented to Board in July 2019 for period end of Quarter 1.	Ongoing	Complete	Complete		**Progress as at July 2019:** The development of the dashboard has continued with wide engagement from staff and directorates on the key data to report and mechanisms for monitor **Progress at November 2019** In the development of the performance framework we have maintained close dialogue with the Board on developments and progress. This has included interactions at Board development sessions in August and formal reporting at September Board. This engagement has facilitated iterative developments to ensure the framework reports information that is of use to the Board on an ongoing basis. The framework has also been shared at HEIW's first Quality & Delivery meeting in September 2019 with positive responses and is due to be discussed at the upcoming JET meeting in November.	nov-19	6	Yes		Yes	No
21	18/19	Performance Management May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	Medium	Each of the performance measures contained within the Consolidated Plan 2018/19 Report for the WCPPE should be allocated to individual officers from within the organisation to help ensure that performance is appropriately monitored. Management should ensure that an update is obtained for all areas contained within the Consolidated Plan 2018/19 report for the period ended March 2019.	This omission is acknowledged and has been rectified for the responses to the end of Quarter 4 in relation to Dentistry. For WCPPE responses, although not specifically named, the returns are based on responses by the Pharmacy Dean and deputies. As a small team at this stage, this is manageable and provides appropriate responses.	Immediate	Complete	Complete		This was amended in line with recommendations.	jul-19	2	Yes		Yes	No
22	18/19	Performance Management May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	Medium	Consideration should be given to providing additional staff resources on a temporary basis to assist with the preparation of quarterly performance reports and the development of the new integrated Performance Framework until additional permanent staff have been recruited to the Planning and Performance Unit.	Resource gaps are acknowledged. A job description has been developed to provide Business Partner support in this area of work. Agency support is to commence on 7 May 2019 whilst permanent recruitment processes are undertaken.	mai-19	Complete	Complete		**Progress as at July 2019:** Roles have been through job evaluation and recruitment processes are awaited for permanent recruitment. Agency staff have been employed in the interim to provide the level of support required and to enable work to be progressed. **Progress at November 2019** Existing agency roles have been extended to the end of 2019. Job descriptions have been revised and are awaiting finalisation, banding and consistency checks before being advertised. Exisitng agency staff are committed to organisation in the interim and are aware of process being undertaken.	nov-19	6	Yes		Yes	No
23	18/19	Performance Management May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	Low	Management should ensure that reports taken to Board are presented so that an appropriate context for the report is established for the reader.	This will be rectified for the upcoming report.	mai-19	Complete	Complete		Complete	jul-19	2	Yes		Yes	No
24	18/19	Corporate Transitional Plan May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	High	Arrangements should be made to sign off the NWIS SLA as soon as is practicably possible. Responsibility for the resolution of issues and queries that are preventing HEIW signing off the NWSSP SLA should be clarified and efforts to resolve the outstanding issues should prioritised as a matter of urgency. This may be achieved by setting up a Working Group led by a senior member of the Executive Team.	The 2018/19 NWIS SLA was signed off on 21/03/2019 and issues with the NWSSP SLA have been resolved, with HEIW being added to the overarching SLA.	mai-19	Complete	Complete		First SLA meeting scheduled for 17 July 2019 to discuss performance and charging schedule for 2019/20.	jul-19	2	Yes		Yes	No
25	18/19	Corporate Transitional Plan May 2019	Reasonable	Deputy Director Planning, Performance & Digital	Director of Workforce and OD	High	The organisation should ensure that all contracts held by the three predecessor organisations have been properly assessed to ensure that they are either cancelled or novated across to HEIW. A register of contracts should be put in place that captures both contracts that have been novated and new contracts entered into by HEIW. The review of contracts should consider if there are any outstanding liability risks.	We are currently working on the development of a contract register. This register will detail a wide range of arrangements relating to the activities of HEIW including identifying known contractual arrangements, value and termination dates to manage risks associated with procurement. The deadline for completing the contracts register is August. The contracts register will be presented at an Executive Team meeting in August and an update provided to the Audit Committee in September.	aug-19	Complete	Complete		**Progress as at July 2019: P**rogress has continued with significant progress made on identifying financial contracts and SLA/MOU arrangements in place. Further work is ongoing to identify further details and to identify respective risks of arrangements to allow further work to be undertaken. **Progress as at November 2019:** A contracts/ agreements register has been collated and is to be presented to the Audit and Assurance Committee in November. Responsibility for maintaining the register will now transfer to the Board Secretary and Governance team to monitor in the future and ensure actions identified are progressed. **Progress at January 2020:** A progress update was shared with the Audit and Assurance Committee in November of progress with recommnedations of how work was to be taken forward. A contracts/agreements register has been collated and transferred to the Board Secretary and Governance Team for ongoing monitoring.	jan-20	5	Yes		Yes	No
26	18/19	Corporate Transitional Plan May 2019	Reasonable	Head of People & OD/Head of Financial Accounting	Director of Workforce & OD/Interim Director of Finance	Medium	The three tasks removed from the finance project plan should be re-instated on the task list and updated to reflect their current status, even if they have now been completed as this ensures a complete record of all actions. This should be reported to the Board. Responsibility for carrying out the HMRC check with casual staff to determine their employment status for tax and NI purposes should be clarified. A process should be put in place to ensure that the employment status of all casual staff is assessed prior to them undertaking any work for HEIW.	Finance and HR jointly held workshop training sessions for the recruiting managers in November 2018, on their roles and responsibilities in recruiting these workers and how to undertake the HMRC check. Further guidance was issued to the recruiting managers such as a toolkit and guidance flow charts on how to complete these checks. Although training and support has been provided, more training is being commissioned from an external specialist provider to further train these recruiting managers. A procurement exercise to source an external provider is currently underway. The remaining items relating to staff induction and budgetary control training have been reinstated on the finance transition plan and marked as complete.	sep-19	Complete	Complete		**Progress as at July 2019**: The People Team have completed the toolkits and flow charts for the recruiting managers. Please note narrative above for the external training. **Progress as at November 2019:** Please note narrative above. **Progress ast at January 2020:** Training to be delivered by Ernst & Young for recruiting managers has been arranged for 6 February 2020**.** **Current Progress:** The training was delivered by Ernst & Young on 6th February 2020, the recruiting managers found the session very informative and they are now fully trained in this area.	feb-20	5	Yes		Yes	No

Internal Audit Completed Recommendations

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
27	18/19	Corporate Transitional Plan May 2019	Reasonable	Board Secretary/ Head of People & OD	Board Secretary/ Director of Workforce & OD	Medium	The Policy Matrix currently being used to record HR / OD policies and procedures should be expanded to include all HEIW policies and procedures. The format of the matrix should also be amended to include the review date for each policy and procedure and a lead officer and timescale for any outstanding polices yet to be developed.	The policy matrix will be expanded to incorporate the non-HR policies, responsible officers and deadlines for review and completion. Management wish to record that any future HEIW policies that are new or for review, will apply a standard and consistent approach for HEIW, which will incorporate the organisation's values and behaviours.	Immediate & July 2019	Complete	Complete		**Progress as at July 2019:** Work is in progress to update the policy matrix for all HEIW policies to reflect the recommendation. **Progress at November:** HEIW has a Policy Register that incorporates all its policies that details the policy author, the policy version, approval date and date of review. The register has a trigger for review set at 6 months prior to the review date. **Progress as at July 2019:** The People Team have a project plan for the review of all HEIW policies. All new policies are including the HEIW values and behaviours. Progress at November 2019: The People team has a fully integrated policy matrix which now includes all policies within HEIW. This has been compiled in collaboration with HEIW's Corporate Governance Manager and is now the assigned person for ensuring all policies are all actioned within the review date and will ensure a standard view of all HEIW policies. Also, the People team has now set up a Policy Review Group that has trade union representatives and members of the	nov-19		Yes		Yes	No
28	18/19	Corporate Transitional Plan May 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Low	To increase the potential number of candidates it is recommended that all vacancies are advertised concurrently on NHS Jobs and the HEIW website.	The HEIW careers/jobs page is work in progress and the People team are working jointly with the Communication team to create the pages on HEIW website.	des-19	Complete	Complete		Complete	jul-19		Yes		Yes	No
29	18/19	Corporate Transitional Plan May 2019	Reasonable	Board Secretary	Board Secretary	Low	Risks that have been resolved and are no longer relevant should be marked as such and removed from the risk register. New risks should be assigned to a lead officer as soon as they are added to the risk register. The risk register should be periodically reported to the Board.	The risk register will be amended to implement the recommendations on marking resolved risks and on assigning lead officers. The risk register was presented at March Board. The Board's Forward Work Programme confirms the risk register will be periodically reported to the Board at March and September Board Meetings.	jun-19	Complete	Complete		The Executive Team reviews the risk register on a monthly basis. The Audit and Assurance Committee review the risk register at each meeting. The Board reviews the risk register on a 6-monthly basis.	jul-19		Yes		Yes	No
30	19/20	Health & Safety July 2019	Reasonable	Head of People & OD Team	Director of Workforce & OD	Medium	A timescale should be drawn up for completion of the outstanding safe work procedures. The Risk Assessment procedure should include a template for carrying out risk assessments. Management should consider developing a Lone Working policy to help protect staff that are not working out of the main office at Ty Dysgu. All policies and procedures should be made available to staff as they are approved.	It is acknowledged that procedures need to be put in place. It is anticipated that this will be completed over the course of the next 3 months.	okt-19	Complete	Complete	Transferred from Planning & Performance to People & OD Team	**Progress as at November 2019:** A number of the Health and Safety procedures that underpin the H&S Policy have been drafted and reviewed by the H&S Group and forwarded to the Executive Team for approval. These are being actioned during October for formal release to the staff shortly: • Assessment and use of DSE; Fire safety; PEEP; First Aid; New and expectant mothers; Young persons; Incident reporting and investigation. The H&S Group also reviewed a draft homeworking procedure and identified a number of issues regarding what standard equipment should be issued to HEIW contracted staff working in Ty Dysgu, HEIW contracted staff working remotely and remote staff employed by the Health Boards (but salary is recharged to HEIW). This also highlighted what additional equipment was available on request and specialised equipment identified through DSE and OH referrals. This discussion also aided agreement on who should have a face to face or online DSE assessment and which groups of staff would be financially supported with a contribution to an eye test, and those items of equipment that will require PAT testing and a process for undertaking this for remote workers. It was felt that the homeworking procedure should be led by the People team and informed by this piece of work. On the 26 September, the H&S Group reviewed the following procedures: • driving for work; risk assessments; drugs and alcohol; mental health; manual handling and control of contractors. A number of these required further amendment and will return to the H&S Group in December prior to submission to the Senior Executive team for formal approval. It was also agreed that the drugs and alcohol and mental health procedures should be paused because of the current Health Needs Assessment being undertaken and agreed that these two specific procedures should then be taken forward by the people team. **Progress as at January 2020:** We have broadened out the Driving for Work Procedure to a Travelling for Work Procedure to be inclusive of other methods of transport i.e. cyclists/walkers. The Risk Assessment Procedure has been expanded and templates for a standard risk assessment form, corporate risk assessment form and a risk assessment inventory list have been revised. The Manual Handling Procedure and Control of Contractors has been rewritten by the Facilities Manager. These procedures were reviewed at the H&S Sub Group on 18 December 2019 and are due to be submitted to the Executive Team for approval during January 2020. The Drugs and Alcohol and Mental Health Procedures have been paused because of the current Health Needs Assessment and will sit now with the People Team. **Progress as at June 2020:** The Alcohol & Substance Misuse and Mental Health & Wellbeing Procedures are part of the Corporate Health Standards. Both policies have been out for staff consultation. The Alcohol & Misuse policy has concluded on 2.6.2020 and will be ratified by the Local Partnership Forum on 8th July. The Mental Health & Wellbeing Policy felt to be a more critical policy in light of the current COVID 19 pandemic. A task and finish group has been set up to support the development of this policy. Staff focus groups will be commencing on 29th June and to conclude in July. The development of a Agile/Flexible/Home/Remote Working Policy has now commenced. A task and finish group has been set up to drive forward the development of this policy. The first meeting is on 24th June.	jan-21	15			Yes	No
31	19/20	Health & Safety July 2019	Reasonable	Business Partner, Planning & Performance	Director of Workforce & OD	Medium	A decision should be made regarding the car park arrangements at Ty Dysgu with consideration to restricting those who can access the car park. When arranging meetings at Ty Dysgu with external parties, staff should be encouraged to provide details of other off-site parking facilities in the area.	Staff who are arranging meetings have been asked to inform potential visitors of the alternative options to park offsite due to the limited availability on the premises. The facilities manager is currently considering options following agreement from the executive team to implement staff only parking via barrier entry solutions.	okt-19	Complete	Complete		The Facilities Manager is working with procurement to change the car park to a staff car park by installing a barrier with ID access and a digital sign to say car park full. There will be a requirement to remove the existing barrier and obsolete metalwork including the current metal cover and filling the hole with cement.	nov-19		Yes		Yes	No
32	19/20	Health & Safety July 2019	Reasonable	Business Partner, Planning & Performance	Director of Workforce & OD	Medium	The Health and Safety Committee and Board should consider what information the Health and Safety Committee should report to the Board, and what format reports will take.	The next scheduled committee is due to take place on 31st July where this will be discussed and where options can be considered to include appropriate data on H&S on the performance framework dashboard that will be provided to Board in line with other organisational performance data on a quarterly basis	okt-19	Complete	Complete		**Progress as at November 2019:** The H&S Group proposed the following items could be reported to Board as part of the performance dashboard. • Frequency and levels of attendance at committee meetings; Report the number of incidents and any remedial action; Number of H&S related policy and procedures equality impact assessments; Number of H&S representatives (fire wardens, DSE assessors, first aiders etc.); Number of training courses undertaken by staff. Work to develop the H&S Dashboard as part of the overall Performance Reporting has commenced and is expected to be finalised during Q4 this **year.** **Progress as at January 2020:** Work to develop the H&S Dashboard as part of the overall Performance Reporting has commenced and is expected to be finalised during Q4 this year. **Current Progress:** Significant progress has been made in establishing which metrics to use for health and safety performance. We have a first iteration of the data that will go to Executive in the next performance report. The data includes Incident Reporting,ESR training compliance,Training courses attended, H&S Volunteer numbers, Policies and procedures produced and approved,Risk Assessments produced and actions completed.	apr-20	6	Yes			
33	19/20	Values and Behaviours Framework July 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Medium	Management should consider establishing a mechanism for monitoring grievances, staff disciplinary action and the number and nature of complaints received in order to identify trends and possible non-compliance with the values and Behaviours Framework.	Management has already established a mechanism for monitoring and reporting disciplinary action and grievance complaints. This will be reported to Board through dashboards. Any trends identified will be supported by further information of action taken by management and reported to Board.	Immediate	Complete	Complete		The People team and Analytics team will be providing this information to Executive and Board on a quarterly basis.	nov-19		Yes		Yes	No
34	19/20	Values and Behaviours Framework July 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Medium	The Culture Committee's governance arrangements, appropriate attendance at meetings, and reporting arrangements, should be monitored to ensure they are operating effectively. When reviewing the draft minutes the Committee should ensure they are an accurate reflection of those members that attended the meeting.	As the Culture Committee has only just recently established its members, Management is currently refining its governance and reporting arrangements to ensure it operates efficiently and effectively.	Immediate	Complete	Complete		Just to clarify, the culture group does not have committee status. It was established in April 2019 with terms of reference which included bi-monthly meetings and a rotational chair (each to serve a duration of three months). An agenda and minutes of each meeting is recorded. To date, the group has a record of six meetings that has taken place, with agenda and minutes, which is an accurate reflection of the members who attended the meeting. At the last meeting early November 2019, there was a discussion regarding the duplication of the work of each of the groups and its champions, such as Time to Change group, Wellbeing group, Diversity & Inclusion group and Communications group. In light of this, the Culture group will evolve/rebrand into a staff engagement group with HEIW Champions representing the workforce and each theme (i.e. wellbeing, inclusion, culture, social, and communications). A draft proposal of a HEIW Champions group is being prepared with a view to this being launched in January 2020.	nov-19		Yes		Yes	No
35	19/20	Values and Behaviours Framework July 2019	Reasonable	Board Secretary	Board Secretary	Low	As best practice, management should consider if key documents that are integral to the organisation should be formally approved by the Board.	Key documents requiring Board approval are identified within HEIW's Standing Orders and Policy on Policies. The Policy on Policies confirms that strategic matters and certain key policies require Board approval. Such key documents are kept under constant review to ensure they are formally approved by the Board.	Ongoing	Complete	Complete		Completed	nov-19		Yes		Yes	No

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
51	19/20	Casual Workers Employment Status - Follow Up November 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Medium	Advice should be sought from HMRC and guidance issued in relation to how to treat workers who are assessed as self-employed but request to be treated as employed and for cases where the ESS toolkit decision is ambiguous. In the meantime: A) Workers assessed as self-employed via the ESS toolkit should be treated as self-employed and not have the HMRC decision overturned. Consideration should be given to developing a pro-forma invoice that can be used to facilitate payment to those self-employed workers that are unable to raise their own invoices. Invoices should be signed by the worker prior to being processed for payment. If there are instances where this is not possible, HEIW should ensure the request to be treated as employed is made in writing and appropriately approved. B) In cases where the ESS check is unable to determine the tax status of casual workers, to reduce exposure to the risk of making income tax and NI payments on behalf of casual workers and incurring financial penalties, the HEIW default position should be that the worker is inside the scope of IR35 and liable for the deduction of income tax and NI contributions from their fees.	A previous staff member who worked in the Finance department with extensive experience in this area, advised that if an ESS check determines someone as 'self-employed' but they are unable to raise invoices, then we should process them as a casual worker. If that is not appropriate, we will look to work with the Finance team to develop a pro-forma invoice. We will also let recruiting managers know that if there are instances where people are unable to raise invoices, then they need to make a request in writing to be treated as a casual worker (employed). The People team will remind all recruiting managers that if an ESS check is unable to determine the tax status of an individual, they are to be treated as inside the scope of IR35.	des-19	Complete	Complete		The People Team has further tighted up this process and an email to recruiting managers on 18th December 2019, has advised them that with immediate effect, if an ESS check determines someone as self-employed for tax purposes, but they are unable to raise an invoice, they must make a request in writing to be processed as a casual woker. In the meantime, the People Team will liaise with Finance to discuss the possibility of developing a pro-forma invoice for those who are deemed as self-employed but cannot raise invoices. The above email also advised managers that if an ESS check is unable to determine the status of an individual, they need to be processed as a casual worker.	jan-20		Yes		Yes	No
52	19/20	Casual Workers Employment Status - Follow Up November 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Medium	A) The 'reference' field on the ESS check should be used to record the casual workers name and allow the reconciliation of checks to individuals. B) Staff should ensure the date that the ESS check was completed is recorded on the supporting documentation forwarded to the People Team. C) Letters notifying the casual worker of their employment status should be sent out promptly after the check has been completed. D) Timesheets should be fully completed and authorised.	The People Team will be sending a communication to remind recruiting managers that the reference field on the ESS check should be used to record the casual workers name, and that the date the check was completed is recorded on supporting documentation. The People Team will also remind managers that the employment status letter needs to be sent out promptly after the check has been done and, ideally, before they do any work for us. Timesheets that are not fully completed and authorised will be returned to the recruiting manager and not processed until fully completed. Recruiting managers have been reminded of this.	des-19	Complete	Complete		An email has been sent to recruiting managers on 16th December 2019, to advice all of the above. The People Team has amended the timesheet to make it more user friendly, by removing the assignment number as it is often left blank, as until casual workers receive a payslip they will not know the assignment number. Managers have been asked to use this going forward.	jan-20		Yes		Yes	No
53	19/20	Casual Workers Employment Status - Follow Up November 2019	Reasonable	Head of People & OD	Director of Workforce & OD	Medium	The checks that are undertaken on the supporting documentation by the People Team should be recorded and evidenced. This could be achieved by developing the existing Casual Worker list maintained by the People Team into a checklist that records the checks carried out, the person carrying out the check and the date was carried out.	The People Team have added a column to our casual worker list to show when document checks are completed.	Immediate	Complete	Complete		The column has been added updated twice as we have only had 2 new engagements since implementing the column. Will continue to monitor.	jan-20		Yes		Yes	No
54	19/20	Casual Workers Employment Status – Follow Up November 2019	Reasonable	Head of People & OD/Head of Financial Accounting	Director of Workforce & OD/Interim Director of Finance	Medium	Management should establish a documented operational procedure (Procurement Manual) for the engagement of casual workers to ensure a standard approach is used across HEIW.	HEIW is in discussion with NWSSP Procurement Team regarding further training and support for staff undertaking procurement within HEIW. Also, Ernst & Young who will be delivering the specialist training to the recruiting managers, will also include specific training and guidance for on the engagement of casual workers in HEIW within that context. The training will also include operational guides, which will be available to the recruiting managers after the training.	des-19	Complete	Complete		**Progress as at January 2020:** Training to be delivered by Ernst & Young for recruiting managers has been arranged for 6 February 2020. **Current progress:** The training was delivered by Ernst & Young on 6th February 2020, staff found the session very informative. The information from the session has been shared with the recruiting managers which is being used as guidance.	feb-20	2	Yes		Yes	No
55	19/20	Casual Workers Employment Status – Follow Up November 2019	Reasonable	Head of People & OD/Head of Financial Accounting	Director of Workforce & OD/Interim Director of Finance	Medium	The training requirements for staff involved in the engagement of casual workers should be assessed against the three quotations obtained to date to establish whether training is required and if so which is the most appropriate provider.	The People Team received the quotes from Deloitte, KPMG and Ernst & Young. The People team has been working with NWSSP Procurement and have appointed Ernst & Young as the training providers. The People team are awaiting confirmation of dates to deliver a training session to all recruiting managers of casual workers.	des-19	Complete	Complete		**Progress as at January 2020:** Training to be delivered by Ernst & Young for recruiting managers has been arranged for 6 February 2020. **Current Progress:** The training was delivered by Ernst Young on 6th February 2020.	feb-20	2	Yes		Yes	No
56	19/20	Freedom of Information (FOI) November 2019	Reasonable	Board Secretary	Board Secretary	High	The publication scheme should be finalised and published as soon as practically possible.	Draft Publication Scheme in development and will be finalised and published by the end of October 2019.	okt-19	Complete	Complete		Published on the website at the end of October 2019	jan-20	3	Yes		Yes	No
57	19/20	Freedom of Information (FOI) November 2019	Reasonable	Board Secretary	Board Secretary	Medium	A disclosure log should be developed and published.	Disclosure Log in development and will be published by the end of October 2019.	okt-19	Complete	Complete		Published on the website at the end of October 2019 and routinely updated as FOI responses are issued	jan-20	3	Yes		Yes	No
58	19/20	Freedom of Information (FOI) November 2019	Reasonable	Board Secretary	Board Secretary	Low	Work should continue to bed in the process and ensure all stages are retained.	HEIW will continue to embed the FoI process and ensure that information from all areas of the process are retained providing an audit trail for all requests.	Immediate	Complete	Complete		Process now in place for all correspondence relating to FOI request information gathering to enable FOI responses to be drafted is kept and electronically filed for auditing purposes.	jan-20		Yes		Yes	No
59	19/20	Freedom of Information (FOI) November 2019	Reasonable	Board Secretary	Board Secretary	Low	The reporting process should be developed as outlined.	Going forward it is confirmed that HEIW will provide a report on FOI compliance to each Audit and Assurance Committee as part of its Information Governance reporting. An annual report, on the previous year's compliance and performance, will be provided in Q1 of each financial year	Immediate	Complete	Complete		An update on the current position and compliance with FOI requests was provided at the Audit and Assurance Committee at its meeting held on 22 November 2019. An FOI update will be provided within the Information Governance quarterly reporting to the Audit and Assurance Committee.	jan-20		Yes		Yes	No
60	19/20	Freedom of Information (FOI) November 2019	Reasonable	Board Secretary	Board Secretary	Low	The reference to the leaflet should be removed from the procedures.	A draft leaflet for people seeking to make and FOI request has been developed and has been appended to the FOI procedure.	okt-19	Complete	Complete		Complete	jan-20	3	Yes		Yes	No
61	19/20	Board and Committee Governance Arrangements November 2019	Substantial	Board Secretary	Board Secretary	Medium	The Board should undertake a self-assessment of their effectiveness, within an appropriate timeframe, and thereafter on an annual basis. While we acknowledge that the Education, Commissioning and Quality Committee has been in existence for less than 12 months, the Board should consider when it would be appropriate for the Education, Commissioning and Quality Committee and Remuneration and Terms of Service Committee to undertake a self-assessment, and plan accordingly.	• Self-assessment for the **Education, Commissioning and Quality Committee** scheduled for Q1 of 2020/21	jun-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at January 2020:** All self-assessments are scheduled into the appropriate Forward Work Programme. **Progress as at April 2020:** It was planned for the Committee to undertake its self-assessment in Q4. However, due to the increased priority of Coronavirus, this has been postponed until further notice. **Progress as at July 2020:** Draft Effectiveness Checklist to be agreed at the July Committee. With an evaluation presented to the October Committee. **Progress as at October 2020:** The evaluation of the effectiveness review is being considered at the October Committee. **Current Progress:** COMPLETE evaluation considered by the Committee in October 2020.	okt-20	4			Yes	No
62	19/20	Board and Committee Governance Arrangements November 2019	Substantial	Board Secretary	Board Secretary	Low	For consistency and clarity, the full standard template should be used for all covering reports taken to the Board and its Committees. Any sections not deemed necessary should be marked as such.	The Board Secretary will ensure that the standard covering report template is used for all Board and Committee reporting.	des-19	Complete	Complete		The Board Secretary has issued an email reminder to all internal and external parties to ensure that the HEIW reporting template is used for all reporting to the Board and Committees. The Board Secretary will continue to monitor compliance on an ongoing basis.	jan-20		Yes		Yes	No

Internal Audit Completed Recommendations

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
70	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	High	1. Management should ensure that directorates have their own risk registers in accordance with the organisation's policy. Where appropriate departmental registers should be considered.	Risk Management Policy to be updated to confirm process for escalating risks from a directorate risk register to the corporate risk register.	jul-20	Complete	Complete		**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20					No
70	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	High	2. Management should review risks recorded on the directorate risk registers to consider if they should be escalated to the corporate risk register for scrutiny by the Board or appropriate committee.	Each Director tasked with ensuring that risks are reviewed to determine whether they should be escalated on a regular basis. Amending this policy will require Board approval.	jul-20	Complete	Complete		**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20					No
70	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	High	3. Mitigating actions stated within risk registers should identify the risk owner, and include a timescale for the implementation of the action to aid the review and scrutiny of the recorded risks.	HEIW Risk Registers to be standardised. Standardised documentation to include guidance on identifying risk owners and deadlines for mitigation action.	jul-20	Complete	Complete		**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20					No
70	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	High	4. As Datix is not being used, a standard template should be used for all directorate and departmental risk registers, that is consistent with the corporate risk register.	Standardised template to be introduced for Risk Register in line with the new IMTP.	apr-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20	3				No
70	19/20	Risk Management March 2020	Reasonable	Medical Director	Medical Director	High	5. The Medical Directorate risk register and the RSU & Dental risk register should be renamed to reflect their current usage.	The Medical Directorate risk register and the RSU & Dental risk register has been renamed in accordance with the recommendation.	Immediate	Complete	Complete		**COMPLETE**			Yes			
71	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	Medium	All staff identified as requiring Risk Management training should enrol on one of the three dates currently being offered. Where they fail to enrol, they should be specifically allocated to one of the scheduled training sessions to ensure attendance is maximised and risk management concepts and processes are embedded into the organisation. A 'mop up' session should then be held for any staff that were unable to attend their allocated session.	All staff who have been identified as requiring Risk management training have received an email confirming that the training is mandatory. Up to the end of February, 40 staff have received the training. 2 sessions in March have been arranged as 'mop up' sessions however, the position will be reviewed again at the end of March 2020.	apr-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** March Sessions cancelled due to COVID 19 restrictions. New sessions will be arranged once normal working has resumed. **Current Progress:** Risk Management Training via Microsoft Teams has been arranged for 7 and 12 October 2020. All Senior Managers who have not received the training will be enrolled onto one of the two dates in October 2020. A Lunch and Learn Session is being planned for November/December to provide an update on the changes to the Risk Management Policy.	okt-20	6				No
72	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	Medium	The HEIW Risk Management Policy should be updated and revised to: * Include the process relating to the escalation of risks from directorate risks registers into the corporate risk register, including the setting of a value above which directorate risks should be considered for inclusion on the corporate risk register. This will ensure the Board are sighted on and monitoring risk consistently across the organisation. * Provide clarity on the need for departmental risk registers and the requirement for directorate risk registers. * Include or provide a cross reference to the guidance on the risk scoring system to ensure consistency across the organisation. * Reflect that the Datix Risk Management System is not being used within the organisation to capture and record identified risks.	The HEIW Risk Management Policy to be updated to include each recommendation. The amended policy will need Board approval.	jul-20	Complete	Complete		**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20					No
73	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	Medium	1. To reduce the number of risks on the corporate risk register consideration should be given to only including on the corporate risk register and reporting on, risks with a higher residual risk rating, in line with the organisation's risk appetite. For example, this could be achieved by only reporting risks with a residual risk score of say 11 and above.	With regards only including matters on the corporate risk register with a minimal residual risk score an appropriate score shall be considered by the Executive Team and the Risk Management Policy shall be amended accordingly.	jul-20	Complete	Complete		**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20					No
73	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	Medium	2. All risks should be clearly assigned to a member of the Executive Team using their post title. Consideration should be given to including the risk mitigation strategies of Treat, Transfer, Tolerate or Terminate against each risk in line with risk management good practice.	The Risk Register will be updated to ensure that Executive Team members are referred to by job title. Consideration has been given to banding risk mitigation strategies into four banding. It has been decided not to amend the current approach to recording mitigation action as the current approach is deemed to be both concise and clear.	Immediate	Complete	Complete		**COMPLETE**						
74	19/20	Risk Management March 2020	Reasonable	Board Secretary	Board Secretary	Low	The Business Continuity Policy, Health and Safety Policy and Information Governance Policy should be revised to incorporate the relevant contents of the Board Assurance Framework into their narrative.	Business Continuity Policy, Health and Safety Policy and Information Governance Policy to be amended to include relevant contents of the BAF.	mai-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Due to the impact of COVID 19 the amendment to these policies has been delayed. It is anticipated that these will be concluded by the end of August 2020. **Progress as at October 2020:** The Business Continuity Policy and Health & Safety Policy have been updated. The IG Policy is being reviewed by the newly appointed IG Officer. **Current Progress:** The IG Policy has been updated and scheduled for approval by the Executive Team on 13 January 2021.	jan-21	8			Yes	No
76	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Digital	Director of Planning, Performance & Corporate Services	Medium	The organisation should actively engage with its Board Members to gather further feedback on the current performance management dashboard, with a view to enhancing if necessary.	We produce a report on a bi-monthly basis for Board. The report will also be utilised to inform discussions with Welsh Government at Quality & Delivery meetings. These regular interactions will provide an opportunity to understand ongoing information requirements and how the report and dashboard could develop.	sep-20	Complete	Complete		**Progress as at July 2020:** We produced an End of Year report presented to Board at May Public meeting and further reports are due bi-monthly. This provides a mechanism for the Board to reflect on information shared and identify future reporting requirements. The impact of COVID-19 is likley to have an impact on future reports and the detail available and provided given the changes made to education and training. **Current Progress:** Regular reporting continues on a bi-monthly basis. Board members are invited to ask questions and provide feedback at each session. The development and finalisation of the performance framework will provide an opportunity for further dialogue and feedback. Additionally, the Board has nominated an IM to work with us on this area.	sep-20					No
81	19/20	Performance Management March 2020	Reasonable	Deputy Director Planning, Performance & Digital	Director of Planning, Performance & Corporate Services	Low	We would suggest that including an element of 'operational' peer review into the validation process as this would add a constructive element in helping to validate performance measures. Sense-checking report data prior to publication might detect some of the minor errors identified in the Q1 dashboard.	Agreed - As part of the development of the Performance Framework, this will form part of the expectations of data owners and data controllers. As we develop the Performance Framework, consideration will be made to enable appropriate validation from operational peers by attempting to provide more time between report completion and required submission for Executive and Board approval.	jun-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** This forms part of the draft performance framework to be finalised. **Progress as at October 2020:** Validation with operational managers was undertaken for the September Board performance report. This proved beneficial in identifying some issues with data around fill rates across a number of specialties and professions. This will be embedded in the final version of the performance management framework. **Current Progress:** This is being undertaken and a performance reporting schedule, including review, has been issued for the twelve months ahead. The Board reporting scheudle has been moved to quarterly reporting to support the actions required to meet this recommendation.	jan-21	7			Yes	No

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
82	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	Decisions that impact on the organisation's financial governance framework should be formally approved and documented.	Agreed - An all-Wales review of Standing Financial Instructions (SFIs) is currently being carried out by a task and finish group of the Directors of Finance forum. It was planned that this work would feed into the agreed review of the HEIW SFIs in September 2019. However, the scope of the all-Wales review was extended and the revised SFIs are now not expected to be agreed by Welsh Government until July 2020. It should be noted that no issues have been identified with the current SFIs and they are considered to be operating effectively, and therefore there has not been any identified risk as a result of this delay. A report will be taken to the Audit & Assurance committee in April 2020 to notify them of the delay in the update of the SFIs.	apr-20	Complete	Complete		**COMPLETE**	apr-20					
83	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	1. Whilst we acknowledge that the virement of budgets between directorates is not a regular occurrence, Finance staff should ensure that Budget Adjustment forms are completed and properly authorised prior to transferring budgets between directorates.	The delay in the approval of the identified virement was due to the absence of one budget holder, although the changes had been discussed and approved at the Executive level.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
83	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	2. The feasibility of producing system generated reports that can distinguish between the various types of journals posted should also be investigated.	We intend to change the narrative for future budget movements to enable them to be identified through a system report, although this will not provide any more information than is currently available through the manual spreadsheet reconciliation.	jun-20	Complete	Complete		**COMPLETE** - The process for budget movements was revised at the start of 2020/21, which ensures that consistent narratives are used across the finance team. This allows us to run Qlikview/Oracle reports identifying the reason for budget movements and reconciling this to any required approvals.	apr-20		Yes - System reports can be run showing the required narratives			
84	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Low	1. Management should ensure that the correct L1 or L2 form is accurately completed for all budget holders.	Agreed - A revised process to review L1 and L2 forms was put in place during 2019-20, but this was not done retrospectively to verify the position for employees in post when HEIW was formed. A full reconciliation has now been carried out and will be repeated on a quarterly basis and signed off by the Head of Financial Accounting.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
84	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Low	2. A reconciliation between delegated limits approved on L1 or L2 forms and amounts set up on Oracle should be carried out to confirm no other discrepancies exist	The form that could not be provided for one budget holder has been retrospectively completed.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
85	19/20	Core Financial Systems March 2020	Reasonable	Board Secretary	Board Secretary	Medium	1.A mechanism should be put in place to ensure contracts that are due to expire are reviewed prior to their end date to determine whether they should be ended, extended or re-tendered. 2. The register should be updated with the missing contract start, end dates and Vendor / Supplier names.	The process to create and maintain the contracts register is still being developed. We will work with the procurement team to ensure that the relevant information is available.	jun-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Meeting held with Head of Procurement and it has been clarified that Procurement hold the contract register on behalf of HEIW as per the SLA. There is a mechanism in place for ensuring that contracts are reviewed at an appropriate timescale before expiry. Continued engagement with Procurement to ensure that the contracts register is complete and kept up to date. **Current Progress:** The Contract Register held by Procurement has been reviewed and updated to include all relevant information. The updated contract register is being presented to the Audit & Assurance Committee at its October meeting.	okt-20	4				No
86	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	1. The Purchasing Card FCP which was due for review in January 2020, should be reviewed and updated to reflect the procedures currently in operation. The updated FCP should include a standard form for authorising amendments to monthly credit limits and individual transaction limits.	Agreed - The original Purchasing card FCP was prepared using the Velindre UHT document as a guide. Due to the differences in the operating models of the organisation it is accepted that a revised FCP is required, although it was agreed at Audit & Governance Committee that the initial annual review was delayed awaiting the internal audit report. The revised FCP is being developed and will be completed after the 2019/20 accounts closure process. It will be brought to the July 2020 Audit & Assurance Committee for approval.	jul-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** The update of the FCP has started, although due to the extended accounts deadlines for 2019/20 it is unlikely that this will be complete and reviewed in time for issue for the July Audit & Assurance Committee. It is requested that the deadline is extended to October 2020 (the next Audit & Assurance Committee), where the full annual review of FCP's will be submitted for consideration. **Current Progress:** The FCP has been reviewed to take account of the audit recommendations and is included within the 'Annual Review of Financial Control Procedures' report to this Committee Meeting (20/10/20)	okt-20	3	Yes - Report to this Committee Meeting (20/10/20)			No
86	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	2. Where high monthly limits are requested, prior to authorisation, consideration should be given as to whether purchasing cards should be used over conventional procurement methods. The authorisation form should clearly document the rationale for the decision made.	With regard to the increases in purchasing card limits, each request is reviewed by the Head of Financial Accounting based on the requirements at the time. The conference expenditure requiring an increase in the limit to £18k (note this was not the cost of the event, but the cumulative expenditure on the card during the month) had been through the appropriate procurement processes and had been approved by the budget holder. The decision to make a payment through the purchasing card is taken in finance depending on the requirements of the individual transaction. The FCP will be amended to reflect this and improvements will be made to the procurement card changes log that is maintained in the financial accounts team.	jul-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** The update of the FCP has started, although due to the extended accounts deadlines for 2019/20 it is unlikely that this will be complete and reviewed in time for issue for the July Audit & Assurance Committee. It is requested that the deadline is extended to October 2020 (the next Audit & Assurance Committee), where the full annual review of FCP's will be submitted for consideration. **Current Progress:** The FCP has been reviewed to take account of the audit recommendations and is included within the 'Annual Review of Financial Control Procedures' report to this Committee Meeting (20/10/20)	okt-20	3	Yes - Report to this Committee Meeting (20/10/20)			No
87	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Medium	The unused cards should be destroyed and cancelled with the card provider.	Agreed - The two purchasing cards were held in finance whilst the operating model for the organisation was established. Based on the current requirements these cards will not be issued so they have been destroyed and the accounts closed. Should this requirement change in the future new cards will be requested.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
88	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Low	Procurement staff should be reminded to ensure that budget holder approval is obtained and financial codes are provided for all orders to be processed via procurement cards.	Agreed - A reminder has been issued to all procurement staff.	Immediate	Complete	Complete		**COMPLETE**	Immediate					

Internal Audit Completed Recommendations

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
89	19/20	Core Financial Systems March 2030	Reasonable	Head of Financial Accounting	Director of Finance	Medium	VAT Returns should be reviewed and signed off as checked prior to submission to HMRC in line with the FCP.	Based on the current internal processes VAT claims are reviewed along with other key balance sheet reconciliations at the end of the relevant month. Due to the timescales required to produce the VAT returns it is has not always possible to review these prior to the submission date. The timetable has been amended and going forward the returns will be reviewed prior to submission.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
90	19/20	Core Financial Systems March 2020	Reasonable	Head of Financial Accounting	Director of Finance	Low	Whilst it is acknowledged that all VAT errors are at present retrospectively recovered, to reduce reliance on the external review and to extract maximum benefit from the reports provided, training in respect of the treatment of VAT and highlighting the errors identified by the external review should be provided to all HEIW staff responsible for processing sales and purchase invoices.	Agreed - VAT training was provided to relevant finance staff by EY LLP in November 2019. Continued support is provided by the financial accounting team and processes will be refined over time to reflect the requirements of the organisation.	Immediate	Complete	Complete		**COMPLETE**	Immediate					
91	19/20	IT Review April 2020	Reasonable	Deputy Director Planning, Performance & Digital/ IT Manager/ Facilities Manager	Director of Workforce & OD	Medium	The server racks should be raised from the floor and a protective cover installed to channel any leaks away.	Following the risk of flooding being identified, HEIW is investigating with NWIS the feasibility of repositioning the server units. A protective cover solution to mitigate the impact of leakages and condensation will be investigated and costed with our contractors.	jul-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Work to be progressed to mitigate risk. Quotes received and agreement to proceed with minor works. NWIS to be scheduled to undertake the required work once access to Ty Dysgu is safe to do so. Flood Risk Specialists will also be inspecting the IT infrastructure in Ty Dysgu once it is safe to do so. **Current Progress:** Works have been completed to mitigate the risks associated with the server units. Further works to mitigate the flooding risk of Ty Dysgu in totality is being taken forward with procurement.	sep-20	2				No
92	19/20	IT Review April 2020	Reasonable	Deputy Director of Planning, Performance & Digital	Director of Workforce & OD	Medium	Work on developing a digital strategy should re-commence as soon as the Director of Digital is in place. In the interim, the organisation should not commit to any long-term (permanent) technology use.	This is agreed. Plans are in place to recruit to Director of Digital, which may be impacted as a result of COVID-19.	sep-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Progress to be made following appointment of Director of Digital. It is anticipated that the recruitment of the Director of Digital will be undertaken in Q3. **Progress as at October 2020:** It is expected that recruitment into the post of Director of Digital will be completed in Q4 2020/21. It is anticipated that the development of the Digital Strategy should be concluded by the end of Q1 2021/22 **Current Progress:** Director of Digital will start on 1.2.21 There have been no new commitments to long-term technology use in the interim. Our IMTP and annual plan objectives	feb-21	5			Yes	No
93	19/20	IT Review April 2020	Reasonable	Digital Manager/ IT Manager	Director of Workforce & OD	Medium	Work on guidance should be completed, with the noted guidance documents provided.	We acknowledge the gaps in documentation and will work to develop HEIW policies and procedures for Executive approval.	jul-20	Complete	Complete	Delayed due to COVID 19 Pandemic	**Progress as at July 2020:** Policies identified are being worked on in readiness for Executive approval. **Progress as at October 2020:** The gaps in local policies has been identified with HEIW specific policies drafted. A number of these policies were considered by the IGIM Group on 29 September 2020 and recommended to the Executive Team for approval. The remaining local policies will be finalised for IGIMG consideration and Executive Team approval. There are a number of national policies that are past their review date however, they remain the extant policies within HEIW until such time as the national IGMAG Group review and update them. **Current Progress:** Considerable work undertaken since report was signed off. Local IT policies and guidance for all key	des-20	5			Yes	No
95	19/20	Information Governance: General Data Protection Regulation (GDPR) April 2020	Reasonable	Board Secretary	Board Secretary	High	All departments should complete their IAR and identify all records held, both electronic and paper. This process should ensure that: * the basis for processing is also established; * information flows are identified; * retention periods are clarified; and * records that are outside the retention period are securely disposed.	A revised approach to the Information Asset collection process was discussed and finally approved. On 18 February 2020, an email was sent to all members of staff within HEIW (regardless of location). This email was sent to request a response from individual staff to confirm whether there was any use, retention, viewing or handling of personal information. From this, over 150 members of staff have outlined their use of identifiable data and inter-departmental discussions have been made regarding the combined completion of Information Asset Registers (this is due to the number of staff all using the same data in a specific department and to prevent duplication of effort). To date, over 10 returns have been provided and several more are expected in the coming months. The Information Governance Manager has also met with several departments to discuss this work. Progress has recently been slowed by the impact of the COVID-19 crisis.	sep-20	Complete	Complete		**Progress as at July 2020:** Progress is being made with the completion of the IAR. A further email was issued in June 2020 requesting that all staff their IAR by the end of June 2020. Over 165 employees have made contact with the seconded IG Manager in respect of updates for the IAR. Templates have been issued and collective responses are being completed. These are being collated as separate returns but to date, there is nothing considered to be a concern in terms of the processing arrangements within the organisation. It should be noted that the IAR would never be fully completed as it is a live document and will be continually reviewed and updated. The seconded IG Manager will ensure that staff are aware of their responsibilities in the processing and holding of personal information and issue regular reminders for the review of the data held to assist with the updating of the IAR. **Current Progress:** Information Asset returns have been received from the majority of departments to enable the development of an Information Asset Repository. The newly appointed full-time Information Governance Officer will undertake 6-monthly reviews of the Information Asset Repository or earlier when any new information system/project is implemented.	sep-20					No
96	19/20	Information Governance: General Data Protection Regulation (GDPR) April 2020	Reasonable	Head of People & OD Team	Director of Workforce & OD/ Board Secretary	Medium	HEIW should ensure that all staff complete the e-learning module, and encourage staff to attend the face-to-face training.	HEIW is currently focussed on increasing its e-learning compliance rates for all mandatory subject matter areas within ESR. It is anticipated that the compliance rates for e-learning in respect of GDPR will significantly increase as a part of this overall campaign. HEIW will seek to reintroduce face to face learning when it is safe to do so.	jul-20	Complete	Complete		**Current Progress:** Regular promotion for the completion of e-learning has continued throughout lockdown and will continue through regular reinforcement and communication. This has been delivered via team meetings and also at induction for new members of staff, which has been delievered virtually via Microsoft Teams. As the processes for regular reinforcement and communication are now in place, it is recommended that this recommendation is closed.	jul-20					
97	19/20	Information Governance: General Data Protection Regulation (GDPR) April 2020	Reasonable	Board Secretary	Board Secretary	Medium	IG leads should be defined within departments and an IG network established to ensure that information is disseminated, and any required actions are completed.	There is now an established Information Governance and Information Management Group (IGIM) and this has draft Terms of Reference and representation from applicable departments on its attendance register. The approval of the draft terms of reference for the IGIM by the Audit and Assurance Committee have been postponed as a result of the current crisis and we currently anticipate their approval at the meeting of the Audit and Assurance Committee in July.	Immediate	Complete	Complete		**COMPLETE**						
98	19/20	Information Governance: General Data Protection Regulation (GDPR) April 2020	Reasonable	Board Secretary	Board Secretary	Low	Departmental managers should actively raise awareness of GDPR within their teams by: * including GDPR in team meetings; and * disseminating information via email groups. This should especially be the case for staff not based in the headquarters building / home based staff.	HEIW will forward an email to managers highlighting the importance of GDPR, the guidance that is available to staff in respect of GDPR and requesting that managers disseminate this information at team meetings. HEIW will also forward an email to all staff in respect of GDPR which is targeted to working from home.	jun-20	Complete	Complete		**Progress as at July 2020:** There are IG Pages on the HEIW intranet which contain useful information for staff. Communication emails and news items on the intranet have been issued to staff. It has been difficult to ascertain how GDPR is included in Team meetings whilst HEIW is working remotely. The IG Manager will issue an email to staff reminding staff regarding IG and is happy to attend team meetings to present a short briefing or answer any questions that involve confidentiality. **Current Progress:** An email has been sent via the communications team highlighting the importance of home working. One of the tasks for the newly appointed IG officer will be to review these communications and how the organisation communicates the importance of IG across departments.	jul-20					No
99	19/20	Information Governance: General Data Protection Regulation (GDPR) April 2020	Reasonable	Board Secretary	Board Secretary	Low	To raise awareness, an information bulletin regarding the PIA process should be issued.	The Information Governance Manager will disseminate an information bulletin regarding the PIA process to all staff.	jun-20	Complete	Complete		**Progress as at July 2020:** A PIA process was developed early in HEIWs establishment which is approved. A PIA Poster has been finalised and approved. The seconded IG Manager will issue a communication to raise awareness of the PIA process and include a copy of the poster. **Current Progress:** The seconded IG Manager sent the poster in a bilingual format to the communications team on the 30th June 2020 for publishing.	jul-20					No

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
100	19/20	Service Review - Medical Commissioning Monitoring	Reasonable	Medical Director/Post Graduate Medical Dean	Medical Director	Medium	HEIW should work with LEP's to help develop a clear action plan to help them improve their responses to concerns raised by trainees. Improvement actions could include specifying content and timescales for responding, for example to acknowledge receipt of a concern, to provide an initial response, and a timescale for periodical updates where necessary and a detailed final response. Consideration should be given to monitoring throughout the year the LEP's performance in managing the concerns raised as such data can help inform the quality reviews undertaken. Clear guidance should be in place for use of the HEIW dedicated email address for raising concerns, the circumstances when it should be used and the link back to the concerns process in place in each LEP.	a) We accept this recommendation, while being mindful that the responsibility for investigating concerns of this sort sit with the LEP. We will engage the LEPs via the Associate Medical Dean (Education) Group and ask for specific updates on the issue.	des-21	Complete	Complete		**Current Progress:** Engagement with LHBs on this issue is an ongoing process but clear understanding of responsibilities around concerns. Agree local processes for issues relating to workplace or patient safety concerns are raised through existing processes within UHBs in the same way as for alll UHB staff. Trainng related concerns are to be raised via faculty network or via HEIW Open. Clear gudinace has been issued as part of the release of HEIW Open.	des-20	1			Yes	No
100	19/20	Service Review - Medical Commissioning Monitoring	Reasonable	Medical Director/Post Graduate Medical Dean	Medical Director	Medium	HEIW should work with LEP's to help develop a clear action plan to help them improve their responses to concerns raised by trainees. Improvement actions could include specifying content and timescales for responding, for example to acknowledge receipt of a concern, to provide an initial response, and a timescale for periodical updates where necessary and a detailed final response. Consideration should be given to monitoring throughout the year the LEP's performance in managing the concerns raised as such data can help inform the quality reviews undertaken. Clear guidance should be in place for use of the HEIW dedicated email address for raising concerns, the circumstances when it should be used and the link back to the concerns process in place in each LEP.	b) We will publish clear guidance on the use of the HEIW dedicated email address for raising concerns.	jun-21	Complete	Complete		**Current Progress:** Engagement with LHBs on this issue is an ongoing process but clear understanding of responsibilities around concerns. Agree local processes for issues relating to workplace or patient safety concerns are raised through existing processes within UHBs in the same way as for alll UHB staff. Trainng related concerns are to be raised via faculty network or via HEIW Open. Clear gudinace has been issued as part of the release of HEIW Open.	des-20	1			Yes	No
103	19/20	Service Review - Medical Commissioning Monitoring	Reasonable	Medical Director/Post Graduate Medical Dean	Medical Director	Low	1) The Trainer Recognition Group should endeavour to meet every two months in line with their approved terms of reference. Alternatively the group's terms of reference should be reviewed and amended to reflect their current meeting requirements.	We accept this recommendation in relation to the Trainer Recognition Group. 1. We will align the terms of reference with the frequency of the meetings.	jun-21	Complete	Complete		**COMPLETE**	des-20	1			Yes	No
103	19/20	Service Review - Medical Commissioning Monitoring	Reasonable	Medical Director/Post Graduate Medical Dean	Medical Director	Low	2) The Group should consider whether the current reporting arrangements are appropriate, or whether they should be reporting to the HEIW Education, Commissioning and Quality Committee as well as, or instead of to the Quality and Postgraduate Education Support Committee within the Wales Deanery. The terms of reference should be updated to reflect any change.	We accept this recommendation in relation to the Trainer Recognition Group. 2. We will clarify the reporting arrangements of this group and update the terms of reference accordingly.	jun-21	Complete	Complete		**COMPLETE**	des-20	1			Yes	No

External Audit Closed Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
36	19/20	Management Letter July 2019	Director of Nursing	Recommendation 1: Arrangements for allocating supplementary funding to universities in year should be strengthened I recommend that follow-up action is taken to ensure that this year's funding has indeed been used in line with the conditions of award. I also recommend that if additional funding is made available in future years, then the Authority should: • put in place procedures to identify such underspends earlier in the year; • attach conditions to the funding, clearly specifying the evidence the Authority requires to receive to ensure the money has been spent for the purposes intended, and by when it is to be utilised; and • establish robust follow-up procedures and communicate these to the universities at the time of the award of the funding.	For the larger grant awards in 2018-19, site visits will be arranged prior to the next contract meeting with each university to verify the procurement of assets. Confirmation of expenditure will be sought from the remaining organisations. If funding is made available in future years the conditions of the award will set out timescales for expenditure, and the evidence required for the expenditure along with any follow-up procedures.	aug-19	Complete	Complete	Complete	Contract meetings arranged for November//December at which time assets will be reviewed. Early financial reviews suggest that HEIW maybe in a position to support supplementary funding to Universities and Health Boards/Trusts. In light of this, procedures and supporting documentation are to be reviewed by the end of November 2019.	nov-19		Yes	
37	19/20	Management Letter July 2020	Director of Workforce & OD	Recommendation 2: The Authority does not hold signed contracts of employment for two members of the executive team I recommend that the Authority ensures it holds signed contracts of employment for all staff.	Management will ensure the contracts of the two individuals are signed.	Immediate	Complete	Complete	Complete	The contracts were signed in July 2019.	nov-19		Yes	
38	19/20	Management Letter July 2019	Interim Director of Finance	Recommendation 3: Accounting arrangements for Property, Plant and Equipment need to be introduced I recommend that the Authority puts procedures in place to ensure the proper stewardship of property, plant and equipment and that the accounts accurately reflect these assets going forward. Specifically: a) a fixed asset register is introduced which records all assets held, which in turn reconciles to the financial statements; b) all assets are tagged so that they can be identified in the asset register; c) procedures are introduced to ensure that any decreases in value due to damage/ obsolescence are identified and recorded, so that they can be impaired in the financial statements and inform the future capital programme; and d) procedures are introduced to control and identify any disposals, so that they can be removed from the fixed asset register and financial statements.	a) The details of assets owned by HEIW are currently recorded on an Excel spreadsheet. Options for a dedicated fixed asset system are being reviewed, but due to the relatively small number of assets owned, the continued use of a spreadsheet solution may be the most appropriate option. A paper outlining the decision process will be prepared. b) The tagging of IT assets commenced during June 2019. ID tags for fixtures and fittings have been ordered and tagging will be completed by the end of August 2019. c) and d) FCP2 (approved at the Shadow Audit Meeting on 2 October 2018) sets out the basic requirements for the disposal and impairment of assets. A separate procedure note will be prepared providing further details of the process.		Complete	Complete	Complete	a) The quote received for the procurement of the asset management system in use across the rest of NHS Wales was prohibitive. Therefore, a spreadsheet solution is currently being prepared that will provide the required information for the management and accounting of fixed assets. This is considered to be appropriate due to the relatively small number of assets owned. This decision will be reviewed in the future shoud the asset base significantly increase. b) Approximately 50% of laptops have been tagged. As this is being carried out in conjunction with additional security markings this is taking longer than anticipated. Tagging of fixtures and fittings needs to be carried out when the office is empty. This has been planned for 16th November to coincide with system testing work that is being carried out over that weekend. c) and d) A revised FCP for non-current assets is included as a separate item for consideration by the Audit and Assurance Committee at its November meeting.	nov-19		Yes	
39	19/20	Management Letter July 2019	Board Secretary	Recommendation 4: Procedures for identifying and reporting of related party transactions should be strengthened I recommend: • officers should be reminded to declare all interests and ensure the names of the interests are disclosed; and • original emails from officers are provided as audit evidence where electronic submission of the declaration of interests has been accepted.	Officers will be reminded of the requirements for declaration with immediate effect. We will update working papers for an appropriate audit trail for the 2019-20 financial statements.	Immediate / April 2020	Complete	Complete	Complete	Reminder emails to officers are issued periodically to ensure relevant interests are declared. The Standards of Behaviour Policy is currently under review and the Declarations of Interest Register has been updated to include the date of the declaration. Hard copy forms and email declarations are filed as audit evidence and kept by the Board Secretary.	nov-19		Yes	
40	19/20	Management Letter July 2019	Interim Director of Finance	Recommendation 5: Working papers to support provisions need to evidence compliance with accounting standards I recommend that working papers supporting any future provisions should document management's consideration of the requirements of IAS37 and provide appropriate evidence (such as legal opinion) where relevant. Specifically: • a description of the circumstances which create the present legal or constructive obligation and the past event that gives rise to this obligation; • the view of management on the likelihood that there will be an outgoing of resources to settle this obligation (in terms of whether it is probable, possible or remote); and • provide a reliable estimate for the provision Where this is not possible, consideration should be given to whether the provision is valid, or whether a contingent liability is more appropriate.	Appropriate working papers to support all provisions will be provided for all future audits.	apr-20	Complete	Complete	Complete	This is a year-end issue, and will be considered during April 2020.	nov-19		Yes	

External Audit Closed Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
41	19/20	Management Letter July 2019	Interim Director of Finance	Recommendation 6: The year-end procedures for identifying prepayments should be strengthened I recommend that year-end procedures to identify prepayments are reviewed and improved, and ensure staff receive appropriate training.	For the 2019-20 year-end a supporting 'Closing Pack' will be prepared outlining the key processes and requirements for finance staff. Appropriate training will be built into the closing timetable.	mar-20	Complete	Complete	Complete	This is a year-end issue, and will be considered during March 2020.	nov-19		Yes	
42	19/20	Management Letter July 2019	Interim Director of Finance	Recommendation 7: VAT advice should be sought to minimise the risk of any future VAT inspections identifying errors in recovering VAT The Authority should seek specialist VAT advice during the 2019-20 financial year to ensure that its VAT arrangements are in line with the contracted-out services guidance.	The procurement exercise to secure the provision of VAT supporting advice has commenced and the contract will be agreed from August 2019. A separate tender process to undertake a retrospective review of the 2018-19 transactions will also be progressed.	aug-19	Complete	Complete	Complete	Complete - The procurement of specialist VAT advice is now complete. The contract has been awarded to EY LLP.	nov-19		Yes	
43	19/20	Management Letter July 2019	Director of Workforce & OD	Recommendation 8: A review should be undertaken of historic allowances to ensure they are still valid Whilst acknowledging that staff transferred over to the Authority under TUPE arrangements, the Authority should determine whether such payments were properly due immediately prior to the transfer and whether to continue paying them.	Management will review all cases to ensure that the individual is still appropriately remunerated, given the length of time they have been in receipt of the allowance.	mar-20	Complete	Complete	Complete	Management has reviewed TUPE arrangements of the senior individuals below executives and sought legal advice to support the appropriateness of individuals' remuneration. Advice was shared with the Renumeration and Terms and Conditions Committee and Board who noted the assurances provided and the arrangements in place.	nov-19		Yes	
44	19/20	Management Letter July 2019	Interim Director of Finance	Recommendation 9: The mapping of the payroll feeder to the ledger needs to be corrected for refunds of pensions The Payroll feeder should be amended to correctly record any pension refunds as netting off against pension payments.	The error occurred as a result of the set-up of the Oracle and ESR interface on formation of HEIW. All refunds are now correctly allocated and this has been confirmed through monthly payroll/pension reconciliations.	Immediate	Complete	Complete	Complete	Complete	nov-19		Yes	
45	19/20	Baseline Review - Structured Assessment July 2019	Board Secretary	Well Led and Well Governed Learning Points: Board and Committees: • IM understanding of Board versus Board Development Sessions important • include details and (open) papers of all committees on website • diagram Board, committees & advisory groups and how they link (IA rec)	HEIW IMs have a clear understanding on the difference between Board and a BDS. All open Board and Committee papers are on the HEIW website. Complete		Complete	Complete	Complete	All areas complete	nov-19		Yes	
45	19/20	Baseline Review - Structured Assessment July 2019	Board Secretary/ Interim Director of Finance	Well Led and Well Governed Learning Points: Proper Business arrangements: • update Scheme of Delegation for IM's champion roles/ responsibilities • keep a register of single tender/quotation actions and review periodically (WAO ref 1)	Subject to further discussion regarding amendment of Standing Orders. Details of single tender/quotation reviews are held by the NWSSP procurement team and will be reported to each Audit & Assurance Committee for review.		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
45	19/20	Baseline Review - Structured Assessment July 2019	Board Secretary	Well Led and Well Governed Learning Points: BAF – risk and performance management: • swift implementation of BAF (with assigned risks) and directorate registers (WAO ref 2) • staff training essential for consistency of risk assessment across HEIW • ensure sufficiently understand performance in interim • IA & EA recommendations tracker should include others (WG/regulators?)	BAF adopted at September Board. BAF to be reviewed on a regular basis. Executive and SLT training undertaken. Traning of managers scheduled for November and December 2019. Executive and SLT training undertaken. Traning of managers scheduled for November and December 2019. Tracker includes recommendations from both internal audit and WAO.		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
45	19/20	Baseline Review - Structured Assessment July 2019	Executive Team	Well Led and Well Governed Learning Points: Organisational structure: • work with WG and regulators to clarify blurred boundaries	• Ongoing 1:1 discussions between CEO and Director General to clarify interface issues • Quality and Delivery meetings with Welsh Government underway • Second JET held on 31 October 2019 • Regular meetings being held with key professional and policy leads		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	

External Audit Closed Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
46	19/20	Baseline Review - Structured Assessment July 2019	Director of Workforce & OD/ Interim Director of Finance	Strategic Planning Learning Points: Vision and Strategic Objectives • keep doing what you are doing! Stakeholder engagement: • timing of engagement with and feedback to key stakeholders in both your and their planning cycle will be critical. Look to develop clear website sign posting for stakeholders inc. trainees and potential trainees. Development of AOP and IMTP: • action key lessons learnt from AOP in developing IMTP. Consider ways to increase planning capacity and capability both short and long term (training / DU / secondments /peer review etc). Operational strategies and plans: • think about how you will go about making informed choices on competing proposals given finite resource (priorities/criteria) KPIs and monitoring of delivery: • be clear about PIs v KPIs. Identify suitable benchmarks. Don't forget about providing insight with data (WAO ref 3)	These are considered advisory points and have been/are being considered. Given this they have not been RAG rated		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
47	19/20	Baseline Review - Structured Assessment July 2019	Interim Director of Finance	Financial Management Learning Points: • opportunity to look at good practice in financial reporting to Board with aim to provide insight into operational areas and really use finance as an enabler (WAO ref 4)	The Finance Academy has produced a best practice guide for financial reporting to the Board. This is being reviewed to refine the information presented.		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
48	19/20	Baseline Review - Structured Assessment July 2019	Director of Workforce & OD	Workforce Management Learning Points: Workforce planning and development: • statutory and mandated training delivery priority • ensure reporting is clear on whether posts are vacancies or future potential posts Staff engagement and culture: • keep doing what you are doing!	These are advisory and are not deemed to require a RAG rating. Some observations included below for information: Statutory and mandated training – The People team are undertaking further ESR training for staff to refresh on using the ESR system. For staff with dual contract (NHS and CU T&Cs) reminders during the training that if staff have already completed their Statutory and mandatory training with their NHS contract, we will accept a screenshot of their completion pages that will be used to update ESR.		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
49	19/20	Baseline Review - Structured Assessment July 2019	Director of Workforce & OD	Procurement arrangements Learning Points: • ensure linked procurement / contracting / commissioning strategies in place with clear management arrangements • identify contracts and compile a contracts register	Work is underway to produce a contracts register. See earlier comments in response to audit recommendations		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	
50	19/20	Baseline Review - Structured Assessment July 2019	Interim Director of Finance	Asset Management Learning Points: • compile asset register • compile lease register (accounting changes in 20-21) • develop asset management strategy	See comments at 46 above; work is underway on these learning points		Complete	Complete	Complete	Advisory Learning Points that will be given consideration	nov-19		Yes	

External Audit Closed Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
65	2019	Structured Assessment 2019 January 2020	Board Secretary	**Managing risk to achieve strategic priorities:** **R3** HEIW should improve its risk management by determining and clearly communicating its risk appetites to ensure a consistent approach to: a) tolerance of risk	a) HEIW January Board will consider the approval of its approach to managing risk appetite which will include setting tolerance levels for risk.	jan-20	Complete	Complete	Complete	**COMPLETE** - The Board approved its risk appetite at the January Board meeting.	jan-20		Y	
65	2019	Structured Assessment 2019 January 2020	Board Secretary	**Managing risk to achieve strategic priorities:** **R3** HEIW should improve its risk management by determining and clearly communicating its risk appetites to ensure a consistent approach to: b) assessing and scoring of risks; and c) escalation/removal of risks to/from the Corporate Risk Register.	b) and c) HEIW's Risk Management policy to be updated to clarify the position in respect of assessing and scoring risk and to outline a consistent approach to escalating and removing risks from the risk register.	mar-20	Complete	Complete	Complete	**Progress as at July 2020:** Scheduled for discussion and Executive Team on 24 June 2020; for Audit & Assurance Committee approval on 16 July 2020 and for Board approval on 30 July 2020. **Current Progress: COMPLETE.** Revisions to the Risk Management Policy approved by the Board on 30 July 2020.	jul-20	4		No
67	2019	Structured Assessment 2019 January 2020	Board Secretary/ Director of Workforce & OD	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: a) appointing a full-time information governance and data protection manager to complete the GDPR action plan and work towards full compliance;	a) Role has been re-advertised. Recruitment currently underway; effective interim cover being provided via secondment arrangement. The GDPR Action Plan is 90% complete with the Information Asset Register being worked towards initial completion.	apr-20	Complete	Complete	Complete	**Progress as at July 2020:** The Head of Cyber Security commenced in post on 29 June 2020. The IG Officer post is currently out to advert for a third recruitment round and is due to close on 6 July 2020. The current secondment arrangements are in place. Progress is being made with the completion of the GDPR Action Plan and IAR. Progress is being made with the completion of the IAR. A further email was issued in June 2020 requesting that all staff their IAR by the end of June 2020. Over 165 employees have made contact with the seconded IG Manager in respect of updates for the IAR. Templates have been issued and collective responses are being completed. These are being collated as separate returns but to date, there is nothing considered to be a concern in terms of the processing arrangements within the organisation. It should be noted that the IAR would never be fully completed as it is a live document and will be continually reviewed and updated. The seconded IG Manager will ensure that staff are aware of their responsibilities in the processing and holding of personal information and issue regular reminders for the review of the data held to assist with the updating of the IAR. **Current Progress:** A full-time IG Officer has been appointed and commenced on 29 September 2020. The GDPR Action Plan is a live Plan and is continually updated. The Information Asset Register is in place and will be regularly reviewed and updated.	okt-20	6		No
67	2019	Structured Assessment 2019 January 2020	Board Secretary	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: b) developing and reporting information governance KPIs;	b) Reports are tabled at specific meetings and committees on the work completed within IG to date. Information Governance and Information Management Group to create and monitor KPIs which shall be presented to the Audit Committee on a quarterly basis.	apr-20	Complete	Complete	Complete	**Current Progress:** The IGIM Group has developed KPIs for reporting. The Group meets on a quarterly basis and will report into the Audit & Assurance Committee.	mar-20			
67	2019	Structured Assessment 2019 January 2020	Board Secretary/ Director of Workforce & OD	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: d) establishing effective cyber security resources and expertise to manage risks;	d) The Board Secretary will lead on cybersecurity at the senior level until the appointment of the new Director of Digital. The Board have approved the recruitment of a cybersecurity analyst, a JD is under development, an agency worker will be recruited to cover in the short term. The Analyst will manage HEIW cyber risks and be responsible for defence measures.	mai-20	Complete	Complete	Complete	**Current Progress:** Appointment to permanent role of Head of Cyber Security commenced on 29 June 2020.	jun-20	1		
67	2019	Structured Assessment 2019 January 2020	Board Secretary/ Director of Workforce & OD	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: e) documenting a cyber security incident response plan to manage attacks;	e) This plan will be developed and implemented by the cybersecurity analyst when recruited.	Summer 2020	Complete	Complete	Complete	**Progress as at July 2020:** Appointment to permanent role of Head of Cyber Security commenced on 29 June 2020. This work has now commenced and is scheduled to be completed by the deadline. **Current Progress:** Cyber Incident Response Policy and Plan was considered by the IGIM Group and was recommended to the Executive Team for approval.	okt-20			No
67	2019	Structured Assessment 2019 January 2020	Board Secretary/ Director of Workforce & OD	**Embedding a sound system of assurance:** **R5** HEIW should strengthen information governance and cyber security arrangements by: f) completing its planned and prioritised actions swiftly.	f) These actions will be completed by the cybersecurity analyst and supported by the processes they implement.	Summer 2020	Complete	Complete	Complete	**Progress as at July 2020:** Appointment to permanent role of Head of Cyber Security commenced on 29 June 2020. This work has now commenced and is scheduled to be completed by the deadline. **Current Progress:** Regular updates pertaining to planned and prioritised actions are regularly provided to the Audit & Assurance Committee.	sep-20			No
68	2019	Structured Assessment 2019 January 2020	Director of Workforce & OD	**Developing Strategic Plans:** **R6** HEIW should strengthen its strategic approach to digital and IT by: b) considering current capacity to deliver the Head of Digital role and whether it needs to appoint to the post	Following changes at Executive level, a review of the senior digital structure is being undertaken to ensure appropriate Board level input.	mar-20	Complete	Complete	Complete	**Current Progress:** We have undertaken initial structurual changes within the digital team and have recently recruited a Head of Digital Services.	jun-20	3		

External Audit Closed Recommendations

HEIW Ref. No.	Year	Report Title	Responsible Officer	Recommendation	Management Response	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
108	2020	Effectiveness of Counter Fraud Arrangements - HEIW September 2020	Director of Finance/ Head of Counter Fraud	**Counter-Fraud Staff Capacity:** Consider the Local Counter-Fraud Specialist capacity required to resource required levels of proactive and investigative work, including staff training, and build in resilience to the team. **Intended Outcome Benefit:** To ensure enough resource to meet counter fraud activity demands.	Since HEIW is a newly formed Special Health Authority then, based on historical data, the Health Body is confident that the number of days in it's current work-plan meets the current requirements. In support of this, regular reviews of the ongoing CF work and resources used are carried out and reported to the A/C. However, should there be an increase in referrals, the need for any additional resource would be discussed with the Finance Director and tabled for approval by the Audit Committee.	jul-20	Complete	Complete	Complete	**COMPLETED**	jul-20		Yes	
110	2020	Structured Assessment 2020 October 2020	Board Secretary	**R1 Corporate risk register scrutiny** We found that the Audit and Assurance Committee scrutinises the corporate risk register at its in-committee sessions. For transparency, unless risks are of a sensitive nature, we recommend the corporate risk register is considered at the public session of the Audit Committee	There is a presumption that the CRR is considered in the public session of the Audit and Assurance Committee. Where there is a risk on the CRR deemed to be of a sensitive nature then this risk only will be considered in-committee with the remainder of the CRR considered in the public session.	des-20	Complete	Complete	Complete	**COMPLETED**	des-20		Yes	No
111	2020	Structured Assessment 2020 October 2020	Director of Finance	**R2 Cost and value improvements** Whilst HEIW is not required to deliver cost improvement plans and does not refer to any in its financial reports, identifying and reporting efficiencies and economies would further improve good financial management for future sustainability. We recommend that HEIW seek to identify cost and value improvement opportunities and record and report those both within HEIW and more widely from its work. This would also clearly evidence tangible benefits and support buy-in to a one NHS approach.	Cost savings will be separately coded and thereby facilitate easier regular reporting. This will commence during q3 of 2020-21 financial year with retrospective analysis undertaken for the first 2 quarters of the year. Value opportunities / assessments will be incorporated within business cases where appropriate and possible.	mar-21	Complete	Complete	Complete	**COMPLETED -** Cost savings have been reported within the monthly monitoring return to Welsh Government since September 2020, backdated to the start of the financial year. These currently relate to estates costs and the lease car scheme. Further opportunities for savings will be reviewed going forward.	mar-21		Yes	No

Internal Audit Advisory Considerations Completed

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
104	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Board Secretary	**STRATEGIC GOVERNANCE: Board and Committee Meetings** Our review identified the following: • The Board, Audit and Assurance Committee and the Education, Commissioning and Quality Committee continued to operate, no committees of the Board were suspended. • During the pandemic there was regular dialogue between the Chair of the Board, independent members, senior executives and the Welsh Government. • The organisation moved quickly to ensure that Board and committee meetings could be held virtually in order to comply with social distancing and other Welsh Government guidance, with executive directors and independent members showing flexibility. • The move to virtual meetings inevitably encountered some minor 'teething problems' but meetings have flowed well with members adapting to the new approach. The default medium has become Microsoft Teams which is proving to be robust. Further development in the formalising of virtual meeting etiquette would be helpful. • Meeting agendas have been streamlined to focus on Covd-19 and business critical issues in compliance with Welsh Government guidance, although it appears that there was no significant change in the length of meetings. As such, the organisation may need to look at the length of meetings when full agendas are re-introduced. However, the experience of members of the Board and committees has been generally positive in terms of connectivity and the effectiveness of technology. • Standing Orders were varied via a Chair's Action to enable meetings to be held virtually and to exclude members of the public. This Action was extended to the end of July 2020 at the Board meeting held in May 2020. • Quoracy requirements remained unchanged, but an additional 'standby' independent member was appointed to each committee of the Board to help ensure committees remained quorate in the event of a late withdrawal of a member or technical issues arising during meetings. • A Crisis Management Team (CMT) which was established in accordance with the organisation's crisis and business continuity plan operated throughout the period and was stood down on 21 July 2020. • Relevant risks continued to be escalated to the Board. • Board and committee papers have continued to be published in advance of meetings, and HEIW has aimed to post meeting notes on its website within 48 hours of their meetings, with full (unconfirmed) minutes posted within 14 days.	We suggest the following considerations as the organisation looks forward: • Refreshing the crisis and business continuity plan to ensure lessons learned and experiences can be incorporated. • If an additional 'standby' independent member approach is to be maintained, the terms of reference of the committees should be updated to reflect this. • Investigate the feasibility of offering 'freephone' dial-in access numbers for members of the public who may not have access to suitable conferencing technology. • Investigate the feasibility of recording committee sessions (most video-conferencing software has this functionality), including written chat - this should help with recording accurate minutes (by reviewing the recording). HEIW should also consider making this recorded session available to the public to view post-meeting. • Ensure all members and participants are suitably trained or offered training to make the best use of conference software. • To clearly set out the etiquette arrangements at the start of each meeting, such as muting microphones when not in use, or the process for raising questions.	The revised BC Plan is in final draft stage and will be taken through the Executive Team for approval in October. At September Board HEIW increased the membership of the Audit and Assurance Committee and the Education Commissioning and Quality Committee with the aim of improving the capacity and resilience of these committees. Internal Audit have agreed to review the approach of other organisations on 'freephone' dial and revert to HEIW with further information. The July and August Board were livestreamed via the Zoom platform. This requires significant resource and in line with other NHS organisations we do not have current plans to extend this to Committees. The Open Board meeting and AGM in September were recorded and the recordings have been placed on the website. We will explore this capability further. All members have received appropriate training when moving to new platforms for holding virtual meetings. Chair's outline basic etiquette for Board and Committee meetings at the beginning of meetings.	okt-20	Complete	Complete	Complete	**COMPLETE**	okt-20	1	Yes	No
104	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Board Secretary/ Director of Planning, Performance & Corporate Services	**STRATEGIC GOVERNANCE: Scheme of Reservation and Delegation (SORD) and Decision Making Arrangements** Our review identified the following: • Authorisation levels were reviewed by management, but no changes were made to delegated limits, and no additions to the SoRD were required as a result of Covid-19. • The CMT, which had up to 30 members, met up to three times a week at the height of the pandemic, and included the senior leadership team and senior staff from across the organisation. • Meeting notes were prepared, and a Covid-19 risk register and action log were maintained and updated following each CMT meeting. • The CMT provided weekly updates to the Board and Welsh Government.	We suggest the following consideration as the organisation looks forward: • The effectiveness of the CMT, and in particular the number of members, should be reviewed to ensure decision making is as efficient and streamlined as possible.	At the peak of the crisis there were approximately 30 participants on the CMT, which was good for communication. However, on reflection, HEIW feels that a smaller, discrete group would benefit critical decision making, whilst engaging others where needed.	okt-20	Complete	Complete	Complete	**COMPLETE**			Yes	No
104	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Board Secretary	**STRATEGIC GOVERNANCE: Risk Management** Our review identified the following: • The Board continued to receive the corporate risk register throughout the pandemic. • A specific Covid-19 risk register was developed by the CMT and was reported to the Board and also to members of the Board informally on a weekly basis. • Significant risks from the Covid-19 risk register have been escalated to the corporate risk register.	There were no considerations identified from our rapid review.	N/A	okt-20	Complete	Complete	Complete	N/A	okt-20		Yes	No
105	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Finance	**FINANCIAL GOVERNANCE: Annual Accounts and Reporting** Our review identified the following: • The organisation had worked to the original accounts production timetable, with draft accounts submitted to the Welsh Government and Audit Wales by the agreed time. This is a notable success as the accounts were produced by the Finance team whilst working remotely. • Audit Wales reported that there were no significant issues identified in the audit of the draft accounts. • The Annual Governance Statement was produced within the required timescales and complied with Welsh Government guidance.	There were no considerations identified from our rapid review.	N/A	okt-20	Complete	Complete	Complete	N/A	okt-20		Yes	No
105	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Finance	**FINANCIAL GOVERNANCE: Financial Systems and Processes** Our review identified the following: • Management did not consider there was a need to update Financial Control Procedures (FCPs) as a result of the pandemic. • No significant investments have been made or assets purchased as a result of the pandemic. • At the time of our fieldwork no losses or write offs had been recorded during the pandemic. • Some nursing and medical trainees were re-deployed into front line duties, and revenue expenditure was incurred on a specialist critical care course for trainees that volunteered for re-deployment to the front line.	There were no considerations identified from our rapid review.	N/A	okt-20	Complete	Complete	Complete	N/A	okt-20		Yes	No
105	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Finance	**FINANCIAL GOVERNANCE: COVID-19 Expenditure (Revenue and Capital)** Our review identified the following: • All expenditure has continued to be made through the organisations financial and payroll systems. • No new financial codes were set up within the financial system specifically to record Covid-19 related expenditure. • There were no payments made in advance	We suggest the following consideration as the organisation looks forward: • Financial codes could be set up within the financial system specifically to record Covid-19 related expenditure. This approach was commonly taken by other health organisations.	As spend wholly related to COVID 19 is at a low level within HEIW and we are able to identify and report it without specific financial codes we have not set them up. We do however understand that specific financial codes would be useful should the level of spend increase or it be indistinguishable from other expenditure.	okt-20	Complete	Complete	Complete	**COMPLETE**	okt-20		Yes	No
105	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Workforce & OD	**FINANCIAL GOVERNANCE: Workforce** Our review identified the following: • Medical and nursing trainees were re-deployed to the front line on a voluntary basis. • Critical care training was procured and provided to re-deployed trainees. • No new posts were created as a result of the pandemic. Recruitment continued as normal with all pre-employment checks being carried out. • No non-agenda for change rates, overtime, bonuses or other incentives were offered to attract staff.	There were no considerations identified from our rapid review.	N/A	okt-20	Complete	Complete	Complete	**COMPLETE**	okt-20		Yes	No

Internal Audit Advisory Considerations Completed

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
106	20/21	Governance Arragnements During COVID 19 Pandemic Advisory Report	Director of Finance	Our review identified the following: • Risk assessments continued to be completed by the counter fraud team to identify emerging risks relating to fraud, such as malware attacks. • A counter fraud steering group and counter fraud management group was set up that met weekly to discuss any potential frauds. • There is a central fraud risk assessment in place and the promotion of local counter fraud arrangements has continued throughout the pandemic.	There were no considerations identified from our rapid review.	N/A	okt-20	Complete	Complete	Complete	N/A	okt-20		Yes	No