Bundle Pwyllgor Archwilio a Sicrwydd (Agored) 1 April 2020

2.6 Drafft o'r Datganiad Llywodraethu Blynyddol ar gyfer 2019/20

2.6a - Cover paper - Draft Annual Governance Statement (DB) cyf maw 20.docx

2.6b - Draft Annual Governance Statement.(16.03.20)docx.docx

2.7 Drafft o Adroddiad Blynyddol y Pwyllgor ar gyfer 2019/20

2.7a - CY_Audit_Assurance_Committee Annual Report_2019-2020 Cover Report V1.docx

2.7b - Draft Audit_Assurance_Committee Annual Report 2019-2020 V4.docx

2.8 Adroddiad ar Gydymffurfiaeth o ran Caffael

2.8a - CY_HEIW Procurement Compliance Report_March_2020.docx

2.8b - HEIW Procurement Compliance Appendices.docx

2.9 Adnodd Tracio Argymhellion Archwiliad

2.9a - CY_Audit Recommendation Tracker Cover Report_April 2020 V1.docx

2.9b - HEIW Audit Tracker as at April 2020.pdf

3 RHAN 3 - ER GWYBODAETH/I'W NODI

3.1 Disgwyliadau Gafael a Rheolaeth Llywodraeth Cymru

3.1a - CY_Grip and Control Expectations Report.docx

3.1b - Grip & Control Expectations 20th Feb 2020.pdf

3.1c - 2020-03-02 AG to CEs and Chairs re grip and control expectations.pdf

4 RHAN 4 - CLOI

4.1 Unrhyw Fater Arall

4.1.1 • Diweddariad Llywodraethu ar gyfer COVID 19

4.1.1a - RB to AG re Advice-Proposals from NHS Board Secretaries and Directors of Corp Gov on COVID-19 - 18032020.pdf

4.1.1b - 200326 - Response to Letter Advice_Proposals from NHS Board Secretaries re Governance on Covid-19 - JD to RB.pdf

4.1.2 • COVID 19 - gwneud penderfyniadau ac arweiniad ariannol

4.1.2a - 2020-03-30 AG to CEs AO letter COVID-19 - Decision Making & Financial Guidance.pdf

4.1.2b - COVID-19 Financial Guidance_FINAL.docx

4.2 Dyddiadau'r Cyfarfodydd Nesaf

4.2.1 • Cyfarfod Cyfrifon Drafft Dydd Mercher, 6 Mai 2020 am 1.00pm I'w gadarnhau ei fod yn digwydd naill ai drwy Skype/telegynadledda neu yn T Dysgu

4.2.2 • Cyfarfod Cyfrifon Terfynol Dydd Mawrth, 26 Mai 2020 am 10.00am I'w gadarnhau ei fod yn digwydd naill ai drwy Skype/telegynadledda neu yn T Dysgu

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

Y PWYLLGOR ARCHWILIO A SICWYDD
Dydd Mercher, 1 Ebrill 2020
1.00pm – 2.30pm
Drwy Skype/Telegynhadledd

AGENDA

PART 1	**MATERION RHAGARWEINIOL**	**13:00-13:10**
1.1	Croeso a Chyflwyniadau	Cadeirydd/ Ar lafar
1.2	Ymddiheuriadau am Absenoldeb	Cadeirydd/ Ar lafar
1.3	Datgan Buddiannau	Cadeirydd/ Ar lafar
1.4	Cofnodion Drafft Cyfarfod y Pwyllgor Archwilio a gynhaliwyd ar 27 Ionawr 2020	Cadeirydd/ Atodiad
1.5	Cofnod Gweithredu yn dilyn y cyfarfod a gynhaliwyd ar 27 Ionawr 2020	Cadeirydd/ Atodiad
1.6	Materion yn Codi	Cadeirydd/ Atodiad
RHAN 2	**MATERION I'W HYSTYRIED**	**13:10-14:25**
2.1	Atal Twyll: • Adroddiad Cynnydd • Cymeradwyo'r Cynllun Blynyddol Atal Twyll	Rheolwr Atal Twyll BIP Caerdydd a'r Fro Atodiadau

2.2	Archwiliad Mewnol:
	• Adroddiad ar Gynnydd
	  ○ Adroddiad Archwilio Mewnol Rheoli risg
	  ○ Adroddiad Archwilio Mewnol Cynllunio Cynllun Tymor Canolig Integredig
	  ○ Adroddiad yr Archwiliad Mewnol ar Reoli Perfformiad
	  ○ Adroddiad yr Archwiliad Mewnol ar Reolaeth Ariannol Graidd
	• Cynllun Archwilio Blynyddol yr Archwiliad Mewnol 2020/21
		Archwiliad Mewnol/ Atodiadau

2.3	Swyddfa Archwilio Cymru: • Adroddiad Cynnydd yn cynnwys yr wybodaeth ddiweddaraf am y Cynllun a'r Ffi Archwilio ar gyfer 2020 • Asesiad Strwythuredig ac Ymateb y Tîm Rheoli	Swyddfa Archwilio Cymru/ Atodiadau
2.4	Ymholiadau Archwilio Swyddfa Archwilio Cymru i'r rheini sy'n gyfrifol am Lywodraethiant a Rheolaeth	Cyfarwyddwr Cyllid/ Atodiad
2.5	Yr wybodaeth ddiweddaraf am yr Adolygiad o Gyfarwyddiadau Ariannol Sefydlog	Cyfarwyddwr Cyllid/ Atodiad

2.6	Drafft o'r Datganiad Llywodraethu Blynyddol ar gyfer 2019/20	Ysgrifennydd y Bwrdd/ Atodiad
2.7	Drafft o Adroddiad Blynyddol y Pwyllgor ar gyfer 2019/20	Ysgrifennydd y Bwrdd/ Atodiad
2.8	Adroddiad ar Gydymffurfiaeth o ran Caffael	Cyfarwyddwr Cyllid/ Pennaeth Caffael Atodiad
2.9	Adnodd Tracio Argymhellion Archwiliad	Ysgrifennydd y Bwrdd/ Atodiad
RHAN 3	**ER GWYBODAETH/I'W NODI**	
3.1	Disgwyliadau Gafael a Rheolaeth Llywodraeth Cymru	Cyfarwyddwr Cyllid/ Atodiad
RHAN 4	**CLOI**	**14:25-14:30**
4.1	Unrhyw Fater Arall: • Diweddariad Llywodraethu ar gyfer COVID 19 • COVID 19 - gwneud penderfyniadau ac arweiniad ariannol	Ysgrifennydd y Bwrdd/ Atodiad Cyfarwyddwr Cyllid/ Atodiad
4.2	Dyddiadau'r Cyfarfodydd Nesaf • **Cyfarfod Cyfrifon Drafft** Dydd Mercher, 6 Mai 2020 am 1.00pm I'w gadarnhau ei fod yn digwydd naill ai drwy Skype/telegynadledda neu yn Tŷ Dysgu • **Cyfarfod Cyfrifon Terfynol** Dydd Mawrth, 26 Mai 2020 am 10.00am I'w gadarnhau ei fod yn digwydd naill ai drwy Skype/telegynadledda neu yn Tŷ Dysgu	

Yn unol â darpariaethau Adran 1(2) Deddf Cyrff Cyhoeddus (Derbyn i Gyfarfodydd) 1960, gwneir penderfyniad i wahardd cynrychiolwyr y wasg ac aelodau eraill y cyhoedd o ran olaf y cyfarfod ar y sail y byddai'n niweidiol i fudd y cyhoedd oherwydd natur gyfrinachol y busnes sydd i'w drafod. Cynhelir rhan hon y cyfarfod yn breifat.

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
cynhaliwyd ar 27 Ionawr 2020
yn yr Ystafell Gynadledda, AaGIC, Tŷ Dysgu, Nantgarw, CF15 7QQ

Bresennol:

Gill Lewis	Aelod Annibynnol (Cadeirydd)
John Hill Tout	Aelod Annibynnol (Is-Gadeirydd AaGIC)
Dr Ruth Hall	Aelod Annibynnol

Yn Bresennol:

Dafydd Bebb	Ysgrifennydd y Bwrdd
Eifion Williams	Cyfarwyddwr Cyllid Dros Dro
Martyn Pennell	Pennaeth Cyfrifyddu Ariannol
Mike Usher	Cyfarwyddwr Ymgysylltu, Swyddfa Archwilio Cymru
Helen Goddard	Rheolwr Archwilio Allanol, Swyddfa Archwilio Cymru
Clare James	Arweinydd Archwilio Perfformiad, Swyddfa Archwilio Cymru
Paul Dalton	Pennaeth Archwilio Mewnol, NWSSP
Julie Rogers	Cyfarwyddwr y Gweithlu ac OD
Nigel Price	Arbenigwr Atal Twyll (BIP Caerdydd a'r Fro) (ar gyfer eitem 2.1)
Christine Thorne	Pennaeth Caffael (NWSSP) (i fyny a chynnwys eitem 2.8)
Kay Barrow	Rheolwr Gwasanaethau Corfforaethol (Ysgrifenyddiaeth))
Huw Owen	Rheolwr Gwasanaethau Iaith Gymraeg
Martin Riley	Pennaeth Addysg, Comisiynu ac Ansawdd (ar gyfer eitem 2.7)
Pushpinder Mangat	Cyfarwyddwr Meddygol (ar gyfer eitem 2.14)

RHAN 1	MATERION RHAGARWEINIOL	Gweithred
PAY: 27/01/1.1	**Croeso a Chyflwyniadau**	
	Croesawodd y Cadeirydd bawb i'r cyfarfod.	
PAY: 27/01/1.2	**Ymddiheuriadau am Absenoldeb**	
	Cafwyd ymddiheuriadau am absenoldeb gan Craig Greenstock, Rheolwr Gwrth-Dwyll (BIP Caerdydd a'r Fro).	
PAY: 27/01/1.3	**Datganiadau o Fuddiant**	
	Nid oedd unrhyw ddatganiadau o fuddiant.	
PAY: 27/01/1.4	**Cofnodion y cyfarfod a gynhaliwyd ar 22 Tachwedd 2019**	

	Derbyniodd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 22 Tachwedd 2019 a gofynnwyd am y newidiadau canlynol: • **Yn bresennol**: Tynnu'r llythyren 'b' o enw'r Cadeirydd fel ei bod yn darllen: 'Gill Lewis'. • **PAY 22/11/2.12 Argymhellion Traciwr Archwilio:** Tynnu'r testun canlynol ar frig tudalen 9 (trydydd paragraff y cofnod cyfeirnod PAY 22/11/2.12) '…a bod argymhellion 36 ymlaen mewn perthynas â Llythyr Rheoli SAC ac Adolygiad Sylfaenol-Asesiad Strwythuredig, hefyd yn cael eu dileu gan fod y rhain yn cael eu dilyn yn rheolaidd gan SAC'. Bydd yr argymhellion hynny nad ydynt wedi'u cwblhau eto yn cael eu hadfer i'r traciwr.	
Datrysiad	**Cymeradwyodd** y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 22 Tachwedd 2019, ar yr amod bod y newidiadau'n cael eu gwneud fel y trafodwyd.	**DB**
PAY: 27/01/1.5	**Log Gweithredu o'r cyfarfod a gynhaliwyd ar 22 Tachwedd 2019**	
	Cafodd y Pwyllgor y Log Gweithredu o'r cyfarfod a gynhaliwyd ar 22 Tachwedd 2019 a'i **ystyried**. Cafwyd y diweddariadau canlynol ar lafar: • **PAY 15/07/2.4 Argymhellion Traciwr Archwilio:** Cadarnhawyd bod y Tîm Gweithredol wedi adolygu'r Traciwr ar 8 Ionawr 2020 a bod y Traciwr wedi'i ddiweddaru yn eitem ddiweddarach ar agenda'r Pwyllgor. Cadarnhawyd y Byddai'r Tîm Gweithredol yn parhau i adolygu'r broses olrhain er mwyn sicrhau nad yw'n mynd yn rhy hir.	
Datrysiad	**Nododd** y Pwyllgor y wybodaeth ddiweddaraf.	
	• **PAY 22/11/2.10 Toriad Rhyddid Gwybodaeth:** Cadarnhawyd bod yr asesiad i ystyried y tramgwydd ac a oedd angen ei adrodd i Swyddfa'r Comisiynydd Gwybodaeth (ICO) wedi'i gynnal. Seiliwyd yr asesiad ar nifer y cofnodion, lefel y data a allai dorri o bosibl, a'r materion y gellid eu profi pe gallai'r data fod yn destun tramgwydd. Roedd y casgliad yn cytuno â phroses ffurfiol ICO, gan nad oedd hyn yn doriad adroddadwy gan ei fod yn risg isel i breifatrwydd unigolyn. Mae'r digwyddiad wedi cael ei adrodd ar system adrodd am ddigwyddiadau AaGIC, 'DATIX', heb unrhyw waith pellach parhaus gan fod y data wedi'i dynnu o bapurau'r Pwyllgor ar wefan iBabs ac AaGIC.	
Datrysiad	**Nododd** y Pwyllgor y wybodaeth ddiweddaraf.	
	Holodd Aelodau'r Pwyllgor am y defnydd o acronymau yn lle'r derminoleg lawn a oedd yn arwain at ddryswch.	
Datrysiad	**Cytunodd** y Pwyllgor i ddatblygu geirfa 'acronym' fel Atodiad cyfeirio at gofnodion y cyfarfod.	**DB**
PAY: 27/01/1.6	**Materion yn Codi**	
	Nid oedd unrhyw faterion yn codi o'r cyfarfod diwethaf.	

RHAN 2	**MATERION I'W HYSTYRIED**	
PAY: 27/01/2.1	**Cynnydd Gwrth-Dwyll**	
	Cafodd y Pwyllgor yr adroddiad cynnydd. Wrth gyflwyno'r adroddiad, dywedodd Nigel Price fod un ychwanegiad i'r adroddiad, gyda chwblhau un Sesiwn Sefydlu yn AaGIC. Dywedodd fod un ymchwiliad 'byw' ar y gweill ac nad oedd unrhyw atgyfeiriadau eraill na materion o bryder a oedd wedi'u codi gyda Gwrth-Dwyll hyd yn hyn. Cadarnhawyd y byddai gweddill y diwrnodau a neilltuwyd ar gyfer y Cynllun Gwaith yn ddigon i gwblhau'r holl agweddau angenrheidiol ar y Cynllun Gwaith. Roedd y Pwyllgor yn falch o weld y Cylchlythyr Gwrth-Dwyll chwarterol diweddar ar fewnrwyd AaGIC. Ceisiwyd eglurhad mewn perthynas â'r gwerth a nodwyd yn Ymarfer Rheoli Risg Caffael Awdurdod Gwrth-dwyll y GIG. Esboniwyd bod y swm yn amcangyfrif blynyddol a nodwyd ledled y DU. Fodd bynnag, dim ond un achos diweddar a oedd gan Gymry. Awgrymodd y Pwyllgor fod yr adroddiad yn cynnwys gwybodaeth fwy perthnasol i'w llacio yn hytrach nag allosod gwaith cenedlaethol. Cadarnhaodd y Pennaeth Caffael fod Caffael Gwasanaethau a Rennir yn gweithio gyda'r Tîm Atal Twyll a bod unrhyw feysydd sy'n peri pryder yn cael eu hychwanegu at Gynllun Gwerth Caffael y Cydwasanaethau i gael sylw. Er y nodwyd bod y rhan fwyaf o atgyfeiriadau Gwrth-Dwyll yn gysylltiedig â'r gyflogres. Roedd y Pwyllgor yn cydnabod bod y swyddogaeth gaffael ganolog o fudd i AaGIC, a oedd yn darparu'r arbenigedd gofynnol a'r prosesau a oedd wedi'u datblygu'n dda. Fodd bynnag, nodwyd bod gwahanol agweddau yn bodoli o gymharu â Byrddau Iechyd ynghylch defnyddio contractwyr a oedd yn unigryw i fusnes AaGIC ac roedd y rhain yn cael eu datblygu. Cadarnhaodd Eifion Williams fod AaGIC wedi comisiynu adolygiad annibynnol o'i systemau a'i brosesau caffael.	
Datrysiad	Y pwyllgor: • **nodi'r** adroddiad. • **cytuno** i dderbyn copi o'r adroddiad yn dilyn yr Adolygiad Annibynnol o systemau Caffael a phrosesau gwybodaeth AaGIC.	**EW**
	Gadawodd Nigel Price y cyfarfod.	
PAY: 27/01/2.2	**Diweddariad Cydymffurfio Cofnod Staff Electronig (ESR) ar Hyfforddiant Gorfodol a PADR**	
	Cafodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, tynnodd Julie Rogers sylw at y ffaith fod yr adroddiadau, yn dilyn y drafodaeth yng nghyfarfod diwethaf y Pwyllgor,	

	wedi'u diweddaru i adlewyrchu'r rhaniad rhwng staff craidd a rhai nad ydynt yn aelodau craidd. O'r 272 o staff craidd, roedd cyfanswm Cydymffurfio'r Arfarniad Perfformiad a'r Adolygiad Datblygu (PADR) ar gyfartaledd a gofnodwyd ar ESR wedi cynyddu o 11.4% i 40% ar 30 Tachwedd 2019. Cydnabuwyd bod hyn yn is na tharged Llywodraeth Cymru, sef 85%, a chyfartaledd Cymru gyfan, sef 68%. Fodd bynnag, roedd 187 o staff craidd o fewn y Gyfarwyddiaeth Feddygol, sef y Gyfarwyddiaeth fwyaf ac roedd ganddi gyfradd gydymffurfiaeth lwyr o 26%. Er y cydnabuwyd bod y rhan fwyaf o'r Gyfarwyddiaeth yn destun ail-ddilysu/addasrwydd i ymarfer, byddai'r broses PADR yn fwy 'cyffyrddiad ysgafnach' oherwydd hyn ac er mwyn osgoi dyblygu. O ran hyfforddiant Statudol a Gorfodol, roedd y gydymffurfiaeth ar gyfer staff craidd wedi cynyddu o 49.5% i 65% ar 30 Tachwedd 2019. Cyfradd cydymffurfiaeth gyfartalog Cymru gyfan oedd 79%. Y Gyfarwyddiaeth Feddygol oedd y Gyfarwyddiaeth â'r perfformiad isaf. Cynlluniwyd gwaith â ffocws gyda Meddygol, Deintyddol a Fferylliaeth i wella'r llwybr at gydymffurfio. Byddai hyn yn cynnwys y Partner Busnes Hŷn sy'n mynychu cyfarfodydd Meddygol, Deintyddol a Fferylliaeth i ddarparu cymorth wedi'i dargedu a hyfforddiant pellach ar ESR. Byddai'r wybodaeth ddiweddaraf am gynnydd yn cael ei hadrodd i'r Tîm Gweithredol. Roedd y Pwyllgor yn siomedig â'r gydymffurfiaeth a adroddwyd ar gyfer y ddau DPA ar ESR ond yn cydnabod bod ymyrraeth wedi'i thargedu yn cael ei chynnal i wella cydymffurfiaeth. Er bod y Pwyllgor yn cefnogi'r gwaith penodol a oedd yn cael ei wneud, nid oedd sicrwydd mewn perthynas â chydymffurfiaeth aelodau staff craidd o ran y ddau fesur ac roeddent yn arbennig o bryderus ynghylch sicrhau bod PADRs yn cael eu cynnal. Dywedodd Julie Rogers, er bod y prif ffocws ar staff craidd, bod AaGIC yn disgwyl i'r sefydliadau eraill roi sicrwydd bod y ddau fesur yn cael eu cwblhau.	
Datrysiad	Mae'r Pwyllgor: • **nodwyd** y sefyllfa a'r gwaith da a oedd yn cael ei wneud; • **gofynnwyd** i'r Cyfarwyddwr Meddygol gael ei wahodd i fod yn bresennol yn y Pwyllgor ym mis Ebrill er mwyn cael trafodaeth gefnogol.	**JR**
PAY: 27/01/2.3	**Swyddfa Archwilio Cymru:**	
	Y Wybodaeth Ddiweddaraf gan Bwyllgor Archwilio SAC **Cafodd** y Pwyllgor yr adroddiad.	

	Wrth gyflwyno'r adroddiad, dywedodd Mike Usher fod y Cynllun Archwilio Ariannol ar gyfer 2018/19 wedi'i gwblhau a bod y cynllunio ar gyfer 2019/20 wedi dechrau ym mis Rhagfyr 2019. O ran y Cynllun Archwilio Perfformiad, nodwyd bod yr Adolygiad Sylfaenol a'r Asesiad Strwythuredig ar gyfer 2019 wedi dod i ben a bod y cynlluniau ar gyfer yr Asesiad Strwythuredig ar gyfer 2020 a gwaith prosiect lleol i fod i gychwyn yn fuan. Nododd y Pwyllgor astudiaethau diweddar eraill gan yr Archwilydd Cyffredinol. Roedd hyn yn cynnwys yr adolygiad ar y cyd o drefniadau llywodraethu ansawdd ym Mwrdd Iechyd Prifysgol Cwm Taf a'r diweddariad mewn perthynas â'r digwyddiadau diweddar a'r rhai sydd i ddod fel rhan o'r Gyfnewidfa Arfer Dda.	
Datrysiad	**Nododd** y Pwyllgor yr adroddiad.	
	Asesiad Strwythuredig 2019 **Cafodd** y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Clare James ei bod wedi cyfarfod â'r Tîm Gweithredol yn gynnar ym mis Ionawr 2020 fel rhan o'r broses o glirio'r adroddiad a bod ymateb y rheolwyr i'r argymhellion yn cael ei ddrafftio. Esboniodd fod yr adroddiad yn gadarnhaol ac yn seiliedig ar yr Adolygiad Sylfaenol cynharach a'r gwaith arall a wnaed. Darparwyd trosolwg o'r canfyddiadau a'r argymhellion a chafwyd trafodaeth. Er bod AaGIC wedi sefydlu'r trefniadau angenrheidiol i gefnogi llywodraethu da, nodwyd bod angen i'r sefydliad wneud mwy o ran: trefniadau rheoli risg; mapio'r ffynonellau yswiriant allweddol er mwyn atgyfnerthu Fframwaith Yswiriant y Bwrdd (BAF), a datblygu rhagor o reolaethau mewnol i ategu'r Fframwaith Rheoli Perfformiad a Llywodraethu Gwybodaeth. Eglurwyd bod y Gofrestr Risg Gorfforaethol yn darparu manylion y risgiau cyfredol sy'n cael eu rheoli gan AaGIC a'r mesurau lliniaru. Fframwaith Sicrwydd y Bwrdd oedd y mecanwaith ar gyfer rhoi sicrwydd mewn perthynas â'r risgiau allweddol o ran AaGIC, sef cyflawni'r amcanion strategol a'r rheolaethau sydd ar waith ar gyfer eu lliniaru. Croesawodd y Pwyllgor yr adroddiad, gan gydnabod yr arweiniad cryf a'r cynnydd sy'n cael ei wneud mewn perthynas â'r weledigaeth strategol wrth ddatblygu'r Cynllun Tymor Canolig Integredig cyntaf.	
Datrysiad	Y Pwyllgor: • **nodi'r** adroddiad • **cytunwyd** y dylai SACau rannu enghreifftiau o arfer da/gorau o ran BAF sy'n gymesur ag AaGIC a manylion cyswllt sefydliadau cymheiriaid ar gyfer meincnodi.	**SAC**
	Adroddiad Archwilio Blynyddol 2019	

	Cafodd y Pwyllgor yr adroddiad. In presenting the report, Mike Usher advised that this was a summary of the findings from the audit work undertaken during the year. Wrth gyflwyno'r adroddiad, cynghorodd Mike Usher mai crynodeb o ganfyddiadau'r gwaith archwilio a wnaed yn ystod y flwyddyn oedd hon. Nododd y Pwyllgor y byddai'r adroddiad yn cael ei gyhoeddi ar wefan Swyddfa Archwilio Cymru.	
Datrysiad	**Nododd** y Pwyllgor yr adroddiad.	
	Cynllun Archwilio Dangosol 2020 gan gynnwys y ffi arfaethedig ar gyfer 2020 **Cafodd** y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Mike Usher, gan fod cynllun dangosol 2020 yn gynnar yn y cylch cynllunio, y byddai'n agored i'w newid. Eglurodd fod cyfanswm y ffi archwilio arfaethedig yn ddangosol yn £165.5k, sef gostyngiad o'i fl wyddyn fl aenorol. Nodwyd y byddai'r ffi yn cael ei chymedroli ymhellach gan yr Archwilydd Cyffredinol ac y byddai'n seiliedig ar y Cynllun Archwilio 2020 wedi'i gadarnhau. Rhoddodd Helen Goddard drosolwg o'r gofynion ar gyfer y cynllun archwilio ariannol a meysydd eraill o sylw archwilio. Eglurodd fod newid i'r dyddiad cyflwyno ar gyfer y datganiadau ariannol drafft y mae'n rhaid eu cyflwyno i'w harchwilio ar 28 Ebrill 2020 erbyn 5pm. Mewn perthynas â'r cyllid atodol i brifysgolion, dywedodd Eifion Williams fod gan AaGIC broses fwy cadarn ar waith a bod trafodaethau wedi'u cynnal hefyd gyda chydweithwyr yn Llywodraeth Cymru ynghylch y dull o ymdrin â'r gwariant. Rhoddodd Clare James drosolwg o'r cynllun archwilio perfformiad a oedd yn cynnwys y gwaith craidd a oedd yn ymwneud â'r Asesiad Strwythuredig 2020 a'r camau dilynol i argymhellion archwilio blaenorol. Fodd bynnag, roedd cwmpas eleni i ymgymryd â gwaith archwilio lleol nad oedd wedi'i gwblhau eto. Roedd Alex Howells wedi awgrymu y gellid canolbwyntio ar y Cynllun Tymor Canolig Integredig (IMTP) a Strategaeth y Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol. Fodd bynnag, roedd lle hefyd i awgrymiadau gan y Pwyllgor.	
Datrys	**Cytunodd** y Pwyllgor y dylid anfon awgrymiadau gan ei aelodau am waith archwilio lleol SAC at Dafydd Bebb yn y lle cyntaf.	**Pawb**
PAY: 27/01/2.4	**Cynllun Cyfrifon Blynyddol 2019/20**	
	Derbyniodd y Pwyllgor Gynllun Cyfrifon Blynyddol 2019/20. Wrth gyflwyno'r cynllun, cynghorodd Martyn Pennell ei fod hefyd yn cysylltu ag amserlen cynhyrchu'r Adroddiad Blynyddol. Dywedodd mai'r	

	unig newid i'r cynllun cau cyfrifon arfaethedig oedd y dyddiad cyflwyno cyfrifon drafft.	
Datrysiad	**Nododd** y Pwyllgor y cynllun.	
PAY: 27/01/2.5	**Amserlen Ddrafft yr Adroddiad Blynyddol 2019/20**	
	Cafodd y Pwyllgor amserlen ddrafft 2019/20 yr adroddiad blynyddol. Wrth gyflwyno'r amserlen, hysbysodd Dafydd Bebb y Pwyllgor fod y Tîm Gweithredol wedi cymeradwyo'r drafft. Dywedodd mai'r unig newid mawr i'r broses ar gyfer eleni oedd dwyn y dyddiad cyflwyno ar gyfer y ddogfen Adroddiad Blynyddol cyfunol terfynol i ben ddydd Gwener, 29 Mai 2020. Mae'r newid hwn yn cyd-fynd â dyddiad cyflwyno'r Cyfrifon Blynyddol terfynol. Cododd y Pwyllgor bryderon ynglŷn â'r nifer sylweddol o dasgau a neilltuwyd i Ysgrifennydd y Bwrdd, a'r amserlen fer rhwng drafftio a chwblhau'r adroddiad i'w gyflwyno i'r Tîm Gweithredol a'r Pwyllgor. Rhoddwyd sicrwydd bod digon o gapasiti o fewn y Tîm Llywodraethu Corfforaethol i ddarparu cymorth ym mhob agwedd ar yr amserlen.	
Datrysiad	**Nododd** y Pwyllgor yr amserlen	
PAY: 27/01/2.6	**Diweddariad ar Lywodraethu Gwybodaeth**	
	Cafodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, dywedodd Dafydd Bebb, yn unol â'r drafodaeth a gafwyd yng nghyfarfod diwethaf y Pwyllgor, fod y rhannau llwyd o'r Cynllun Gwaith Llywodraethu Gwybodaeth wedi'u diweddaru i statws 'gwyrdd' gan eu bod yn cael eu hadolygu a'u hasesu'n barhaus . Eglurodd mai Nº15 Gweithredu'r Rheolwyr oedd yr unig ardal 'goch' ac roedd yn ymwneud â'r gofyniad i Archwiliad Rheoli Cofnodion fesur lefel y wybodaeth a gaiff ei harchifo a'i storio mewn AaGIC. Nodwyd bod hyn yn amodol ar gwblhau'r Gofrestr Asedau Gwybodaeth a oedd bod i gael ei chwblhau ym mis Mawrth 2020. Mewn ymateb i ymholiad a godwyd am y strwythur staffio a phenodi Swyddog Llywodraethu Gwybodaeth llawn amser, cadarnhawyd bod y swydd wedi'i hysbysebu am yr eildro. Roedd yr hysbyseb wedi denu 24 o geisiadau a'r gobaith oedd gwneud apwyntiad ar yr achlysur hwn. Mae'r trefniadau secondiad presennol gyda Gwasanaethau a Rennir ar gyfer cymorth Llywodraethu Gwybodaeth 2 ddiwrnod yr wythnos yn dal ar waith. Mewn perthynas â rôl y Pennaeth Digidol a TG, nodwyd y byddai hyn yn destun trafodaeth Bwrdd 'yn y Pwyllgor' ynghylch strwythur y sefydliad. Croesawodd y Pwyllgor dablau'r Cynllun Gwaith wedi'u diweddaru. Fodd bynnag, roedd ymholiadau gyda'r naratif, yn enwedig yn y golofn 'statws RAG/ Cwblhau erbyn', a bod angen i'r pennawd colofn cynnydd fod yn	

	gyson drwy'r ddogfen gyfan. Gan mai dogfen sicrwydd oedd hwn, awgrymwyd y dylid adolygu'r naratif ac y dylid ei gynnwys yn y golofn cynnydd yn ôl yr angen. Cadarnhawyd bod y gyfradd gydymffurfiaeth staff craidd ar gyfer Llywodraethu Gwybodaeth ar ESR tua 67-68%.	
Datrysiad	Y Pwyllgor: • **nodi'r** adroddiad; • **gofynnwyd** am ddiweddaru pennawd y golofn cynnydd i sicrhau cysondeb drwy'r ddogfen gyfan. • **gofynnwyd** i'r naratif sy'n cyd-fynd â'r golofn 'statws RAG/cwblhau erbyn' gael ei adolygu a'i ymgorffori yn y golofn cynnydd.	 **DB** **DB**
	Ymunodd Martin Riley â'r cyfarfod	
PAY: 27/01/2.7	**Y diweddaraf am sefyllfa bresennol yr adolygiad strategol o addysg gofal iechyd yng Nghymru**	
	Cafodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, cadarnhaodd Martin Riley fod yr adroddiad yn bapur 'agored' ac nad oedd yn 'gaeedig' fel y nodwyd ar y ddalen eglurhaol. Darparwyd trosolwg o'r adroddiad a oedd yn amlinellu'r themâu allweddol a ddeilliodd o adolygiad KPMG a'r Cynllun Ymgysylltu Caffael i sicrhau bod manyleb y contract yn cael ei datblygu i ddiwallu anghenion Cymru yn llawn. Esboniodd y byddai manyleb y contract yn cael ei datblygu erbyn mis Mai 2020 yn barod ar gyfer yr ymarfer tendro a dyfarnu'r contract. Nododd y Pwyllgor y byddai hysbysiad addasu yn cael ei gyhoeddi er mwyn ymestyn y contractau presennol ar gyfer 2020/21. Roedd AaGIC yn gweithio'n agos gyda chydweithwyr Cyfreithiol a Chaffael i gwblhau'r broses. Croesawodd y Pwyllgor yr adroddiad a gofynnodd am y broses ar gyfer drafftio'r contractau. Cadarnhawyd mai'r Cyfarwyddwr Nyrsio oedd y SRO a byddai'r ddau is-grŵp mewnol ac allanol newydd o'r Pwyllgor Addysg, Comisiynu ac Ansawdd (PACA) yn cael eu cynnwys o amgylch y broses gontractio. Amlygwyd y ffaith y byddai manyleb y contract yn cael ei drafftio gan AaGIC ac y byddai'r ddogfennaeth gyfreithiol yn cael ei drafftio gan Wasanaethau Cyfreithiol a Gwasanaethau Risg. Eglurodd Ruth Hall, Cadeirydd y PACA, fod hwn wedi bod yn ddarn sylweddol o waith. Roedd y PACA wedi derbyn adroddiad cynhwysfawr yn ei gyfarfod ar 16 Ionawr 2020 a bod sylwadau wedi cael eu darparu. Dywedodd fod angen edrych hefyd ar adolygiad KPMG o ran darparu cyd-destun. Roedd risgiau o ran rheoli'r broses ac, yn benodol, o ran y contract a chomisiynu. Roedd Siart Gantt y Rhaglen yn arwydd o'r her.	

	Cadarnhawyd bod y Cynllun Archwilio Mewnol ar gyfer 2019/20 wedi cynnwys darn yswiriant o amgylch yr Adolygiad Strategol, fodd bynnag, oherwydd yr oedi, byddai'r darn hwn o waith yn cael ei wneud fel rhan o'r Cynllun Archwilio Mewnol yn 2020/21. Gofynnwyd cwestiwn mewn perthynas â Strategaeth ddiweddar y Gweithlu Iechyd a Gofal Cymdeithasol ac, yn arbennig, yr agenda gofal cymdeithasol a sut mae'r gwaith hwn yn cysylltu â'r hyfforddiant cyfansawdd. Dywedodd Martin Riley ei fod yn ymwybodol o'r Strategaeth a oedd AaGIC yn hyfforddi'r grŵp staff cywir ac ar y lefel gywir. Roedd y rhaglen waith yn cysylltu â'r Strategaeth ac yn ei herio i gyd-fynd â hi. Croesawodd y Pwyllgor yr adroddiad a chydnabu'r cynnydd a oedd yn cael ei wneud.	
Datrysiad	**Nododd** y Pwyllgor yr adroddiad.	
PAY: 27/01/2.8	**Adroddiad Cydymffurfio Caffael**	
	Cafodd y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, cynghorodd Martyn Pennell fod yr adrodd yn unol â'r gofyniad am Gyfarwyddiadau Ariannol Sefydlog AaGIC. Amlygwyd bod y ddau gytundeb yn Atodiad 1 i'w hadolygu ym mis Gorffennaf 2020 a bod y niferoedd yn gostwng. Mewn ymateb i ymholiad a godwyd mewn perthynas ag Atodiad 2 a sylw i gydymffurfiaeth 'heb ei gymeradwyo', eglurwyd mai'r rheswm am hyn oedd nad oedd Cyllid na Chaffael wedi'u cynnwys. Roedd Hyfforddiant Caffael pellach yn cael ei ddarparu i staff yn ystod mis Chwefror a mis Mawrth 2020 i godi ymwybyddiaeth o'r broses gaffael.	
Datrysiad	**Nododd** y Pwyllgor yr adroddiad.	
	Gadawodd Christine Thorne y cyfarfod	
PAY: 27/01/2.9	**Archwilio Mewnol:**	
	Adroddiad Cynnydd yr Archwiliad Mewnol **Cafodd** y Pwyllgor yr adroddiad. Wrth gyflwyno'r adroddiad, rhoddodd Paul Dalton drosolwg o'r ddarpariaeth yn erbyn y Cynllun Archwilio Mewnol ar gyfer 2019/20. Roedd cynllunio ar gyfer cynllun archwilio 2020/21 yn mynd rhagddo. Cadarnhawyd bod cynllun adnoddau ar waith o fewn yr Archwiliad Mewnol er mwyn darparu'r nifer o ddyddiau y cytunwyd arnynt yn y Cynllun Archwilio. Fodd bynnag, pe bai unrhyw faterion yn codi, byddai archwiliad mewnol yn codi gyda'r Cadeirydd.	
Datrysiad	**Nododd** y Pwyllgor yr adroddiad.	

PAY: 27/01/2.10	**Datgan Buddiannau – Adolygu Arferion o fewn sefydliadau eraill**	
	Gofynnodd y Pwyllgor am yswiriant mewn perthynas â datgan arferion o ran buddiannau pe bai gwrthdaro'n codi yn ystod y broses gaffael. Cadarnhaodd Eifion Williams fod angen i unrhyw aelod o staff a oedd mewn rôl penderfynu yn y broses gaffael lenwi a llofnodi datganiad o fuddiant ar yr adeg honno. Fodd bynnag, roedd y Pwyllgor yn pryderu am yr achosion pan nad oedd Caffael neu Gyllid yn rhan o'r achosion hynny a nodwyd yn y 'heb eu cymeradwyo'.	
Datrysiad	**Gofynnodd** y Pwyllgor i adroddiad yswiriant gael ei ddarparu i egluro'r broses pan fydd datganiadau o wrthdaro buddiannau yn codi o fewn y broses gaffael ar gyfer achosion a gofnodir fel rhai 'heb eu cymeradwyo'.	**EW/CT**
PAY: 27/01/2.11	**AaGIC a AIC Memorandwm Cyd-ddealltwriaeth**	
	Cafodd y Pwyllgor ddiweddariad llafar. Wrth gyflwyno'r diweddariad, dywedodd Dafydd Bebb fod y Memorandwm Cyd-ddealltwriaeth gydag Arolygiaeth Iechyd Cymru (AIC) yn dal i gael ei ddatblygu	
Datrysiad	**Cytunodd** y Pwyllgor i dderbyn y Memorandwm Cyd-ddealltwriaeth derfynol yn ei bwyllgor ym mis Ebrill.	**DB**
PAY: 27/01/2.12	**Traciwr Argymhellion Archwilio**	
	Derbyniodd y Pwyllgor y Traciwr Argymhellion Archwilio. Wrth gyflwyno'r Traciwr, tynnodd Dafydd Bebb sylw at y ffaith bod 16 o argymhellion yn deillio o adroddiadau archwilio a oedd ar y gweill ar hyn o bryd. Roedd 5 argymhelliad statws 'coch' lle'r oedd cynnydd da yn cael ei wneud, ond y tu allan i'r dyddiad targed. Un statws 'ambr' lle nad oedd y weithred wedi cyrraedd y dyddiad cau. Roedd 10 o'r argymhellion wedi cael eu hasesu fel statws 'gwyrdd' lle cafodd camau eu cwblhau. Ystyriodd y Pwyllgor y Traciwr a chytunodd y gellid dileu'r camau gweithredu hynny a oedd wedi'u hasesu'n 'wyrdd' ac wedi'u cwblhau'n llawn. Awgrymwyd, ar gyfer yr argymhellion hynny a oedd wedi dyddio o'r dyddiad cau gwreiddiol, y dylid pennu dyddiad targed diwygiedig er mwyn sicrhau eu bod yn dod i gasgliad ac yn esbonio pam eu bod wedi methu'r targed. Y dyddiad targed gwreiddiol i'w gadw ar y traciwr.	
Datrysiad	Y Pwyllgor: • **nodi'r** Traciwr a statws yr argymhellion; • **cytuno** pe bai statws argymhelliad yn 'wyrdd' ac wedi'i gwblhau'n llawn, y gellid ei ddileu o'r traciwr; • **cytuno** i bennu dyddiad targed diwygiedig ar gyfer yr argymhellion hynny ar ôl eu dyddiad cau gwreiddiol ac esboniad o ran pam eu bod wedi methu'r targed.	**DB** **DB**
PAY: 27/01/2.13	**I Adolygu'r Gofrestr Risg Gorfforaethol**	
	Cafodd y Pwyllgor y Gofrestr Risg Gorfforaethol.	

	Wrth gyflwyno'r Gofrestr, rhoddodd Dafydd Bebb drosolwg o'r asesiad o'r risgiau. Eglurodd fod y 2 risg statws 'Coch' yn gysylltiedig â thelerau ac amodau Bwrsariaeth y GIG a drafodwyd fel rhan o'r sesiwn gynharach 'yn y Pwyllgor' a Seiberddiogelwch. Cyflwyno papur i roi'r wybodaeth ddiweddaraf am y sefyllfa o ran seiberddiogelwch ym Mhwyllgor mis Ebrill. Nododd y Pwyllgor y sefyllfa mewn perthynas ag asesu'r risgiau a'r angen i ychwanegu 2 risg newydd sy'n ymwneud â Pholisi Bwrsariaeth GIG Cymru a Bwrsariaeth GIG Cymru yn erbyn y Cynllun Newydd a Gyflwynwyd yn Lloegr, a'r rhesymau dros eu cynnwys. Fodd bynnag, cafwyd ymholiad ynghylch y broses o greu risgiau newydd. Cadarnhawyd bod proses anffurfiol ar waith er hynny, roedd gwaith ar y gweill i ddatblygu proses fwy ffurfiol. Awgrymodd Mike Usher y dylid ychwanegu'r matrics risg i'r papur clawr ac i ddatblygu 'tudalen i bob golwg' ar gyfer pob risg er mwyn rhoi trosolwg o'r newidiadau mewn perthynas â lliniaru a chynnydd. Dywedodd y Cadeirydd fod gormod o risgiau ar y gofrestr o hyd a bod angen adolygu hyn. Dywedodd Dafydd Bebb y byddai'r Bwrdd yn ystyried ei Archwaeth Risg yn ei gyfarfod ar 30 Ionawr 2020 a bod gwaith ar y gweill i Gysoni'r Gofrestr Risg â'r IMTP. Gofynnodd y Cadeirydd a ddylai fod risg mewn perthynas â Strategaeth y Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol. Dywedodd Julie Rogers fod gan AaGIC a Gofal Cymdeithasol Cymru'r dasg o gyflawni'r strategaeth erbyn diwedd Rhagfyr 2019. Esboniodd fod nifer o'r camau gweithredu yn y Strategaeth wedi'u hychwanegu at y IMTP a bod Llywodraeth Cymru wedi cael gwybod. Cytunodd y Pwyllgor i ddileu unrhyw risgiau 'Gwyrdd'	
Datrysiad	Y Pwyllgor: • **nodi'r** Gofrestr Risg a'r asesiad o'r risgiau presennol; • **cytunodd** y Pwyllgor y dylid cyflwyno papur diweddaru ar seiberddiogelwch ym Mhwyllgor mis Ebrill; • **cytuno** y dylid ffurfioli'r broses uwch gyfeirio risg; • **cytuno** i ddileu risgiau 'gwyrdd' o'r gofrestr risg.	 **DB** **DB** **DB**
	Ymunodd Pushpinder Mangat â'r cyfarfod	
PAY: 27/01/2.14	**Datblygu Trefniant Tariff ar gyfer Cyfarwyddwyr Rhaglenni Hyfforddiant Gofal Eilaidd Iedled Cymru i gefnogi Proffesiynoli'r rôl**	
	Cafodd y Pwyllgor yr achos busnes. Wrth gyflwyno'r achos busnes, cynghorodd Pushpinder Mangat fod hyn wedi bod yn fater etifeddol o fewn y Ddeoniaeth ers nifer o flynyddoedd. Esboniodd fod yr arferion ym mhob arbenigedd yn amrywio. Fodd bynnag, roedd yr achos busnes yn cynnig sicrhau cysondeb ar draws	

	rolau'r TPD o fewn AaGIC a fyddai'n dilyn y trefniadau a oedd ar waith yng ngweddill y DU. Roedd y Pwyllgor Addysg, Comisiynu ac Ansawdd (PACA) wedi ystyried yr achos yn ei gyfarfod ar 16 Ionawr 2020 ac roedd yn gefnogol o'r achos busnes i weithredu trefniant tariff. Fodd bynnag, nid oedd y PACA yn glir mewn perthynas â'r achos ariannol dros y gydnabyddiaeth. Dywedodd Eifion Williams fod y pecyn tâl yn cynnwys cyllid a oedd eisoes yn y gyllideb gwasanaeth a rhai costau ychwanegol a fyddai'n cael eu talu gan ddefnyddio gorbenion sy'n gysylltiedig ag ehangu lleoedd hyfforddi. Bydd hyn yn galluogi Llywodraeth Cymru i gefnogi'r gost o ehangu hyfforddiant. Bydd y cyllid hwn yn rhan o ddyraniad ariannol AaGIC o Lywodraeth Cymru ar gyfer y flwyddyn ariannol 2020/21. Cynghorodd Pushpinder Mangat fod y trefniadau tâl hyn wedi helpu i gadw'r tair swydd bresennol.	
Datrysiad	**Cymeradwyodd** y Pwyllgor yr achos busnes ariannol.	
	Gadawodd y Pushpinder Mangat y cyfarfod.	
PAY: 27/01/2.15	**Adolygiad o Effeithiolrwydd y Pwyllgor**	
	Cafodd y Pwyllgor Rhestr Wirio Hunanasesu drafft y Pwyllgor. Wrth gyflwyno'r Rhestr Wirio, cynghorodd Dafydd Bebb fod y drafft ar gyfer sylwadau o ran cynnwys ac amserlen. Eglurwyd bod y cwestiynau ychwanegol yn deillio o'r rhai a ddefnyddiwyd ym Mwrdd Iechyd Prifysgol Aneurin Bevan ac y byddent yn helpu i ychwanegu gwerth at y gwerthusiad.	
Datrysiad	Y Pwyllgor: • **cytunwyd** y dylid e-bostio'r Rhestr Wirio at Aelodau'r Pwyllgor a Swyddogion y Pwyllgor i'w gwblhau erbyn dydd Gwener, 21 Chwefror 2020. • **cytunwyd** y dylid cyflwyno'r gwerthusiad o'r Rhestr Wirio i bwyllgor mis Ebrill.	**DB** **DB**
RHAN 3	**CAU**	
PAY: 27/01/3.1	**Unrhyw Fater Arall**	
	Nid oedd unrhyw fusnes pellach	
PAY: 27/01/3.2	**Dyddiad y Cyfarfod Nesaf**	
	Cadarnhawyd dyddiad y cyfarfod nesaf fyddai dydd Mercher, 1 Ebrill 2020 am 1pm yn Ystafell Gyfarfod AaGIC 11, Tŷ Dysgu, Nantgarw.	

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Gill Lewis (Cadeirydd) **Dyddiad:**

RHESTR O DERMAU

AAC	Y Pwyllgor Archwilio a Risg
AfC	Agenda ar gyfer Newid
AHP	Gweithiwr Proffesiynol Perthynol i Iechyd
AOP	Cynllun Gweithredu Blynyddol
BAF	Fframwaith Sicrwydd y Bwrdd
CCN	Nodyn Newid Contract
CF	Atal Twyll
CRR	Y Gofrestr Risg Gorfforaethol
DATIX	System meddalwedd ar gyfer rheoli risg
DoF	Cyfarwyddwr Cyllid
DoI	Datgan Buddiant
DPO	Swyddog Diogelu Data
DSAR	Cais am Fynediad at Ddata gan y Testun
ECQC	Y Pwyllgor Addysg, Comisiynu ac Ansawdd
ESR	Cofnod Staff Electronig
ESS	Hunanwasanaeth Cyflogaeth
FCP	Gweithdrefn Rheoli Cyllid
FFP	Addasrwydd i Ymarfer
FoIA	Deddf Rhyddid Gwybodaeth 2000
FTE	Cyfwerth ag Amser Llawn
GDPR	Y Rheoliad Cyffredinol ar Ddiogelu Data
GHS	Rhodd, lletygarwch, nawdd
GPX	Cyfnewidfa Arfer Da
HB	Bwrdd Iechyd
CCAUC	Cyngor Cyllido Addysg Uwch Cymru
HEI	Sefydliadau Addysg Uwch
HIW	Arolygiaeth Iechyd Cymru
IA	Archwiliad Mewnol
IAO	Perchennog Asedau Gwybodaeth
IAR	Cofrestr Asedau Gwybodaeth
IBABS	Porth i gael mynediad at bapurau cyfarfodydd
ICO	Swyddfa'r Comisiynydd Gwybodaeth
IG	Llywodraethu Gwybodaeth
IM	Aelod Annibynnol
IMTP	Cynllun Tymor Canolig Integredig
IPE	Addysg Ryngbroffesiynol
TG	Technoleg Gwybodaeth
JD	Disgrifiad Swydd
JE	Gwerthusiad o’r Swydd
DPA	Dangosydd Perfformiad Allweddol
LCFS	Gwasanaeth Atal Twyll Lleol
LD	Anableddau Dysgu
MDT	Tîm Amlddisgyblaethol
MECC	Gwneud i Bob Cyswllt Gyfrif
MOU	Memorandwm Cyd-ddealltwriaeth
NADEX	Gwasanaeth e-bost a seilwaith cenedlaethol

NSS	Arolwg Myfyrwyr Cenedlaethol
NWIS	Gwasanaeth Gwybodeg GIG Cymru
NWSSP	Partneriaeth Cydwasanaethau GIG Cymru
OD	Datblygu'r Sefydliad
ODP	Ymarferydd Adran Lawdriniaethau
OJEU	Cyfnodolyn Swyddogol yr Undeb Ewropeaidd
PADR	Adolygiad Datblygu a Gwerthuso Perfformiad
PDP	Cynllun Datblygu Personol
PEF	Hwylusydd Addysg Ymarfer
PGME	Addysg Feddygol Ôl-raddedig
PIA	Asesiad o'r Effaith ar Breifatrwydd
PROMPT	Hyfforddiant Amlbroffesiwn Ymarferol - Obstetreg
PS	Manyleb y Person
QA	Sicrhau Ansawdd
RAG	Coch, Melyn, Gwyrdd – risg/tuedd cyflawni/statws
RATS	Tâl Cydnabyddiaeth a Thelerau'r Gwasanaeth
RFI	Cais am wybodaeth
RSP	Partneriaeth Sgiliau Rhanbarthol
GCC	Gofal Cymdeithasol Cymru
SFI	Cyfarwyddyd Ariannol Sefydlog
SHA	Awdurdod Iechyd Arbennig
SHF	Fforwm Iechyd i Fyfyrwyr
SIRO	Swyddog Cyfrifol Gwybodaeth Uwch
SLA	Cytundeb Lefel Gwasanaeth
SO	Rheol Sefydlog
SoD	Cynllun Dirprwyo
SQA	Gweithred Ddyfynbrisio Unigol
SRO	Uwch Swyddog Cyfrifol
SRT	Adnodd Hunanadolygu
STA	Gweithred Dendro Unigol
TOR	Cylch Gorchwyl
TPD	Cyfarwyddwr Rhaglenni Hyfforddi
TUPE	Rheoliadau Trosglwyddo Ymgymeriadau (Diogelu Cyflogaeth) 2006
VFM	Gwerth am Arian
WAO	Swyddfa Archwilio Cymru
WASPI	Cytundeb Rhannu Gwybodaeth Bersonol Cymru
WBFGA	Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015
WCPPE	Canolfan Addysg Broffesiynol Cymru – Fferylliaeth
WEDS	Gwasanaethau Addysg a Datblygu'r Gweithlu GIG Cymru
WG	Llywodraeth Cymru
WHO	Sefydliad Iechyd y Byd
WTE	Cyfwerth ag Amser Llawn

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

Agenda Item: 1.5

Pwyllgor Archwilio a Sicrwydd (Agored)
27 Ionawr 2020
Log Gweithredu

(Mae'r Daflen Weithredu hefyd yn cynnwys camau y cytunwyd arnynt yng nghyfarfodydd blaenorol y Pwyllgor Archwilio a Sicrwydd ac maent yn aros i gael eu cwblhau neu wedi'u hamserlennu i'r Pwyllgor eu hystyried yn y dyfodol. Mae'r rhain wedi'u cysgodi yn yr adran gyntaf. Pan gaiff ei gymeradwyo gan y Pwyllgor Archwilio a Sicrwydd, cymerir y camau gweithredu oddi ar y ddalen weithredu treigl.)

Cyfeirnod Cofnod	Gweithredu y Cytunwyd Arno	Arwain	Dyddiad Targed	Cynnydd/ Cwblhau
PAY: 27/01/1.4	**Cofnodion y Cyfarfod a gynhaliwyd ar 22 Tachwedd 2019**			
	• **Yn bresennol**: Tynnu'r llythyren 'b' o enw'r Cadeirydd fel ei bod yn darllen: 'Gill Lewis'.	**Ysgrifennydd y Bwrdd**	O fewn 1 wythnos	Cwblhau.
	• **PAY 22/11/2.12 Argymhellion Traciwr Archwilio:** Tynnu'r testun canlynol ar frig tudalen 9 (trydydd paragraff y cofnod cyfeirnod PAY 22/11/2.12) '…a bod argymhellion 36 ymlaen mewn perthynas â Llythyr Rheoli SAC ac Adolygiad Sylfaenol-Asesiad Strwythuredig, hefyd yn cael eu dileu gan fod y rhain yn cael eu dilyn yn rheolaidd gan SAC'. Bydd yr argymhellion hynny nad ydynt wedi'u cwblhau eto yn cael eu hadfer i'r tracir.	**Ysgrifennydd y Bwrdd**	O fewn 1 wythnos	Cwblhau.

Cyfeirnod Cofnod	Gweithredu y Cytunwyd Arno	Arwain	Dyddiad Targed	Cynnydd/ Cwblhau
PAY: 22/11/1.5	**Log Gweithredu**			
	• Mae geirfa acronym i'w datblygu fel atodiad cyfeirio at gofnodion y cyfarfod.	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Cwblhau.
PAY: 27/01/2.1	**Cynnydd Gwrthddadl**			
	• Y Pwyllgor i gael copi o'r adroddiad yn dilyn yr Adolygiad Annibynnol o systemau Caffael a phrosesau gwybodaeth AaGIG.	**Cyfarwyddwr Cyllid**	I'w gadarnhau	Mae'r adolygiad hwn yn parhau
PAY: 27/01/2.2	**Diweddariad Cydymffurfio Cofnod Staff Electronig (ESR) ar Hyfforddiant Gorfodol a PADR**			
	• Gwahodd y Cyfarwyddwr Meddygol i ddod i'r Pwyllgor ym mis Ebrill i gael trafodaeth gefnogol.	**Cyfarwyddwr y Gweithlu ac OD**	Gorffennaf 2020	Yng ngoleuni'r pandemig coronafeirws, gohiriwyd yr eitem hon â'r Pwyllgor ym mis Gorffennaf.
PAY: 27/01/2.3	**Asesiad Strwythuredig 2019**			
	• SAC i rannu enghreifftiau o arferion da/arfer gorau a sefydliad cymheiriaid, manylion cyswllt ar gyfer meincnodi.	**Swyddfa Archwilio Cymru**	O fewn 1 mis	Cwblhau.
PAY: 27/01/2.3	**2020 Cynllun Archwilio dangosol gan gynnwys y ffi arfaethedig ar gyfer 2020**			
	• Awgrymiadau ar gyfer gwaith archwilio lleol SAC i'w hanfon at Dafydd Bebb yn y lle cyntaf.	**Holl**	Ebrill 2020	Cwblhau.

Cyfeirnod Cofnod	Gweithredu y Cytunwyd Arno	Arwain	Dyddiad Targed	Cynnydd/ Cwblhau
PAY: 27/01/2.6	**Diweddariad ar Lywodraethu Gwybodaeth**			
	• Bydd pennawd y golofn cynnydd yn cael ei ddiweddaru i sicrhau cysondeb drwy'r ddogfen gyfan.	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Cwblhau.
	• Caiff y naratif sy'n cyd-fynd â'r golofn 'statws RAG/cwblhau erbyn' ei adolygu ac fe'i hymgorfforwyd yn y golofn cynnydd.	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Cwblhau.
PAY: 27/01/2.10	**Datgan Buddiannau – Adolygu Arferion o fewn sefydliadau eraill**			
	• Adroddiad sicrwydd i'w ddarparu i egluro'r broses pan fydd datganiadau o wrthdaro buddiannau yn codi o fewn y broses gaffael ar gyfer achosion a gofnodir fel rhai 'heb eu cymeradwyo'.	**Cyfarwyddwr Cyllid / Pennaeth Caffael**	I'w gadarnhau	Caiff yr adroddiad sicrwydd ei gylchredeg i Aelodau'r Pwyllgor pan gaiff ei gwblhau.
PAY: 27/10/2.11	**AaGIC ac AGIC Memorandwm Cyd-ddealltwriaeth**			
	• Memorandwm Cyd-ddealltwriaeth derfynol i'w gyflwyno i bwyllgor mis Ebrill.	**Ysgrifennydd y Bwrdd**	Ebrill 2020	Mae'r memorandwm cyd-ddealltwriaeth yn dal i gael ei ddatblygu. Gohiriwyd yr eitem hon tan y Pwyllgor ym mis Gorffennaf.
PAY: 27/01//2.12	**Argymhellion Traciwr Archwilio**			
	• Tynnu argymhellion pan fydd y statws yn 'Wyrdd' ac wedi'i gwblhau'n llawn.	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Cwblhau.

Cyfeirnod Cofnod	Gweithredu y Cytunwyd Arno	Arwain	Dyddiad Targed	Cynnydd/ Cwblhau
	• Pennu dyddiad targed diwygiedig ar gyfer yr argymhellion hynny wedi'r dyddiad cau gwreiddiol ac esboniad ynghylch pam eu bod wedi methu'r targed.	**Ysgrifennydd y Bwrdd**	O fewn 1 mis	Adlewyrchwyd hyn yn y traciwr ac mae'n eitem ar agenda'r Pwyllgor
PAY: 22/11/2.13	**Gofrestr Risg Gorfforaethol**			
	• Cyflwynir papur ar ddiogelwch seiber yn y Pwyllgor ym mis Ebrill.	**Ysgrifennydd y Bwrdd**	Ebrill 2020	Eitem ar agenda mis Ebrill ' yn y Pwyllgor '.
	• Mae'r broses uwch gyfeirio risg yn cael ei ffurfioli.	**Ysgrifennydd y Bwrdd**	Gorffennaf 2020	Bydd y polisi rheoli risg yn cael ei ddiweddaru i egluro'r broses ar gyfer dwysáu a diraddio risg i'r gofrestr risg gorfforaethol. Caiff y polisi wedi'i ddiweddaru ei gyflwyno i'r Pwyllgor ym mis Gorffennaf 2020 ar ôl iddo gael ei gymeradwyo gan y tîm gweithredol.
	• Dileu risgiau 'Gwyrdd' o'r gofrestr risg	**Ysgrifennydd y Bwrdd**	O fewn 2 wythnos	Cwblhau.
PAY: 22/11/3.1	**Adolygiad o Effeithiolrwydd y Pwyllgor**			
	• Dylid e-bostio'r rhestr gyfeirio at Aelodau'r Pwyllgor a Swyddogion y Pwyllgor i'w llenwi erbyn dydd Gwener, 21 Chwefror 2020.	**Ysgrifennydd y Bwrdd**	Chwefror 2020	Cwblhau.
	• Dylid cyflwyno'r gwerthusiad o'r rhestr wirio i Bwyllgor mis Ebrill.	**Ysgrifennydd y Bwrdd**	Ebrill 2020	Yng ngoleuni'r pandemig coronafeirws, gohiriwyd yr eitem hon â'r Pwyllgor ym mis Gorffennaf.

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.1**
Teitl yr Adroddiad	Adroddiad Cynnydd Gwrth-dwyll - 31 Mawrth 2019		
Awdur yr Adroddiad	Craig Greenstock – Gwasanaeth Atal Twyll Lleol		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid		
Cyflwynwyd gan	Eifion Williams, Cyfarwyddwr Cyllid		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Pwrpas yr adroddiad hwn yw cyflwyno'r: • Adroddiad Cynnydd Gwrth-dwyll i'r Pwyllgor Archwilio a Sicrwydd a rhoi'r wybodaeth ddiweddaraf ynglŷn â'r gwaith Gwrth-dwyll sydd wedi'i wneud o fewn y Corff Iechyd dros y cyfnod a ddaeth i ben ar 31 Mawrth 2020 . • Rhaglen Waith Flynyddol y Gwasanaeth Atal Twyll Lleol ar gyfer 2020/21 fel y cytunwyd gan y Cyfarwyddwr Cyllid.		
Materion Allweddol	Gofynnir i'r Pwyllgor: • Nodi'r cynnydd a'r gwaith sydd wedi'i gwblhai o'i gymharu â'n cynllun ar gyfer 2019/20 • Cymeradwyo Rhaglen Waith Flynyddol y Gwasanaeth Atal Twyll Lleol ar gyfer 2020/21		

Cam Penodol i'w Gymryd *(plîs ✓ dim ond un)*	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
				✓

ADRODDIAD CYNNYDD GWRTH-DYWYLL - 31 MAWRTH 2019

1. CYFLWYNIAD

Pwrpas yr Adroddiad Cynnydd Gwrth-dwyll yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd ynglŷn â'r gwaith Gwrth-dwyll sydd wedi'i wneud o fewn Corff Iechyd dros y cyfnod a ddaeth i ben ar 31 Mawrth 2020.
Mae arddull yr adroddiad wedi cael ei fabwysiadu, yn dilyn ymgynghoriad a'r Cyfarwyddwr Cyllid, a'i brif amcan yw hysbysu a diweddaru aelodau'r Pwyllgor Archwilio a Sicrwydd o fanylion unrhyw newidiadau sylweddol sydd wedi bod yn yr achosion a ddeliwyd â nhw dros y cyfnod, yn ogystal ag unrhyw faterion gweithredu cyfredol.

2. CEFNDIR

Yn unol â Chyfarwyddiadau'r Ysgrifennydd Gwladol Dros Iechyd ar gyfer mynd i'r afael â thwyll yn y GIG, mae'n rhaid cyflwyno adroddiadau cynnydd rheolaidd i Bwyllgor Archwilio a Sicrwydd y Cyrff Iechyd. Dylai'r adroddiad amlinnellu sefyllfa bresennol unrhyw waith Gwrth-dwyll a Llygredd a wnaed o fewn y Corff Iechyd hyd at ddyddiad cyfarfod y Pwyllgor Archwilio a Sicrwydd.

Ar y cyd â'r Cyfarwyddwr Cyllid, dylai'r Gwasanaeth Atal Twyll Lleol gynllunio a chytuno ar Gynllun Gwaith Blynyddol yn cynnwys nifer penodol o ddyddiau sy'n fframwaith ar gyfer datblygu trefniadau Gwrth-dwyll fwy cadarn ac sy'n argymell, i Bwyllgor Archwilio a Sicrwydd y Cyrff Iechyd, yr adnodau sydd eu hangen er mwyn gallu gweithio'n effeithiol ar draws y camau gweithredu sy'n cael eu hamlinellu ym Mholisïau a Gweithdrefnau Gwrth-dwyll y GIG.

3. MATERION LLYWODRAETHU A RISG

Trwy fabwysiadu strwythur llywodraethu cadarn, dylai'r Corff Iechyd ganolbwyntio ar brosesau effeithiol ar gyfer asesu risgiau twyll. Yn ei dro rhaid dilyn y strwythur gan ganolbwyntio ar atal twyll, canfod twyll, ac ymchwilio i dwyll. Rhaid ystyried asesiadau risg twyll a'r tair prif nodwedd sef:

- canfod peryglon cynhenid o dwyll (y peryglon o dwyll)
- asesu tebygolrwydd ac effaith pob perygl cynhenid o dwyll
- ymateb i beryglon cynhenid sylweddol a/neu debygol

Er mwyn asesu'r materion risg, rhaid i staff AaGIC ddeall bod y mwyafrif yn ymwneud â dogfenau ffug, llofnodau ffug, adroddiadau twyllodrus, camddefnyddio a/neu lygredd.

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

- Symbyliadau, pwysau a chyfleoedd o ganlyniad i wendidau yn y system
- Y perygl bod Uwch Reolwyr yn anwybyddu polisïau a/neu yn diystyru rheoliadau
- Technoleg Gwybodaeth
- Perygl twyll i reoliadau, cyfreithiau a/neu enw da

Wrth asesu tebygrwydd ac effaith peryglon o dwyll, dylai unrhyw asesiad ystyried y canlynol:

- Hanes o dwyll o fewn y sefydliad
- Achosion o'r twyll o fewn y GIG gydag unrhyw achosion "tebyg"
- Cymhlethdod y peryglon
- Y peryglon i unigolion a/neu adrannau penodol
- Nifer y bobl a/neu'r trafodion cysylltiedig

Wrth amcangyfrif yr effaith, dylid ystyried
gweithrediadau, enw da a rhwymedigaeth gyfreithiol (troseddol, sifil a rheolaethol) y sefydliad.

Dylai asesiadau risg twyll y Cyrff Iechyd gael eu cofnodi yn defnyddio fframwaith strwythuredig a dylai unrhyw ganfyddiadau gael eu rhoi i'r Pwyllgor Archwilio a Sicrwydd.

Dylai'r broses gyfan fod yn ddogfen "fyw" a dylai'r prif ffocws fod ar welliant parhaus Gellir datblygu hyn drwy sicrhau, drwy sesiynau ymwybyddiaeth, digwyddiadau a chyhoeddiadau gwahanol, bod staff a rheolwyr ar bob lefel o fewn AaGIC yn ymwybodol ac yn meddu ar y canlynol:

- darllen a deall eu cyfrifoldebau, fel yr amlinellir ym mholisi/gweithdrefn Gwrth-dwyll y Cyrff Iechyd
- deall twyll ac adnabod unrhyw feysydd sy'n peri pryder
- deall eu swyddi a'u cyfrifoldebau unigol o fewn y fframwaith rheolaeth mewnol yn enwedig mewn perthynas ag unrhyw wendidau posib yn y system
- creu diwylliant gwrth-dwyll drwy sicrhau amgylchedd o reolaeth gadarn
- adrodd ar unrhyw amheuon a/neu achosion honedig o dwyll
- cydweithio'n llawn ag unrhyw ymchwiliadau'n ymwneud â thwyll

4. GOBLYGIADAU ARIANNOL

Mae gan dwyll yn erbyn y GIG efaill ariannol, oherwydd byddai'r Corff Iechyd wedi dioddef colled ariannol gychwynol o ganlyniad i weithredoedd yr unigolyn.

Mae gwaith staff Gwrth-dwyll y Corff Iechyd yn cael ei wneud er mwyn ceisio lleihau lefel y twyll a/neu lygredd yn AaGIC a'i gadw ar lefel isel er mwyn rhyddhau adnoddau ar gyfer gofal i gleifion.

5. ARGYMHELLIAD

Gall unrhyw gyhoeddusrwydd negyddol o ganlyniad i adroddiadau yn y cyfryngau effeithio ar enw da'r Corff Iechyd. 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.

Gofynnir i'r Pwyllgor:

- Nodi'r cynnydd a'r gwaith sydd wedi'i gwblhai o'i gymharu â'n cynllun ar gyfer 2019/20
- Cymeradwyo Rhaglen Waith Flynyddol y Gwasanaeth Atal Twyll Lleol ar gyfer 2020/21

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	✓			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad Cleifion
Dim wedi'u nodi
Goblygiadau Ariannol
Mae gan dwyll yn erbyn y GIG efaill ariannol, oherwydd byddai'r Corff Iechyd wedi dioddef colled ariannol gychwynol o ganlyniad i weithredoedd yr unigolyn. Mae gwaith staff Gwrth-dwyll y Corff Iechyd yn cael ei wneud er mwyn ceisio lleihau lefel y twyll a/neu lygredd yn AaGIC a'i gadw ar lefel isel er mwyn rhyddhau adnoddau ar gyfer gofalu am gleifion.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Lle mae tystiolaeth o dwyll prima facie yn cael ei nodi byddwn ni'n gofyn am gyngor gan Adran Dwyll Arbennigol Gwasanaeth Erlyn y Goron ar sut i symud ymlaen a ph'un ai 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	Adroddiad Cynnydd y Gwasanaeth Atal Twyll Lleol Cynllun Gwaith Blynyddol y Gwasanaeth Atal Twyll Lleol ar gyfer 2020/21

NHS WALES
Health Education & Improvement Wales

Audit & Assurance Committee 1st April 2020
Counter Fraud Update

Craig Greenstock
Counter Fraud Manager
Cardiff and Vale University Health Board

AUDIT COMMITTEE 1st April 2020

COUNTER FRAUD UPDATE

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

Mission Statement

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

1. INTRODUCTION

1.1 In compliance with the Directions on Countering Fraud in the NHS, Counter Fraud is required to provide updates to the Audit and Assurance Committee on the work that has been carried out against the agreed work-plan.

This update provides the Audit Committee with an update at 31st March 2020.

2. CURRENT CASE UPDATE

2.1 As at 31st March 2020, a total of **50** days have been spent on counter fraud work within HEIW and the breakdown of this work is detailed in **Appendix 1**.

2.2 There is currently one (1) case currently under investigation for which a verbal update on the progress made to date will be given to the Audit Committee.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

Some fraud awareness sessions have already taken place with both the Finance and Senior Leadership Teams (SLT). However, despite some initial interest from SLT members, there were then only a few enquiries received for presentations to be carried out. Further to this, some of the planned sessions had to be cancelled, but those will be re-arranged to take place during the next financial year.

In view of this and following discussion with the Interim Director of Finance, in order to try to promote the counter fraud work that is being undertaken, a follow up e-mail invitation will be re-issued, at the start of the 2020/21 financial year, to all SLT members and other departments within HEIW and it is hoped that this will encourage further participation in the process.

3.2 Quarterly CF Newsletter

The next edition of the quarterly CF Newsletter will be issued in due course to HEIW Communications Dept and this will then be disseminated to all HEIW staff.

The newsletter, which it is hoped will also supplement any planned fraud awareness sessions, will include information about recent cases that have appeared in the public domain. The same newsletter will also contain further details to HEIW staff as to how and where they can report any concerns relating to NHS fraud.

3.2 NHS Counter Fraud Authority - Thematic Assessment (Wales Shared Services)

Background

Welsh NHS Health Bodies are governed by the Welsh Assembly and have a requirement to comply with all NHS Counter Fraud Authority (NHSCFA) standards. The NHSCFA

describe the requirements for these counter fraud arrangements within a set of Fraud, Bribery and Corruption Standards, which are published annually for both NHS Providers, Commissioners and NHS Bodies in Wales.

The NHSCFA standards include key requirements in respect of pre-employment checks, procurement fraud and invoice fraud, emphasising the need for comprehensive risk assessment relating to all fraud, bribery and corruption risks within the Health Body. The Fraud, Bribery and Corruption Standards have, since their inception, identified the requirement for a fraud, bribery and corruption risk assessment to be undertaken in order to ensure appropriate measures are in place to counter fraud, bribery and/or corruption within the areas of pre-employment check, procurement and invoice payments.

With this in mind, standards 3.4, 3.5 and 3.6 of the Fraud, Bribery and Corruption Standards set out the requirements of Welsh NHS Bodies to ensure that areas of risk are mitigated and that NHSCFA guidance documents are adhered to.

These areas of work are overseen by NHS Wales Shared Services Partnership (NWSSP) and Welsh NHS Bodies with support from the NHS Counter Fraud Service (Wales).

To undertake an exercise applied to all Welsh NHS Bodies, who have submitted an Self Review Tool (SRT) for 2019 as part of the required Qualitative Assessment process in order to assess the level and detail of counter-fraud, bribery and corruption prevention measures in place both centrally within NWSSP and across the Health Bodies, with specific focus an standards 3.4, 3.5 and 3.6 of the NHS Counter Fraud Authority standards.

Test compliance of standards 3.4, 3.5 and 3.6 of the 2019/20 standards.

- To understand the range of policies, protocols and procedures in use both centrally at NWSSP across the health bodies.
- To test compliance with policies, protocols and procedures within the health bodies
- To publish any findings through a thematic report to NHS Wales Counter Fraud Steering Group (CFSG), NWSSP and all Health Bodies, Directors of Finance and Lead LCFS' identifying good practice and, where not compliant with the requirements of the standards, recommendations to mitigate risks.

Purpose

To provide assurances to NHS Wales CFSG that appropriate measures to prevent fraud, bribery and/or corruption in the areas of pre-employment, procurement and invoice payment are in place. Where they are not in place, to make recommendations to address any system weaknesses.

Executive Summary

All Welsh NHS Bodies have the capacity to adopt policies and procedures that have been put in place by the NHS Wales Shared Services Partnership (NWSSP). These policies and protocols are robust in nature and are regularly reviewed, evaluated and

audited for effectiveness. However, not all NHS Wales have Bodies adopted all those policies and protocols and so a number of localised systems have then been adopted. The body of the report has set out the detailed findings and recommendations that NHS Wales Bodies should consider to manage risk and ensure compliance with the NHSCFA standards.

Pre- employment checks appear to be weak in relation specifically to Agency staff, with a belief within Welsh NHS Bodies and also NWSSP, that Agencies, who are on the framework, are undertaking these checks in order to meet the requirements. Whilst this may well be true, the responsibility for ensuring that all relevant pre-employment checks are undertaken to the required standard does lie with the Health Body.

Recommendations have been made in the report to mitigate those areas of risk and assurances should be sought, from the relevant Welsh NHS Body, that risk analysis is undertaken and that any subsequent action plans are then managed appropriately.

The findings of the report also show that there are some potential areas of weakness in how procurement processes are fraud proofed. Whilst these areas are less prolific, than pre-employment checks for Agency staff, they still carry a high level of risk and should be addressed in line with the recommendations in the report.

Invoice fraud appears to be in the main being managed well across Wales with limited recommendations being made in the report.

Whilst the full report has been issued to Directors of Finance and Lead LCFS', it is not being made available, at this time, to this Committee. The reason for this is that the full report has not been redacted and so contains information, which is relevant to all Welsh NHS Bodies and not solely to HEIW, which has now been relayed back to the report's author. In view of this, a separate report, containing all HEIW related issues, NWSSP responses, NHS CFA suggested action and the LCFS' action plan, will be presented to the next meeting of this Committee.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2019/20

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	1
Production of Reports and attendance at Audit & Assurance	4	4
Liaison with the DoF, NHS CFA, Welsh Government	0	0
Self Review Tool (SRT) and QA Assessment	1	1
Annual Activity		
Create an Anti-Fraud Culture	5	5
Presentations, Briefings, Newsletters etc.	15	12
Fraud Awareness Events	0	0
Deterrence		
Review/develop Policies/Strategies	3	3
Prevention		
The reduction of opportunities for Fraud and Corruption to occur.	0	0
Detection		
National Pro-Active Exercises (e.g. Procurement)	2	2
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	15	18
Ensure that Sanctions are applied to cases as appropriate	1	1
Seek redress, where fraud has been proven to have taken place	2	2
TOTAL HEALTH EDUCATION IMPROVEMENT WALES	**50**	**50**

Counter Fraud Service

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 Work-Plan provides a basis to formulate local Counter Fraud arrangements. The tasks outlined should be considered and reviewed on an annual basis. This guidance recommends the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on an annual Quality Assurance Programme, comprising two main processes, assurance and assessment. Both of which are closely liked to the anti-fraud, corruption and bribery corruption standards set out on an annual basis by NHS Counter Fraud Authority

1.2 The Quality Assurance process includes an Annual Self- Review against the standards, which is conducted by the individual Health Body and submitted to NHS Counter Fraud Authority together with the organisation's Counter Fraud Annual Report. The Quality Assurance process is conducted by NHS Counter Fraud Authority's Quality and Compliance team in partnership with the Health Body.

1.3 This Work-Plan is applicable to all NHS Trust's, Health Boards and Hosted Bodies in Wales. The individual NHS Trust's and integrated Health Board's are responsible for planning, designing, developing and securing delivery of Primary, Community, Secondary Care services, and Specialist and Tertiary services for their areas, to meet identified local needs within the National Policy and Standards Framework as set out by the Cabinet Secretary for Health.

1.4 The reorganisation of NHS Wales came into effect on 1st October 2009 and as such NHS Counter Fraud Authority, formerly NHS Protect, maintains a commitment to supporting the new structure via this Work-Plan for the year 2020-21. Organisations are expected to formulate Work-Plans by taking a Risk Based Approach, and this guidance should be used to assist in providing a framework on which such arrangements can be developed. Future guidance will encourage organisations to formulate bespoke plans.

1.5 The Wales Audit Office, in relation to the tem-plated work-plan, previously made the following comments:

" - - - [the Template 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, particularly in the light of NHS reorganisation in Wales."

The Wales Audit Office also recognised that effective delivery of the plan does represent a substantive programme of work.

1.6 The total number of suggested **pro-active and reactive days** to be allocated in 2020-21 for the Health Education and Improvement Wales (HEIW) is **50days**. This response has been allocated using data from previous years work and organisations in both Primary and Secondary Care Sectors.

1.7 When planning the resources for Counter Fraud work, it is important that the Health Body legislates for reactive time and this should be reflected in any contracting arrangements with Counter Fraud providers. Reactive work is highlighted in boxes throughout this Work Plan.

1.8 Pro-Active work (i.e. 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 needs to be undertaken otherwise the Health Body may be at risk from Fraud and/or Corruption.

1.9 We appreciate that organisations can vary in size and they should use the following scale to adjust the number of days accordingly.

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

1.10 It is important to note that, whilst this is a Work-Plan to ensure effective Counter Fraud arrangements, it is not a maximum requirement and both NHS Trusts and Health Boards are strongly urged to consider further local requirements that might result in the recommended resource levels being exceeded. This Work-Plan provides assistance when considering Counter Fraud arrangements, but it is important that bespoke plans are implemented for each organisation using a Risk Based approach (see section 2).

1.11 Organisations that fall below this guidance should be able to provide evidence as to why decisions on work planning have been taken and these should be provided to NHS Counter Fraud Authority and/or NHS CFS (Wales) upon request. It should be noted that the **50days** referred to above are specific to HEIW own work-plan.

1.12 The Work-Plan is a framework on which to build robust Counter Fraud arrangements and is therefore analogous with the Annual Quality Assurance Programme and Self Risk Assessment that each NHS Trust and Health Board is then asked to submit at the end of the financial year.

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

2.1 Those who are locally based are best placed to identify and understand the Counter Fraud requirements for their organisation. The successful implementation of NHS Policy for Countering Fraud relies greatly on the success of the Local Counter Fraud Specialist (LCFS) role.

2.2 The Counter Fraud Work-Plan should be bespoke for the NHS organisation it is designed for. For example, utilising local Annual Staff Survey results will identify areas to concentrate on in terms of awareness work, whilst examination of referral data might reveal the need for increased work on prevention or highlight that greater awareness is needed in a particular area or staff group.

2.3 Meeting with key personnel within HEIW is crucial to information gathering and, along with staff survey results, can assist in the formulation of planning and provide information on the most effective methods of communication. Responses may also indicate areas of perceived risk and this may also be supported by previous experiences which could highlight a need for Pro-Active preventative or detection work.

2.4 The LCFS should have effective liaison with the individual whom, within the HEIW and/or Hosted Body, is responsible for managing risk. It is recommended that frauds that have occurred within the organisation and beyond be brought to this person's attention to ascertain the risk to the HEIW and/or Hosted Body, from the same type of fraud. Once identified, the fraud can be proactively addressed.

2.5 Risks identified by the LCFS need to be placed onto the Risk Register to provide another level of assurance that the risk will be managed appropriately.

2.6 Whilst every effort should be made to identify local risks, it is also important that consideration is given to information provided from outside the organisation (for example, from NHS Counter Fraud Authority fraud alerts) and this too must be incorporated into risk-based planning in the same way that local information is.

2.7 Keeping accurate records of Counter Fraud work is crucial for successful work-planning as is utilising previous LCFS outcomes, Risk Register entries and Internal Audit Reports. The end of year Quality Assurance Programme and Self Risk Assessment also encourages accurate record keeping and accountability and these documents should also be used to identify strengths and weaknesses.

2.8 To assist organisations to take a risk-based approach to Counter Fraud work and work planning, NHS Counter Fraud Authority has issued a Risk Assessment tool to guide LCFS' to undertake a Risk Assessment of the Counter Fraud arrangements in place at their own organisation. This tool has also been designed to complement the Quality Assurance process, and provides organisations with a mechanism to review Counter Fraud arrangements prior to completing the end of year Quality Assurance Programme.

3 Focusing on outcomes and not merely activity

3.1 The Counter Fraud work that is completed at the organisation should have outcomes that are demonstrable, they might relate to successful investigations or progress being made in the proactive areas. For example, the staff survey supports progress being made in developing an Anti-Fraud Culture or that Fraud Proofing Policies has seen a cessation of referrals from that particular area. 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 template

INFORM AND INVOLVE		
Number of allocated days for Inform and Involve (25)	**Recommended task / objective**	**Outcome and Impact**
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public	Take part in the development of the Induction programme for all HEIW staff and deliver awareness presentations on Counter Fraud work to those staff.	
	LCFS is to provide all staff with their role and contact details and inform staff that such Counter Fraud presentations are available to all staff groups.	
	Review the induction pack to be distributed during HEIW's induction process, including slides handouts, leaflets and CFS forms.	
	A programme of counter fraud awareness training to be delivered to staff at all levels within HEIW (e.g. managerial staff, junior staff etc). The LCFS should aim to complete at least 10 presentations to staff groups. The aim of this is to ensure the Health Body is being proactive in raising fraud awareness and able to build a real anti-fraud culture. These should include presentations: • at Senior Leadership Team meetings • at Student Induction events • at any Team Briefings/Meetings (e.g. Finance) • at Management Forums • to any Authorised Signatories • as part of Counter Fraud displays relating to any fraud awareness initiatives	
	Evaluate all presentations, collate results, and amend presentations as a result of feedback. Write up a report on the outcomes for the Director of Finance.	
	Review localised fraud leaflets, posters, and newsletters, to promote the anti-fraud work being undertaken within HEIW. Distribute at appropriate locations.	
	Develop and maintain counter fraud information on HEIW's intranet site. Having a Counter Fraud site will allow staff easy access to Counter Fraud related information. Items to include on the site are:	

	• overview of the Counter Fraud initiative locally and nationally • Role of the LCFS • Counter Fraud Policy • Proven NHS fraud related cases • Presentation Slides • Link to NHS Counter Fraud Authority website • Link to any appropriate HR policies (including whistleblowing policy) • Counter Fraud articles • Contact details of the Lead LCFS • Feedback Form The LCFS should be able to maintain a record of the number of staff who may have visited the site.	
	Undertake and analyse one or more of the following methods to identify level of fraud awareness (**NB.** this list is not exhaustive): • staff survey (consider putting a link on the intranet) • focus groups • internet quizzes • number of hits on the Counter Fraud webpage	
	LCFS to meet with key personnel within HEIW to discuss fraud matters including: • Chief Executive • Board Members • Director of Finance	
	Arrange for a pay-slip message to be utilised when required.	
	Undertake and/or participate in Local Fraud Awareness initiatives and events.	
	The HEIW has an Anti-Fraud, bribery and corruption policy which has been approved by Velindre NHS Trust's Board. The policy is reviewed and updated as required.	

	Meet regularly with the Head of Internal Audit and in accordance with the agreed protocol to discuss potential system weaknesses identified during audits or investigations and highlight work being undertaken by the LCFS, e.g. National or local proactive work.	
	Regular liaison with other bodies and forums to keep updated of any local concerns and/or issues	

PREVENT and DETER		
Number of allocated days for Prevent and Deter (5)	**Recommended task / objective**	**Outcome and Impact**
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	Meet with HEIW's Communications staff to discuss: • NHS Counter Fraud Authority Communications & Business Development Unit (CBDU) • Publicity of Counter Fraud work • Advance Warning system • Utilise not only publicity at HEIW but also local, regional and national cases that may be relevant.	
	Review the Communication Strategy so that the most effective ways to communicate with staff at HEIW are utilised.	
	Intelligence bulletins and alerts issued by NHS Counter Fraud Authority and/or NHS CFS Wales are actioned and followed up to ensure that preventative measures applied have achieved their intended outcome.	

	Recommended task / objective	Outcome and Impact
	Review distribution of the annual Conflict of Interest statements and ascertain if this is sufficient to deter potential risks in this area. Are the sanctions for fraud clearly indicated on the declaration which is then required to be signed by staff?	
	Include a heading entry in the Risk Register to specifically record fraud as a risk to HEIW. Periodically review the Risk Register.	
	Liaise with HEIWs Risk Management Group to establish a link between Risk and Counter Fraud work and a methodology for addressing this. The intelligence gathered should be used proactively to make Risk Assessments. Meet with managers to discuss risk areas and refer high risk areas or trends to NHS Counter Fraud Authority's Head of Risk.	
	Meet with HEIW's Head of Corporate Services to discuss risk areas or other areas of concern	
	Establish a formal written protocol with Internal Audit for the dissemination of information for areas where control weaknesses may allow a potential fraud to remain undetected and where investigations have identified system weaknesses that may require a future Internal Audit review.	
	Fraud proof a selection of general policies, procedures and claim forms used throughout HEIW where there is a potential risk of fraud occurring. *Policies/procedures/claim forms that could be considered for fraud proofing may include:* ➢ *Recruitment including the controls covering qualification, employment history checks and DBS checks* ➢ *Timesheets and associated procedures/policies* ➢ *Travel and associated expenses* ➢ *Security of confidential data held by HEIW* ➢ *Recovery of overpayments/advances of pay* ➢ *Service contracts checking work completed prior to payment* ➢ *Asset verification checks (inventory and capital items)*	

	Recommended task / objective	**Outcome and Impact**
	➢ *Standards of Business Conduct and conflict of interest declarations* ➢ *Acceptance of gifts and hospitality* ➢ *Mobile phone policy and private phone calls* ➢ *Losses and Special Payment controls and monitoring* ➢ *Delegated ordering controls* ➢ *Authorising signatory controls* ➢ *Absence Reporting and Monitoring* *Checks to be undertaken with Internal Audit to avoid duplication of effort when looking at such documentation/policies and procedures.*	
	Use the Systems Weakness Reporting (SWR) form to inform NHS CFS (Wales) at the earliest opportunity of any system weaknesses identified during the course of investigations which have potential national implications.	

	Recommended task / objective	**Outcome and Impact**
	Undertake local Pro-Active Exercises at HEIW as agreed with the Director of Finance and in conjunction with HEIW's Internal Audit Plan.	
	Provide NHS Counter Fraud Authority Central Intelligence Unit with information to support the intelligence function using the facilities provided. Information submitted may be about a person, organisation or methodology and should relate to fraud or corruption within the NHS.	

HOLD to ACCOUNT		
Number of allocated days for Hold to Account (15)	**Recommended task / objective**	**Outcome and Impact**
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result	Conduct investigations as required in line with Appendix 5 of the *NHS Counter Fraud and Corruption Manual*, which outlines relevant procedural investigative legislation. Interviews under caution are conducted in line with the Police and Criminal Evidence Act 1984 Witness statements follow best practice and comply with national guidelines.	
	Assist NHS Counter Fraud Authority with information as required for any regional or national fraud cases. Ensure comprehensive information to enable risk exercises to be carried out effectively is submitted in a timely manner.	
	The development (or revision) of a policy with HEIW nominated Employment Services on the interaction of these parties and the application of parallel sanctions: civil, disciplinary and criminal, as outlined in the NHS policy document *Applying Appropriate Sanctions Consistently (December 2007)* should provide a framework to this work. Knowledge of this process should be delivered to and agreed by HEIW Senior Managers in conjunction with Velindre NHS Trust and should be tested to ensure it is understood, this will assist in the message becoming embedded within the organisational culture.	
	That HEIW shows a commitment in pursuing the full range of available sanctions and that these sanctions are applied consistently	

	That HEIW seeks to recover any NHS monies which can be identified as having been lost and/or diverted through fraud, bribery and/or corruption.	
	That HEIW publicises cases that have led to the successful recovery of any NHS funds which have been lost through fraud, corruption and/or bribery.	
	Identify and maintain a record of the actual proven amount of loss to HEIW so that appropriate recovery procedures can be actioned. To ensure that HEIW has a procedure in place to recover money.	

STRATEGIC GOVERNANCE		
Number of allocated days for Strategic Governance (5)	**Recommended task / objective**	**Outcome and Impact**
Ensuring that anti crime measures are embedded at all levels across the organisation	Attendance at all LCFS meetings held by NHS CFS (Wales).	
	Completion and agreement of Work-Plan with Director of Finance.	
	Regular meetings/liaison with Director of Finance are held	
	That HEIW reports annually on the anti fraud, bribery, and corruption work carried out and details corrective action if standards have not been met.	
	Takes active part in the collation and preparation of the hosted body's, Velindre NHS Trust, Quality Assurance programme and Self Risk Assessment Tool.	
	Preparation for and attendance at HEIW Audit Committee meetings. (including providing regular progress reports)	
	Undertake additional related training as required by NHS CFS (Wales) and/or NHS Counter Fraud Authority. The HEIW ensures that there are effective lines of communication and reporting between those responsible for anti-fraud, bribery, and corruption work, and key operational staff and management The HEIW demonstrates proactive support and direction for the anti-fraud, bribery, and corruption work	

	The HEIW has at least one or more qualified and accredited LCFS to undertake the full range of anti-fraud bribery and corruption work, and there are sufficient resources in place to allow this work to be fully supported.	
	Conduct a risk assessment on overall counter fraud bribery and corruption arrangements in place. Any identified risks are translated into HEIW's work plan.	

Appendix 1

Number of Days agreed with Health Education Improvement Wales (HEIW) Finance Director for the 2020/21 Financial Year is 50 days.

Agreed/signed by

Signature: **Date:**

EIFION WILLIAMS
Director of Finance - HEIW

Signature: **Date:**

CRAIG GREENSTOCK
Counter Fraud Manager - Cardiff and Vale University Health Board

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**		**Eitem ar yr Agenda**	**2.2**
Teitl yr Adroddiad	**Adroddiad ar Gynnydd yr Archwiliad Mewnol**			
Awdur yr Adroddiad	Archwiliad Mewnol			
Noddwr yr Adroddiad	Pennaeth yr Archwiliad Mewnol			
Cyflwynwyd gan	Archwiliad Mewnol			
Rhyddid Gwybodaeth	Agored			
Pwrpas yr Adroddiad	Rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Sicrwydd ar weithgarwch yr Archwiliad Mewnol ar gyfer 2019/2020			
Materion Allweddol	Diweddariad ar weithgarwch yr Archwiliad Mewnol yn erbyn Cynllun Archwilio 2019/20			
Cam Penodol i'w Gymryd *(un ✓ yn unig)*	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
	✓			
Argymhellion	Amh.			

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol *(rhowch ✓)*	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad Cleifion
Amh.
Goblygiadau Ariannol
Amh.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Amh.
Goblygiadau Staffio
Amh.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Amh.

Hanes yr Adroddiad	Amh.
Atodiadau	Atodiad 1 – Adroddiad ar Gynnydd yr Archwiliad Mewnol Atodiad 2 – Adroddiad yr Archwiliad Mewnol ar Reoli Risg Atodiad 3 – Adroddiad yr Archwiliad Mewnol ar Gynllunio'r IMTP Atodiad 4 – Adroddiad yr Archwiliad Mewnol ar Reoli Perfformiad Atodiad 5 – Adroddiad yr Archwiliad Mewnol ar Reolaeth Ariannol Graidd

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

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

Health Education and Improvement Wales

INTERNAL AUDIT PROGRESS REPORT

Audit and Assurance Committee - March 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents

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 20 March 2020.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the 2019/20 programme of work, and any required updates.

2. Outcomes from completed audit reviews

2.1 Since the January meeting of the committee four reports have been finalised and one has been issued in draft relating to the 2019/20 programme of work.

Assignments 2019/20	Assurance rating
Risk management	Reasonable
IMTP planning	Substantial
Performance management	Reasonable
Core financial systems	Reasonable
Data protection – GDPR (Draft)	Reasonable

3 Delivery of 2019/20 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.

4 Planning for 2020/21 Internal Audit plan

4.1 We have met with officers and include our plan in the papers for the March Audit and Assurance Committee.

Table 1: Status of 2019/20 reviews to be reported to Audit and Assurance Committee

Assignment	Indicative audit days	Status	Assurance	Timing	Notes
Workforce review (Values and Behaviours Framework)	10	Final	Reasonable	Q1	Reported in July 2019
Health & Safety	10	Final	Reasonable	Q1	Reported in July 2019
Board and Committee - Governance arrangements	10	Final	Substantial	Q2	Reported in November 2019
Freedom of Information (FoI)	5	Final	Reasonable	Q2	Reported in November 2019
Casual workers employment status – follow up	5	Final	Reasonable	October	Reported in November 2019
Risk management	10	Final	Reasonable	Q3	Findings and recommendations report issued 23 December and full report issued 9 January
IMTP planning	15	Final	Substantial	Q3	Draft report issued 05.03.20 and final report issued 09.03.20
Performance management	10	Final	Reasonable	Q3	Reported in March 2020

Assignment	Indicative audit days	Status	Assurance	Timing	Notes
Core Financial Systems	15	Final	Reasonable	Q3	-
Data Protection (GDPR)	5	Draft	Reasonable	Q4	Draft report issued 26.02.20
Service review – Medical training commissioning	10	WIP	-	Q4	Start was delayed due to change of focus during scoping. Fieldwork ongoing.
IT/digital review	15	WIP	-	Q4	HEIW requested to delay until Q4. Review considers our baseline report and HEIW developments. Fieldwork is ongoing.
Workforce strategy review	10	Defer	-	Q4	Propose to not take this forward. Strategy remains in draft with Welsh Government. Link HEIW strategic planning considered as part of our IMTP review.

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)

Risk Management

Internal Audit Report

HEIW 2019/20

March 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	HEIW-1920-02
Report status:	Final Report
Fieldwork commencement:	17 October 2019
Fieldwork completion:	19 December 2019
Draft report issued:	23 December 2019, 9 January 2020, & 11 March 2020
Management response received:	13 March 2020
Final report issued:	16 March 2020
Auditors:	Stuart Bodman, Principal Auditor Ken Hughes, Audit Manager
Executive sign off:	Dafydd Bebb, Board Secretary
Distribution:	Julie Rogers, Deputy Chief Executive / Director of Workforce and OD Push Mangat, Medical Director Stephen Griffiths, Nursing Director Eifion Williams, Interim Director of Finance
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 2019/20 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation') a review of risk management was undertaken. The review sought to provide assurance to the HEIW Audit and Assurance Committee that there are effective processes in place to manage the organisation's risks.

The Institute of Internal Auditors International Standards define a risk as 'the possibility of an event occurring that will have an impact on the achievement of objectives. Risk is measured in terms of impact and likelihood'. For most organisations, risk management covers the positive and negative aspects of risk. So as well as managing things that could have an adverse impact on the organisation, effective risk management also looks at the potential benefits that can arise as a result of accepting a pre-determined level of risk.

HEIW became operational in October 2018, and brought together three key organisations for health: the Wales Deanery; NHS Wales's Workforce and Development Services (WEDS); and the Wales Centre for Pharmacy Professional Education (WCPPE). During 2018/19 the organisation maintained a risk register that captured inherited risks from the legacy organisations, and also risks identified relating to the newly formed HEIW.

The Board of HEIW approved the organisation's risk management policy in July 2019.

The relevant lead for the review is the Board Secretary.

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 risk management arrangements. The review sought to provide assurance to the Audit and Assurance Committee that risks material to the system’s objectives are managed appropriately.

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

- HEIW’s risk management policy is appropriately complete, giving consideration to key elements of risk management.
- Supporting polices have been developed, or there is a clear and reasonable timetable for their development.
- The organisation has a comprehensive plan in place for the development and implementation of its approach to risk management.
- Reasonable progress has been made towards the development of a Board Assurance Framework (BAF) including:
    - The proposed BAF provides reference to the organisation’s strategic objectives.

  - The BAF has been incorporated into the organisation's risk management policies and processes.
  - The BAF contains sufficient fields and appropriate content, including sources of assurance and Committees charged with scrutiny, to provide robust assurance once implemented.
  - The process of drafting the BAF has engaged Executive Directors.
  - The progress of developing the Board Assurance Framework has been reported appropriately at Board level.
- Training has been delivered, or there is a clear plan to deliver training to appropriate officers as identified in the risk management policy.
- Risk appetite has been developed in line with HEIW's risk management policy.
- Strategic risks, as identified in the annual plan, have been captured and are appropriately monitored.
- The corporate and directorate risk registers are in place that capture and escalate risk appropriately. These risk registers have been aligned to the risk management policy, with risks assessed in line with the risk appetite, and appropriate mitigating actions and controls recorded against risks.
- Risk is actively monitored and scrutinised by an appropriate committee and at an appropriate level within the organisation.

At the January 2020 Audit and Assurance Committee, Wales Audit Office (WAO) reported the findings from their Structured Assessment 2019. The findings in our report should be considered alongside the recommendations made by WAO.

3. Associated Risks

The potential risks considered in the review were as follows:

- Risk becomes an issue as risks are not managed in line with the approved policy.
- Risk becomes an issue as staff are unaware of the process for managing them.
- Risks to the achievement of the organisation's objectives are not effectively managed.

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 established controls over risk management 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 previous review of risk management within the organisation was concluded in May 2019 and at that time a transitional risk register was in in place. In the six months following that review, we note that reasonable progress has been made in the introduction of a risk management structure which is supported by a formal Risk Management policy and procedures. There was evidence of implementation of the policy at corporate level, and across all four directorates, with alignment to the Board Assurance Framework (BAF). In recent months, work to better define the organisations risk appetite has taken place, with formal Board approval being sought in January 2020.

The organisation is still developing and legacy practices from the three constituent organisations may still be in place. As such, there are areas for improvement to ensure that a risk management system continues to evolve and embed throughout the organisation.

The areas that require management attention and action relate to:

- The relationship between the directorate risk registers and the corporate risk register. At the current time the directorate registers are standalone with no process in place to ensure that risks are escalated or de-escalated as necessary.
- Minimal uptake of risk management training offered to middle and line management.

- Whilst there are risk registers in place for the Nursing Directorate and Medical Directorate, there are no overarching directorate risk registers in place for the Finance or Workforce and Organisational Development Directorates. Similarly there are no departmental registers in place for the Global Engagement and SAS Deanery departments within the Medical Directorate, yet other departments within this directorate do retain registers.
- The Risk Management Policy is silent on the need for department risk registers, though does refer to directorate risk registers. As such there is inconsistency across the organisation.
- Risk registers that are in place vary in format, and we saw instances where risk mitigation action plans were not supported by a risk owner, and did not have a progress timescale for completion.

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	Risk management policy			✓	
2	Supporting policies				✓
3	Agreed development & implementation of risk management				✓
4	Board Assurance Framework			✓	
5	Risk management training			✓	
6	Risk appetite				✓
7	Annual plan strategic risks				✓
8	Capture and escalation of risks through corporate & directorate risk registers			✓	
9	Committee risk management monitoring			✓	

** 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 three issues that are classified as weaknesses in the system control/design for risk management.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for risk management.

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: HEIW's risk management policy is appropriately complete, giving consideration to key elements of risk management.

We note the following area of good practice:

- The risk management policy states the key requirements that underpin the delivery of risk management within the organisation and expectations to identify and mitigate risks where identified.

We identified the following findings:

- The risk management policy does not identify the process for escalating risks between directorate risk registers and the corporate risk register. The policy is also silent on the risk scoring mechanism to be used across the organisation, although this is included as an appendix to the corporate risk register.
- The Datix risk management database is cited within the risk management policy as the means by which risks will be recorded and managed, but currently no directorates are using the system, instead a mixture of spreadsheets and word documents are used.

Objective 2: Supporting policies have been developed, or there is a clear and reasonable timetable for their development.

We note the following area of good practice:

- The supporting policies cited within the risk management policy (Business Continuity Risk Policy, Information Risk Policy, Health & Safety Policy) are in place, current and are accessible to staff via the HEIW intranet site.

We did not identify any findings under this objective.

Objective 3: The organisation has a comprehensive plan in place for the development and implementation of its approach to risk management.

We note the following areas of good practice:

- The Annual Plan for 2019/20 outlines the approach for the creation of the new risk management processes to be undertaken in the

organisation such as the need for Board development sessions and training. It also cites the key strategic risks to the organisation.

- The Audit and Assurance Committee was regularly briefed by the Chief Executive and Board Secretary in respect of the development of the corporate risk register.

We did not identify any findings under this objective.

Objective 4: The Board Assurance Framework includes strategic objectives, risk management policies & procedures, assurance groups and reporting arrangements.

We note the following areas of good practice:

- The Board Assurance Framework (BAF) approved by the HEIW Board in September 2019 clearly references the organisation's strategic objectives.
- The BAF clearly states its sources of assurance and committees charged with scrutiny, to provide assurance once implemented.
- The Executive Directors were engaged with the drafting of the BAF.
- The BAF is subject to regular and formal progress updates provided to the Board by the Board Secretary.

We identified the following finding:

- The Business Continuity Policy, Health and Safety Policy and Information Governance Policy do not cite the Board Assurance Framework strategic objectives.

Objective 5: Training has been delivered, or there is a clear plan to deliver training to appropriate officers as identified in the risk management policy.

We note the following area of good practice:

- Risk management training has been provided to the Executive Team by an external training provider as part of a Board Development session in February 2019.

We identified the following findings:

- Our discussions with four directorate leads (Medical, Nursing, Workforce and Organisational Development and Planning, Performance & Digital) identified that training had not yet been fully cascaded down to either line management or departmental staff.

  At the time of the audit, only 17 of the 81 line managers identified as requiring risk management training had attended the training sessions run during December 2019.

Objective 6: Risk appetite has been developed in line with HEIW's risk management policy.

We note the following area of good practice:

- The risk appetite and tolerance levels for a series of risk areas has been documented and was presented to the Board at a development session in December 2019.

We did not identify any findings under this objective.

Objective 7: Strategic risks, as identified in the annual plan, have been captured and are appropriately monitored.

We note the following area of good practice:

- Strategic risks identified in the Annual Plan are formally scored, recorded within the corporate risk register and are subject to regular monitoring by both the Board and the Audit & Assurance Committee.

We did not identify any findings under this objective.

Objective 8: Corporate and directorate risk registers are in place that capture and escalate risk appropriately.

We note the following area of good practice:

- There is a corporate risk register in place along with two directorate risk registers and several departmental risk registers.

We identified the following findings:

- We could not evidence the escalation or de-escalation of risks between department, directorate and the corporate risks register. As stated, there is no guidance within the Risk Management Policy in relation to this.

  <u>Corporate risk register:</u>

- Not all risks were clearly assigned to a member of the Executive Team and the cause and effect of each risk and the risk mitigation strategy for each risk was not clearly documented.
- The risk register contains a number of low scoring risks as risks relating to the finance department are included as they do not hold their own register.

  <u>Directorate / Departmental risk registers:</u>

- There is no register for the Global Engagement and SAS Deanery departments within the Medical Directorate, yet other departments within this directorate do retain risk registers.
- Not all risk mitigation action plans recorded on the risk registers that we reviewed were supported by a named risk owner, nor was there a progress implementation timescale for completion or mitigation of the risk.

- There is no standardised risk register template in use across the organisation.

Objective 9: Risk is actively monitored and scrutinised by an appropriate committee and at an appropriate level within the organisation.

We note the following area of good practice:

- Review and discussion of the corporate risk register is a standing agenda item at each Audit & Assurance Committee meeting.

While we did not identify any findings under this objective, issues identified in findings 1 and 3 of Appendix A relate to this objective. These have been discussed above and relate to the escalation of risks to the corporate risk register.

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	**1**	**3**	**1**	**5**

Finding 1 - Directorate risk registers (Operating effectiveness)	Risk
The Risk Management Policy states that Datix risk management system is the means by which risks and any mitigating actions should be recorded. We were informed by the Board Secretary, that following a review of the Datix system, it has been deemed unsuitable for the organisation's needs and is not going to be used to record risks. As an alternative a mix of 'Excel' spreadsheets and tables in 'Word' documents are being used. Our review of the risk registers for the four directorates within the organisation identified that there is no consistent template in use. Whilst all were similar in nature, there were variations. We also identified the following: **Finance, Corporate Services, Digital & IT Directorate** • While there is no directorate wide risk register in place, the Digital department and Health & Safety department have risk registers. However, some of the mitigating actions on the registers are not supported by implementation or completion timescales. None of the risks on both Digital department and Health & Safety department risk registers state a risk owner or person responsible to ensure the actions recorded are implemented. • The risks relating to the finance department are included directly onto the corporate risk register.	Risk is actively monitored and scrutinised by an appropriate committee and at an appropriate level within the organisation.

Medical Directorate • Our review of this directorate's risk register identified a risk scoring '20' that related to the recruitment and retention of junior doctors. This risk has not be escalated to the corporate risk register even though its score is higher than some risks recorded on the corporate risk register. • The Medical Directorate risk register and the Dental and Revalidation Support Unit (RSU) departmental risk register were titled 'HEIW Corporate Transitional Risk Register' and as such implies that the original HEIW corporate transitional risk register has been split up to form these risk registers. • Whilst the respective Medical, Pharmacy, Dental and RSU risk registers are current, some of the mitigating actions stated on each are not supported by implementation or completion timescales. For example, risk 9 'Quality Management' on the Medical Directorate register has not been scored, has not been assigned to anyone, and has no progress update. Furthermore, as some of the progress sections within each risk register are empty, it is unclear whether there are any transitional risks still in place that need addressing, whether the transitional risks have been updated, or if any new risks have been identified and added. • There is currently no risk register in place for the Global Engagement and SAS Deanery departments within this directorate. **Nursing Directorate** • Our review of the directorate risk register identified that whilst it is current, appropriately completed and states risk ownership for each stated risk, the	

sections on risk mitigation could be more detailed with regards to the actions to be taken, and the timescales for implementation of each action. **Workforce and Organisational Development Directorate** • While there is no directorate risk register in place, the four departments that make up the directorate have either departmental or programme risk registers in place. Higher scoring risks are escalated to the corporate risk register. Some of the mitigating actions on the registers are not supported by implementation or completion timescales. • None of the risks on any of the department risk registers state a risk owner or person responsible to ensure the actions recorded are implemented. However, this information is recorded on the risk register /log for Leadership Steering Group.	
Recommendation	**Priority level**
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. 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. 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.	**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. 5. The Medical Directorate risk register and the RSU & Dental risk register should be renamed to reflect their current usage.	
Management Response	**Responsible Officer/ Deadline**
1. Risk Management Policy to be updated to confirm process for escalating risks from a directorate risk register to the corporate risk register. 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.	Board Secretary July Board
2. HEIW Risk Registers to be standardised. Standardised documentation to include guidance on identifying risk owners and deadlines for mitigation action.	Board Secretary July Board
3. Standardised template to be introduced for Risk Register in line with the new IMTP.	Board Secretary – April
4. The Medical Directorate risk register and the RSU & Dental risk register has been renamed in accordance with the recommendation.	Medical Director – Completed

Finding 2 - Risk management training (Operating effectiveness)	Risk
In February 2019 a Board development session took place where risk management training was provided to the Executive Team by an external training provider, Amberwing. We note that risk management training has been offered to 81 managers via a series of in-house training sessions scheduled to be delivered between December 2019 and February 2020. However, the first planned session was cancelled due to lack of numbers. At the time of our fieldwork, two training sessions had been delivered and only 17 of the 81 managers identified as requiring the training had received it. Given the fact that the organisation is still relatively new and many of the current staff will have transferred from three different organisations, the need for training to ensure a consistent approach to risk management across the organisation is key. An email was sent to all relevant managers in early January reminding them that participation in the training sessions is mandatory and requesting them to enrol on a forthcoming course.	Risk becomes an issue as staff are unaware of the process for managing them.

Recommendation	Priority level
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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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.	Board Secretary April 2020

Finding 3 - Risk management policy (Control design)	Risk
The HEIW Risk Management policy states the key processes to be used to underpin the delivery of risk management within the organisation. Our review of the policy identified that: • Although the risk scoring mechanism is included as an appendix to the corporate risk register, there is no cross reference to it in the risk management policy and as such, how risks should be scored to ensure consistency across the organisation. • The corporate risk register is the register taken to Board and its committees. If a risk is not included on this register, members may not be sighted on key risks that they would expect to monitor. However, the policy does not provide guidance on the process for the escalation of risks from directorate risks registers to the corporate risk register. For example, if there is a risk score above which directorate risks should be considered for inclusion on the corporate risk register. • We note that some departments maintain their own risk registers that feed into a directorate register. However, the Risk Management Policy is silent on the need for department risk registers. Reference is made in the policy to directorate risk registers, though our testing has identified that registers are not consistently in place across the organisation.	Risk becomes an issue as risks are not managed in line with the approved policy.

Recommendation	Priority level
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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The HEIW Risk Management Policy to be updated to include each recommendation. The amended policy will need Board approval.	Board Secretary July 2020 Board.

Finding 4 - Corporate risk register (Control design)	Risk
Our review of the corporate risk register at the time of the audit fieldwork identified a number of areas for development and improvement: • Two of the current risks (25 and 29) had not been assigned to a member of the Executive Team as the risk owner. • Where recorded, risk owners were identified only by their initials, which was recorded within the risk description field. • The risk mitigation strategy for each risk was not recorded (Treat, Transfer, Tolerate or Terminate). • The risk register currently has a large number of recorded risks (29). Eighteen of the 29 risks had a residual risk score of 10 or below. In contrast a number of risks recorded on the directorate risk registers had higher scores, but had not been considered for inclusion on the corporate risk register. There is no clear process in place for escalation or de-escalation of risks between departmental and directorate risk registers and the corporate risk register.	Risk is actively monitored and scrutinised by an appropriate committee and at an appropriate level within the organisation.
Recommendation	**Priority level**
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	**Medium**

appetite. For example, this could be achieved by only reporting risks with a residual risk score of say 11 and above. 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.	
Management Response	**Responsible Officer/ Deadline**
1. 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. 2. 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.	July Board Board Secretary Completed Board Secretary

Finding 5 - Alignment of BAF strategic objectives and supporting risk management policies (Control design)	Risk
We note that Pages 2 and 4 of the Risk Management Policy cite the use of the Board Assurance Framework as a tool for the scrutiny of corporate risks and organisational strategic objectives. However, none of the three supporting policies as cited in the Risk Management Policy include, or reference their connection to the Board Assurance Framework's strategic objectives.	Risks to the achievement of the organisation's objectives are not effectively managed.
Recommendation	**Priority level**
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.	**Low**
Management Response	**Responsible Officer/ Deadline**
Business Continuity Policy, Health and Safety Policy and Information Governance Policy to be amended to include relevant contents of the BAF.	Board Secretary May 2020

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.

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)

Strategic planning - IMTP

Final Internal Audit Report

HEIW 2019/20

March 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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

ACKNOWLEDGEMENT
NHS Wales Audit 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 Committee.

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1. Introduction and Background

In line with the 2019/20 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation') a review of the strategic planning approach to the development of HEIW's Integrated Medium Term Plan (IMTP) was undertaken. The review sought to provide assurance to the Audit and Assurance Committee that there are effective processes in place to manage the risks associated the planning of the 2020/23 IMTP.

Since its formation in October 2018, HEIW has been required to produce an Annual Plan setting out its strategic objectives, and a programme of work for the year designed to achieve those objectives. The 2019/20 Annual Plan was approved by both the Board and Welsh Government. From April 2020 the organisation has a statutory duty to operate within the bounds of a Welsh Government approved three year IMTP, the first covering the period 2020 - 2023. This will bring the organisation in line with all of the other Health Bodies in Wales.

Reviewed annually, the NHS Planning Framework provides specific guidance and sets out the core content expected within an organisation's IMTP. The IMTP is the key planning document for the organisation that sets out the milestones and actions they are taking and the expected outcomes, in order to achieve their strategic objectives. Our audit focused on the process for developing HEIWs first IMTP.

The relevant leads for the review are the Deputy Chief Executive / Director of Workforce and OD and the Chief Executive.

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 strategic planning arrangements. The review sought to provide assurance to the Audit and Assurance Committee that risks material the system's objectives are managed appropriately.

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

- There are clear corporate governance arrangements in place to oversee and scrutinise the IMTP and its development.
- The development of the IMTP is appropriately aligned to Welsh Government's expectations as set out in the NHS Wales Planning Framework.
- The development of the IMTP has taken into consideration other key strategic documents such as the Workforce Strategy for Health and Social Care.
- The IMTP picks up themes identified in the 2019/20 Annual Plan, and incorporates existing projects and programmes of work.
- The organisation has actively engaged with external NHS partners to ensure alignment with relevant Health Board and Trust IMTPs.

- There has been engagement with relevant internal stakeholders in developing the IMTP including ensuring the directorate processes such as job planning and performance appraisals are aligned to supporting the achievement of the IMTP.

3. Associated Risks

The potential risks considered in the review were as follows:

- The organisation does not deliver its strategic objectives as appropriate priorities and deliverables are not set in the IMTP.
- The IMTP is not approved by the Welsh Government within set timeframes.
- Strategic objectives within IMTP are not delivered as key stakeholders have not been engaged to help support delivery.

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 strategic planning for the IMTP is Substantial Assurance.

RATING	INDICATOR	DEFINITION
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.

Our review of the IMTP development process found that the plan has been subject to regular review and approval from both the Executive Team and the Board. There has also been regular formal and informal meetings with the Welsh Government (WG) throughout the development process, and this resulted in formal WG feedback in November 2019 and January 2020.

The draft IMTP was approved by the Board at the end of January 2020 and was and submitted to Welsh Government by the 31 January deadline. Our

review confirmed that the draft IMTP has been developed in line with the NHS Wales Planning Framework 2020-23. It has also taken into consideration the NHS Wales National IMTP 2019-2022, and other key strategic documents including the Workforce Strategy for Health and Social Care. Where appropriate, themes and work programmes from the 2019/20 annual Plan had also been incorporated into the plan. There was good evidence that the plan has been developed with input from internal stakeholders including the Senior Leadership Team, and engagement with external stakeholders was undertaken via two large stakeholder events held in North and South Wales respectively.

Whilst a number of queries were raised and discussed with the Planning Team during the course of our review, no findings have been identified. We are therefore pleased to report that no recommendations have been raised on this occasion.

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	Corporate governance arrangements				✓
2	Aligned to NHS Wales Planning Framework				✓
3	Links to other key strategic documents				✓
4	2019/20 Annual Plan themes				✓
5	Engagement with external NHS partners				✓
6	Engagement with internal stakeholders				✓

** 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 no issues that are classified as weaknesses in the system control / design.

Operation of System/Controls

The findings from the review have highlighted no issues that is classified as weaknesses in the operation of the designed system / control.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise any findings made during our audit fieldwork.

Objective 1: There are clear corporate governance arrangements in place to oversee and scrutinise the IMTP and its development.

We note the following area of good practice:

- The development of the IMTP has been overseen, scrutinised and regularly approved by the Senior Leadership Team and the Board.

We did not identify and findings under this objective.

Objective 2: The development of the IMTP is appropriately aligned to Welsh Government expectations as set out in the NHS Wales Planning Framework.

We note the following area of good practice:

- The final draft of the HEIW IMTP 2020-23 was appropriately aligned to Welsh Government expectations as set out in the NHS Wales Planning Framework.

We did not identify any findings under this objective.

Objective 3: The development of the IMTP has taken into consideration other key strategic documents such as the Workforce Strategy for Health and Social Care.

We note the following area of good practice:

- The development of the IMTP has taken into consideration key strategic documents including the 19/20 HEIW Annual Plan.

We did not identify any findings under this objective.

Objective 4: The IMTP picks up themes identified in the 2019/20 Annual Plan, and incorporates existing projects and programmes of work.

We note the following area of good practice:

- The IMTP contained a number of projects and work programmes that stemmed from the work included in the 2019/20 Annual Plan.

We did not identify any findings under this objective.

Objective 5: The organisation has actively engaged with external NHS partners to ensure alignment with relevant Health Board and Trust IMTPs.

We note the following area of good practice:

- Engagement with a wide range external NHS Partners was undertaken via two stakeholder events undertaken in North and South Wales respectively.
- Further engagement with other Welsh Health Boards and Trusts was undertaken on an individual basis.

We did not identify any findings under this objective.

Objective 6: There has been engagement with relevant internal stake holders in developing the IMTP including ensuring the directorate processes such as job planning and performance appraisals are aligned to supporting the achievement of the IMTP.

We note the following areas of good practice:

- There was evidence of regular engagement with relevant internal stakeholders during the development of the IMTP.

We did not identify any findings under this objective.

Appendix A - 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.

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 & Improvement Wales

Performance Management

Final Internal Audit Report

2019/20

March 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditors:	Ken Hughes - Audit Manager Adam Davies - Auditor
Executive sign off:	Alex Howells, Chief Executive
Distribution:	Dafydd Bebb, Board Secretary Chris Payne, Deputy Director, Planning, Performance & Digital
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:

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1. Introduction and Background

In line with the 2019/20 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation') a review of performance management was undertaken. The review sought to provide assurance to the HEIW Audit and Assurance Committee that there were effective processes in place to manage performance risks.

Performance management can be described as the process of ensuring that activities and outputs meet an organisation's goals in an effective and efficient manner. Performance management can focus on the performance of an organisation, a department, an employee, or the processes in place to manage particular tasks.

HEIW was created from three key organisations for health and became operational in October 2018. Our initial review of performance management, undertaken in March 2019, focused on the performance management measures and indicators that were inherited from each of the three legacy organisations. However, a performance management framework is being developed for the new organisation as a whole. The key features to date are the formation of a Performance Management Group and introduction of a KPI dashboard report. Therefore, our audit will focus on the development and implementation of the new performance management framework.

The relevant lead for the review was the Chief Executive.

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 performance management arrangements. 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:

- Performance measures from the three legacy organisations have been reviewed and where deemed appropriate incorporated into the new performance framework.
- There has been input to the development of the performance framework and dashboard from the Board and members of the Executive Team.
- The performance measures set are Specific, Measurable, Achievable, Realistic and Time-bound (SMART).
- Responsibility for each performance measure included in the new performance framework has been specifically assigned to an executive lead and responsible officer.

- There are clear processes in place to capture and validate the data required to produce performance information, whilst maintaining its integrity.
- Individual staff, department and directorate objectives, performance measures and indicators are aligned with those of the organisation.
- Performance is monitored at individual staff and department / directorate level as well as organisational level with appropriate reporting.

3. Associated Risks

The potential risks considered in the review were as follows:

- Failure to achieve objectives due to limited monitoring and reporting of performance information.
- Poor decisions made by the Executive Team as a result of receiving inaccurate performance data.

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 performance management 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.

HEIW set 31 March 2020 as a target date to introduce an integrated Performance Management Framework. Given the unique and specialist nature of organisational activities, the need to forge together the three legacy organisations, as well as the resource demands placed on the organisation, the timescale is demanding and is unlikely to be met.

We identified that the following major building blocks of a performance management system are in place and being further developed, namely:

- A Performance Management Group charged with responsibility for designing and developing the Performance Management Framework architecture over the next few years.
- A KPI dashboard report that has been reported to the Board.
- A Data Glossary to define and validate KPI data.

However, in order to capitalise on these elements, the next key step, which will require the full input of the Board, is to establish a formal Performance Management Framework within which HEIW can drive forward its performance management function.

It should be noted that the Wales Audit Office reviewed performance management in their Structured Assessment 2019 that was reported in

January 2020. The findings from that assessment were substantially in line with those contained within this report.

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	Allocation of legacy performance measures			✓	
2	Board and Executive Team input to the performance framework and dashboard			✓	
3	The performance measures set are SMART				✓
4	Responsibility for performance measures has been assigned		✓		
5	Capture and validation of performance information data				✓
6	Staff, department and directorate objectives, performance measures and indicators are aligned with those of the organisation			✓	
7	Performance monitoring			✓	

** 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 four issues that are classified as a weakness in the system control / design.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as a weakness in the operation of the designed system / control.

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: Performance measures transferred from the previous organisations have been appropriately allocated to responsible officers within the organisation.

We note the following areas of good practice:

- Those performance measures transferred from the legacy organisations' had been allocated to relevant responsible officers within the organisation, and these were recorded on the Consolidated Plan 2018/19 Performance Report.
- The key elements of the 2018/19 Consolidated Plan were carried forward to create the initial KPI dashboard.

We identified the following finding:

- In compiling the dashboard reports the performance measures in the Consolidated Plan had not been formally debriefed to ensure all relevant KPIs or metrics were captured. (Finding 5 - Medium)

Objective 2: There has been input to the development of the performance framework and dashboard from the Board and members of the Executive Team.

We note the following area of good practice:

- Board and Independent Members have had early engagement in developing and assessing the KPI dashboard report.

We identified the following finding:

- There was no evidence of the Board having any further input to the development of the performance framework or dashboard. (Finding 2 - Medium)

Objective 3: The performance measures set are Specific, Measurable, Achievable, Realistic and Time-bound (SMART).

We note the following area of good practice:

- The KPIs that we assessed did fit SMART criteria definitions. The compilation of the Data Glossary should assist in providing further rigour to performance measures.

We identified the following finding:

- Whilst the KPIs set were SMART, the range of 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 the associated 'Attrition Rate' would add an extra dimension to the management decision-making process. (Finding 6 - Low)

Objective 4: Responsibility for each performance measure included in the new performance framework has been specifically assigned to an executive lead and responsible officer.

We note the following area of good practice:

- Operationally, KPI data owners and teams are identified, are represented in the Performance Management Group, and are responsible for compilation of their element of the Data Glossary.

We identified the following finding:

- A Performance Management Framework needs to be developed to define and formalise the current performance management approach within HEIW. (Finding 1 - High)

Objective 5: There are clear processes in place to capture and validate the data required to produce performance information, whilst maintaining its integrity.

We note the following areas of good practice:

- Data validation is being built into the compilation of the Data Glossary, which is a component of the dashboard KPI system. We understand that this will ensure a standardised approach to data collection and reporting.
- Teams and sections have a range of quality procedures that inform the KPI production.
- Our testing of a sample of KPIs to source systems indicated that core data was validated. We note though that many of the databases used are live systems and so retrospective timing differences arise.

We identified the following finding:

- We were informed that whilst data validation by the Workforce and Data Analytics Team would be incorporated into the process of compiling the Data Glossary, data will not be subject to operational validation. (Finding 7 - Low)

Objective 6: Individual staff, department and directorate objectives, performance measures and indicators are aligned with those of the organisation.

We note the following area of good practice:

- Our testing evidenced the link between team targets and KPIs.

We identified the following finding:

- Organisational projects did not have any associated KPIs or additional metrics. (Finding 3 - Medium)

Objective 7: Performance is monitored at individual staff and department / directorate level as well as organisational level with appropriate reporting.

We note the following area of good practice:

- The staff appraisal system is being developed and used to monitor performance at individual staff level. Appraisal compliance is one of the KPIs reported via the performance dashboard.

We identified the following finding:

- Reporting via the dashboard could be improved by developing KPIs for additional areas such as finance, and by including targets and comparisons against previous quarter's data. (Finding 4 - Medium)

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	**1**	**4**	**2**	**7**

Finding 1 - Performance Management Framework (Control Design)	Risk
The key building blocks of a performance management framework are in place. These include a Performance Management Group, dashboard reporting and a Data Glossary, (which outlines the sources of data for each performance measure). Both the dashboard and glossary remain under constant review and update, with the glossary still being in its infancy. However there is no over-arching Performance Management Framework to define what the organisation is aiming to achieve though its performance management process, and how it will orchestrate a robust corporate approach to performance management and improvement. The lack of a framework means the executive leads, and therefore the lines of ownership and reporting of KPIs, are not clearly recorded. We recognise that the reporting lines are often implicit, but the need to define these is essential to achieve a robust Performance Management Framework. Currently, the challenge for performance management is to interface more with improvement and quality agendas across organisations and sectors. Such an approach would augment the KPIs being used primarily as an organisational monitoring tool. As HEIW works with, and reports to, a range of stakeholders, it would be useful to assess and integrate the reporting lines as part of the Performance Management Framework.	Performance management arrangements are not optimised and subject to scrutiny.

Recommendation 1	Priority level
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 further advanced in developing a Performance Management Framework could be contacted.	**High**
Management Response	**Responsible Officer/ Deadline**
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.	Deputy Director Planning, Performance & Digital / End April 2020

Finding 2 - Board involvement (Operating effectiveness)	Risk
In April 2019 a Board development session was held to discuss the development of the Performance Management Framework and dashboard. At a similar time, individual input was also obtained from one Independent Member. Quarter 1 and 2 dashboards were reported to Board. Following the September Board meeting comments and queries were fed back by an Independent Member to the Performance Manager. However, we have not seen any evidence of further input from the Board to the development of the dashboard through another Board development session or similar event.	Performance management arrangements are not optimised and subject to scrutiny.
Recommendation 2	**Priority level**
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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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.	Deputy Director Planning, Performance & Digital / Sept 2020

Finding 3 - KPI reporting (Control Design)	Risk
Within the performance management dashboard the various projects and work programmes for each strategic objective are identified and progress updates are provided. The dashboard also contains a number of KPIs, but at the current time there is no clear link between the reported KPIs and the projects and work programmes being undertaken to achieve the strategic objectives. Our review identified that several of the KPIs could be linked through to the team workloads and via projects to strategic objectives. For example, Objective 3 - *Social Care Wales - shaping the workforce*, could be linked to the KPI on GP Fill Rates. We recognise that there does not necessarily have to be such a link, for example, there appear to be no associated KPIs for Objective 2 - Building a Sustainable and Flexible Health Care Workforce.	Dashboard Reports do not facilitate scrutiny of all organisational activities and performance.
Recommendation 3	**Priority level**
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.	**Medium**

Management Response	Responsible Officer/ Deadline
Following approval of our IMTP, where feasible and through iterations of the report and dashboard, we will look to incorporate this recommendation where possible.	Deputy Director Planning, Performance & Digital / June 2020

Finding 4 - Dashboard reporting (Control Design)	Risk
From our review we consider there are a number of areas where the dashboard could be further developed and improved. For example by including activity on financial indicators. We also note that whilst KPI performance is reported, for most of the KPI's no target data is included, making it difficult to interpret the performance. Furthermore, the quarter two report does not make comparisons to the previous quarter's KPI to allow trends to be identified and monitored.	Dashboard reports are not accurate or complete.
Recommendation 4	**Priority level**
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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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	Deputy Director Planning, Performance & Digital / June 2020

iterations.	

Finding 5 - Legacy organisations (Control Design)	Risk
Performance measures transferred from the legacy organisations have been allocated to relevant responsible officers within the organisation. These were recorded on the Consolidated Plan 2018/19 performance report. Our review identified that key measures, such as those relating to 'Fill Rates' for various professions have been taken forward in to the dashboard. However, there has not been a formal process to ensure that all the measures from the Consolidated Plan have been brought forward into the dashboard and Data Glossary where still relevant. We recognise that not all three of the legacy organisations' previously formally reported KPIs will be relevant, and that in establishing its own Performance Management Framework, HEIW is establishing its own specific performance criteria.	Not all relevant KPI's and metrics are captured.
Recommendation 5	**Priority level**
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.	**Medium**

Management Response	Responsible Officer/ Deadline
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.	Deputy Director Planning, Performance & Digital / June 2020

Finding 6 - SMART KPIs (Operating Effectiveness)	Risk
We reviewed and discussed the KPIs in the newly formulated Quarter 1 and Quarter 2 dashboard reports. From discussions with staff and review of information we identified that the KPIs reported could be extended to provide a more comprehensive understanding of the operational dynamics around the lead indicator. For example, GP Fill Rates are already reported but the details on 'Attrition Rates' and the number of GP Training Practices, would provide a better picture of the overall framework to assist decision making.	KPI's and metrics do not provide a full picture of key activities so impairing decision making.
Recommendation 6	**Priority level**
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.	**Low**
Management Response	**Responsible Officer/ Deadline**
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.	Deputy Director Planning, Performance & Digital / End June 2020

Finding 7 - Data validation (Operating effectiveness)	Risk
At the current time data is validated by the data owners prior to inclusion in the performance management dashboard. We were informed that as part of the process to develop the Data Glossary, data validation will be undertaken by the Workforce and Data Analytics Team as opposed to by the data owners. Whilst this will provide independent rigour to the validation process, this will mean a reduced level of operational review. We noted that there were some errors in the data that were not identified prior to publication of the quarter 1 dashboard, for example where the actual number of Revalidation Support Unit appraisals for medical and primary care staff were reversed. Also GP LTFT (Less Than Full Time) fill rates at 91% were incorrectly reported.	Data is not subject to operational validation.
Recommendation 7	**Priority level**
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.	**Low**

Management Response	Responsible Officer/ Deadline
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.	Deputy Director Planning, Performance & Digital / End June 2020

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*
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Shared Services Partnership
Audit and Assurance Services

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

Core Financial Systems

Final Internal Audit Report

Health Education and Improvement Wales

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March 2020

NHS Wales Shared Services Partnership

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Auditors:	Olubanke Ajayi-Olaoye, Principal Auditor Ken Hughes, Audit Manager
Executive sign off:	Eifion Williams, Interim Director of Finance
Distribution:	Martyn Pennell, Head of Financial Accounting Rhiannon Beckett, Deputy Director of Financial Management, Costing and Contracting
Committee:	Audit and Assurance Committee

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1. Introduction and Background

In line with the 2019/20 Internal Audit Plan for Health Education and Improvement Wales ('HEIW' or 'the organisation'), a review of elements of the Core Financial Systems was undertaken. The review was required to provide assurance to the HEIW Audit and Assurance Committee that effective processes were in place to manage the risks associated with elements of the financial systems.

On a cyclical basis, we will review different elements of the financial system dependant on risk and prior years' audit findings. HEIW, in line with other health organisations in Wales, is using Oracle as its financial system.

The relevant lead for the review is the Interim Director of Finance and Corporate Services.

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 aspects of the organisation's core financial systems. The review undertaken 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:

Asset Register

- Procedural guidance is in place that is appropriate and up to date.
- There is an up to date asset register in place that accurately records all assets including valuation, depreciation and indexation.
- New assets and asset disposals are accurately identified and promptly recorded on or removed from the register.
- Processes have been established to periodically reconcile the asset register to the general ledger.

Budgetary control

- Budgets are agreed by budget holders.
- Budgetary responsibility is clearly delegated to budget holders and is consistent with the Scheme of Delegation and limits set up in Oracle.
- Sufficient, relevant, reliable information is available to budget holders, including forecasts of the year-end position.
- The monitoring and reviewing of budgets takes place through structured meetings with budget holders where identified issues are raised.
- Budget information reported to the Board, its sub-committees or external bodies is appropriate, timely and clear.
- Budget variances are monitored and corrective action is taken where significant budget over or under spends occur.

- Budget virements are correctly processed, including sufficient evidence trail of the transfer and authorisation process, by participating budget holders.

Contracts Register

- A register has been set up that records all the organisations current contracts.
- Each contract has a unique identifying reference and is assigned to a responsible officer.
- The register includes all necessary fields including the name of the contractor, a description or purpose of the contract, the contract value, start date, end date, current status and details of any potential extensions.
- Procedures have been established for ensuring that all new or qualifying contracts are entered on the register, and that contacts coming to an end are flagged so they can be extended or re-let.

Purchasing cards

- Procedures exist for the use of cards and all cardholder have received a copy and have signed to confirm responsibility for use of the card.
- Appropriate limits have been approved for individual card holders that are in line with the overall credit limit that has been set for the organisation.
- Usage is restricted to appropriate suppliers, merchants or retailers.
- There is a division of duties between use of the cards and reconciliation of invoice logs and statements.
- Appropriate controls are in place for the physical security of the procurement cards.

VAT Returns

- Adequate guidance is available to staff completing VAT Returns.
- There are controls in place to ensure the correct VAT rate is applied to both sales and purchase invoices.
- VAT Returns are completed accurately and are checked and authorised prior to submission to HMRC.
- Monthly and end of year VAT Returns are completed and submitted to HMRC by the due deadlines.
- There is a record kept of all VAT Returns submitted to HMRC.

Limitation of scope

As part of our agreed scope we planned to review HEIWs' asset register. Whilst there is an up to date Financial Control Procedure in place in relation to non-current assets, as at the time of our audit fieldwork, the register

itself had not been developed. As such, we have not been able to undertake work in this area.

3. Associated Risks

The potential risks considered in the review were as follows:

- Corrective action is not taken to reduce overspends.
- Contracts are not accurately recorded.
- Inappropriate expenditure.
- VAT is not correctly accounted for.

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 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. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within Core Financial Systems is **Reasonable Assurance**.

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.

We identified that the processes around budgetary control are far more embedded than they were during the 2018/19 audit review and there are some areas of good practice. In particular, 'Budget Holder Financial Limit L2' forms were widely used for delegated budget holders below the Executive Team level. In addition, we saw evidence that budget holders were well supported by Finance Business Partners. However, further improvements could be made by ensuring that the appropriate documentation is completed and 'signed off' to support budget virements between directorates. We also note that the organisation's Standing Financial Instructions were now out of date.

We reviewed the newly created contracts register, which is comprehensive and contains all of the fields we would expect. We also note that it has been compiled with input from all four of HEIWs' directorates. However, we noted a number of instances where the start and end dates of the contract had not been recorded, and three contracts that had expired were still showing as 'in contract'.

Our review of Purchasing Cards identified that all of the cardholders that we tested had signed cardholder agreements in place. In addition, each month purchasing card transactions were reconciled to both supporting documentation and the credit card statement. All of the expenditure that we reviewed was in line with the Financial Control Procedure guidance and card issuer terms and conditions. However, there were elements of the Purchasing Cards Financial Control Procedure that did not accurately reflect the current processes and procedures in place. Several transactions that we tested did not have budget holder approval. We also identified two purchasing cards that had not been issued to the cardholders, but had been kept in a safe since last year, exposing the organisation to increased risk of misappropriation of funds.

VAT returns are prepared and submitted to HMRC each month by the due date. There was an audit trail of the VAT transactions included in the returns that we reviewed. However, returns were not always being reviewed and approved prior to submission to HMRC. The returns are reviewed for accuracy every six month by external VAT consultants. We note that the external review of transactions highlighted a number of coding errors by HEIW staff for both Sales and Purchase invoices which means adjustments have to be made to future claims.

We were unable to carry out our review of the Asset Register as originally planned, as the register was not available for review at the time of our audit.

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	Budgetary Control			✓	
2	Contracts Register			✓	
3	Purchasing Cards			✓	
4	VAT Returns			✓	

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

Design of Systems/Controls

The findings from the review did not highlight any issues that were classified as weaknesses in the system control / design for Core Financial Systems.

Operation of System/Controls

The findings from the review have highlighted 9 issues that are classified as weaknesses in the operation of the designed system / control for Core Financial Systems.

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).

Audit Area 1: Budgetary Control

We note the following areas of good practice:

- There is an up to date Budgetary Control Financial Control Procedure in place.
- The Executive Team and designated budget holders had all signed to accept responsibility for their budgets.
- Budget holders are supported by a Finance Business Partner that meet with them each month to review actual income and expenditure against budgets and to investigate any budget variances.

- Responsibility for ensuring that the Oracle system is kept up to date with budget holders' delegated limits of authority has been assigned to a specific member of staff.
- The financial position is reported to each meeting of the Senior Leadership Team and Board.
- All budget virements that we tested within the same directorate were appropriately authorised and had relevant backing documentation to support the budget movement.

We identified the following findings:

- The organisation's Standing Financial Instructions were due for review in September 2019 and were therefore out of date. The decision to delay the review and update was not formally recorded (Finding 1 - Medium).
- At the time of our audit there was no system generated report of budget virements, and backing documentation to support budget virements between directorates had been retrospectively signed off by the budget holders (Finding 2 - Medium).
- Our review of a sample of 'Budget Holder Financial Limit' forms identified a number of minor administrative issues (Finding 3 - Low).

Audit Area 2: Contract Register

We note the following area of good practice:

- We saw evidence that all four directorates had been engaged in compiling the organisation's Contract Register.

We identified the following finding:

- Some contracts had missing start dates, end dates and supplier / vendor names, and three contracts with a status of 'in contract' had expired (Finding 4 - Medium).

Audit Area 3: Purchasing Cards

We note the following areas of good practice:

- There were signed cardholder agreements in place for all cardholders that we tested.
- Purchasing card transactions are reconciled to supporting documentation and the credit card statement each month.
- All purchasing card expenditure that we reviewed was in line with the Financial Control Procedure and card issuer terms and conditions.

We identified the following findings:

- The Financial Control Procedure (FCP 6) is in need of updating as it does not accurately reflect the current processes and procedures in place in a number of areas (Finding 5 - Medium).

- Two purchasing cards that had not been issued to the named cardholders due to a change in the procurement strategy, were being retained intact in the Finance safe (Finding 6 - Low).
- Our testing of a sample of transactions identified three instances where the purchases had not been approved by the budget holder, and two instances where cost codes had not been provided within the approving documentation (Finding 7 - Low).

Audit Area 4: VAT Returns

We note the following areas of good practice:

- There is a Financial Control Procedure in place that covers the completion of VAT Returns.
- All VAT transactions are reviewed for accuracy by external tax consultants every six months which enables corrective adjustments to be made to VAT Returns for identified errors.

We identified the following findings:

- VAT returns were not always reviewed and approved prior to submission to HMRC (Finding 8 - Medium).
- The review of VAT transactions by external tax consultants for the period ended 31 March 2019 identified a number of erroneous VAT transactions that had to be rectified (Finding 9 - Low).

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**	**5**	**4**	**9**

Budgetary Control

Finding 1 - Review of Standing Financial Instruction (Operating Effectiveness)	Risk
The Welsh Government requires HEIW to have a set of Standing Financial Instructions in place for the regulation of their financial proceedings and business which includes Budgetary Control. We note that the Standing Financial Instructions, which are published on the HEIW internet pages, were approved by the Board in October 2018 and were due for review in September 2019. However, at the time of our audit fieldwork this review had not happened. We understand that the review has been intentionally delayed due to ongoing All Wales work to revise the SFI's, which may mean the organisation would need to do further update in a short space of time. However the decision to delay the review of SFI's had not been formally approved and documented.	Non-compliance with internal procedures and Welsh Government requirements.
Recommendation	**Priority level**
Decisions that impact on the organisation's financial governance framework should be formally approved and documented.	**Medium**

Management Response	Responsible Officer/ Deadline
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.	Head of Financial Accounting, April 2020

Finding 2 – Authorisation of inter-directorate budget virements (Operating Effectiveness)	Risk
Where budget virements take place between directorates, the transfer of budgets should be authorised by both the giving and receiving budget holders using a standard 'Budget Adjustment' form. It was identified during testing that although a Budget Journal Tracker is maintained for budget virements in the form of an excel spreadsheet, a system generated report of budget virements was not available. Our review of the Budget Journal Tracker did not identify any inter-directorate budget virements, but on enquiry we were informed one inter-directorate budget virement had been processed during the current financial year. However following further enquiries we were provided with Budget Adjustment forms for two inter-directorate budget virements, both of which had been retrospectively approved by the budget holders due to the absence of one budget holder	Budgets are transferred between Directorates without the approval of the respective budget holders.
Recommendation	**Priority level**
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. 2. The feasibility of producing system generated reports that can distinguish between the various types of journals posted should also be investigated.	**Medium**

Management Response	Responsible Officer/ Deadline
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. 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.	Complete Head of Financial Accounting, June 2020

Finding 3 - Review of delegated responsibility (Operating effectiveness)	Risk
Budget Holder Financial Limit Forms (L1) are used to delegate budgets from Level 1 budget holders (Executive Team), to Level 2 budget holders (Senior Management). L2 forms are used to further delegate budgets down to a nominated deputy. We tested a sample of 20 budget holders to ensure that for each budget holder the appropriate L1 or L2 form had been fully and accurately completed and signed off. Our testing identified the following: • There was no L1 form provided for one delegated budget holder. • In two instances an L1 form had been used rather than the L2 form. • One budget holder form had a delegated limit of £1k but the delegated budget on Oracle was £5k.	Budgets are not delegated in accordance with the Scheme of Delegation.
Recommendation	**Priority level**
1. Management should ensure that the correct L1 or L2 form is accurately completed for all budget holders. 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.	**Low**

Management Response	Responsible Officer/ Deadline
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.	Complete
The form that could not be provided for one budget holder has been retrospectively completed.	Complete

Contracts Register

Finding 4 - Validity of contracts (Operating effectiveness)	Risk
Our review of the contracts register identified that the following three contracts had expired but their contract status was recorded as 'in contract': • Contract ID 1002 expired 31/12/2019 • Contract ID 1004 expired 31/01/2020 • Contract ID 1179 expired 31/12/2019 In addition nine contracts had no start dates recorded (Contract IDs 1005 and 1181 - 1188), and one contract had no end date recorded (Contract ID 1046). There were also six contracts where the Vendor / Supplier name was not recorded. The references for these contracts are: • Contract ID 1026 - No Vendor / Supplier Name • Contract ID 1027 - No Vendor / Supplier Name • Contract ID 1046 - No Vendor / Supplier Name • Contract ID 1072 - No Vendor / Supplier Name • Contract ID 1147 - No Vendor / Supplier Name • Contract ID 1148 - No Vendor / Supplier Name	Contracts that have expired are not market tested and continue to be used resulting in a lack of VFM and potential challenge from non-contracted service providers or suppliers.

Recommendation	Priority level
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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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.	Board Secretary, June 2020

Purchasing Cards

Finding 5 - Financial Control Procedure (Operating Effectiveness)	Risk
Our review of purchasing cards identified some discrepancies between the current processes and procedures in place and those recorded in the Financial Control Procedure (FCP 6). These are: • There are different processes in place for members of the executive team and other cardholders. For example, the ordering procedure for staff has changed so that orders must now be raised through the e-ticketing system rather than by completing the standard Purchasing Card Order Form. Due to the introduction of the e-ticketing system, the requirement to complete the Purchasing Card Record of transactions in Section 4 of the FCP only applies to members of the executive team. • Section 5 of the FCP relating to cardholder credit limits states that these can be amended if agreed by the cardholder's line manager / budget holder. However, we identified a temporary increase to one cardholder's monthly credit limit from £2k to £18k for approximately three weeks, but this was not supported by written authorisation. We were informed that this credit limit has now been increased to £10k on a permanent basis. There is no standard approval form for credit limit changes within the FCP. We understand that this higher amount was granted to cover expenditure in relation to a conference. However, the FCP states '*The main objective of the purchasing card scheme is to reduce paperwork and administration time involved in the ordering and invoicing process for low value, high*	Inappropriate expenditure due to out of date guidance for staff.

volume goods and services not covered by any purchasing agreements or contracts.' As such, the change in the limit does not appear to be in line with the spirit of the FCP.	
Recommendation	**Priority level**
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. 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.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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.	Head of Financial Accounting, July 2020

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.	Head of Financial Accounting, July 2020

Finding 6 - Unused purchasing cards (Operating effectiveness)	Risk
At the time of our audit Barclaycard had issued 10 purchasing cards in the name of individual HEIW staff. However, two of these cards had not been issued by HEIW to the cardholder but were stored in the Finance safe. We understand that the cards, which have remained in the safe since our previous audit of purchasing cards, have been withheld to improve financial control by restricting the use of purchasing cards to members of the procurement team.	Inappropriate expenditure as retaining the cards in the safe could result in their unauthorised use.
Recommendation	**Priority level**
The unused cards should be destroyed and cancelled with the card provider.	**Low**
Management Response	**Responsible Officer/ Deadline**
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.	Complete

Finding 7 - Purchasing card transactions (Operating effectiveness)	Risk
We tested a sample of 20 purchasing card transactions to ensure the budget holder had approved them. There was adequate backing documentation to support the transaction, and the transaction details had been accurately recorded in the financial system. Our testing identified the following issues: • 2/20 purchase card transactions for £205 and £597 respectively did not have budget holder approval (via the e-ticketing system). • 1/20 transactions was approved for an amount £70 less than the sum invoiced. • 3/20 transactions did not include a financial code when the order was raised in the e-ticketing system.	Inappropriate expenditure.
Recommendation	**Priority level**
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.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed - A reminder has been issued to all procurement staff.	Complete

VAT Returns

Finding 8 - VAT return reconciliations (Operating effectiveness)	Risk
The VAT FCP states that VAT returns, which are submitted electronically, should be fully reconciled in line with the internal finance timetable, and that all VAT returns should be printed, signed, reviewed and filed with a clear cross reference to all supporting documents. We reviewed three VAT returns to ensure they had been checked prior to submission and submitted to the HMRC by the due date. We found that although the three selected returns had been reviewed, 2/3 had been reviewed after submission to HMRC.	VAT is not correctly accounted for.
Recommendation	**Priority level**
VAT Returns should be reviewed and signed off as checked prior to submission to HMRC in line with the FCP.	**Medium**
Management Response	**Responsible Officer/ Deadline**
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.	Complete

Finding 9 - VAT Code Errors (Operating effectiveness)	Risk
All sales and purchase invoices are VAT coded by HEIW staff and as noted above, are not always checked prior to submission to HMRC. In order for HEIW to ensure the correct VAT rates are applied to both sales and purchase invoices, all VAT transactions are reviewed by external VAT consultants for accuracy every six months. Adjustments for any errors identified are then made to the next available VAT Return. The most recent external review was undertaken for the 6 month period ended 31st March 2019. This identified a total of 202 erroneous VAT transactions with a gross value of £21.5k. The annual cost of VAT Consultancy advice, which includes the 6 monthly review of VAT transactions, is £8k per annum. As we were unable to obtain a copy of the external review for the period April to September 2019, we could not determine if the same errors are being made when coding VAT.	VAT is not correctly accounted for.
Recommendation	**Priority level**
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.	**Low**

Management Response	Responsible Officer/ Deadline
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.	Complete

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem Agenda**	**2.2**
Teitl yr Adroddiad	**Cynllun Archwilio Mewnol 2020/21**		
Awdur yr Adroddiad	Archwilio Mewnol		
Noddwr yr Adroddiad	Pennaeth Archwilio Mewnol		
Wedi'i gyflwyno gan	Archwilio Mewnol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Nodi'r rhaglen waith arfaethedig ar gyfer 2020/21.		
Materion Allweddol	Mae'r Cynllun Archwilio Mewnol yn nodi'r Cynllun Archwilio Mewnol ar gyfer AaGIC ar gyfer 2020/21 sy'n nodi manylion yr archwiliadau sydd i'w cynnal a dadansoddiad o'r adnoddau cyfatebol. Mae hefyd yn cynnwys y Siarter Archwilio Mewnol, sy'n diffinio'r diben trosfwaol, awdurdod a chyfrifoldeb yr archwiliad mewnol a'r dangosyddion perfformiad allweddol ar gyfer y gwasanaeth.		

Cam penodol i'w gymryd *(ticiwch ✓ un)*	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
		✓		✓

Argymhellion	Gwahoddir y Pwyllgor Archwilio a sicrwydd i: • Ystyried y cynllun archwilio mewnol ar gyfer 2020/21; • Cymeradwyo'r cynllun archwilio mewnol ar gyfer 2020/21; • Cymeradwyo'r Siarter Archwilio mewnol; • Nodi'r gofynion adnoddau archwilio mewnol a'r dangosyddion perfformiad allweddol cysylltiedig.

Llywodraethu a Sicrwydd				
Cysylltu i'r amcanion corfforaethol ***(ticiwch ✓)***	Fel sefydliad newydd, sefydlu HEIW fel partner gwerthfawr a dibynadwy, cyflogwr rhagorol a brand arbenigol gydag enw da.	Creu gweithlu iechyd a gofal hyblyg a chynaliadwy ar gyfer y dyfodol.	Gyda Gofal Cymdeithasol Cymru, addasu'r gweithlu i ddarparu gofal yn nes at adref ac integreiddio gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy helpu sefydliadau'r GIG i ddod o hyd i atebion gweithlu cynaliadwy a chynt er mwyn ymateb i'r her o ddarparu gwasanaethau blaenoriaeth. .
	Gwella'r cyfle i ddefnyddio technoleg a gwasanaethau digidol wrth ddarparu addysg a gofal.	Adfywio'r broses o ddatblygu arweinyddiaeth a chynllunio olyniaeth ar draws iechyd a gofal cymdeithasol, mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales	Dangos gwerth buddsoddi yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad y Claf
Amherthnasol.
Goblygiadau Ariannol
Amherthnasol.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Amherthnasol.
Goblygiadau Staffio
Amherthnasol.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Amherthnasol.

Hanes Adrodd	Amherthnasol.
Atodiadau	Atodiad 1 – Cynllun Archwilio Mewnol 2020/21

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

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

Health Education and Improvement Wales

Internal Audit Plan 2020/21

March 2020

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for Health Education and Improvement Wales (HEIW or the 'organisation') for 2020/21 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter, which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Assurance Committee, 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 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 2020/21. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division 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 external auditors 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;
- coverage of the audit domains; and
- audit resources required to provide a balanced and comprehensive view.

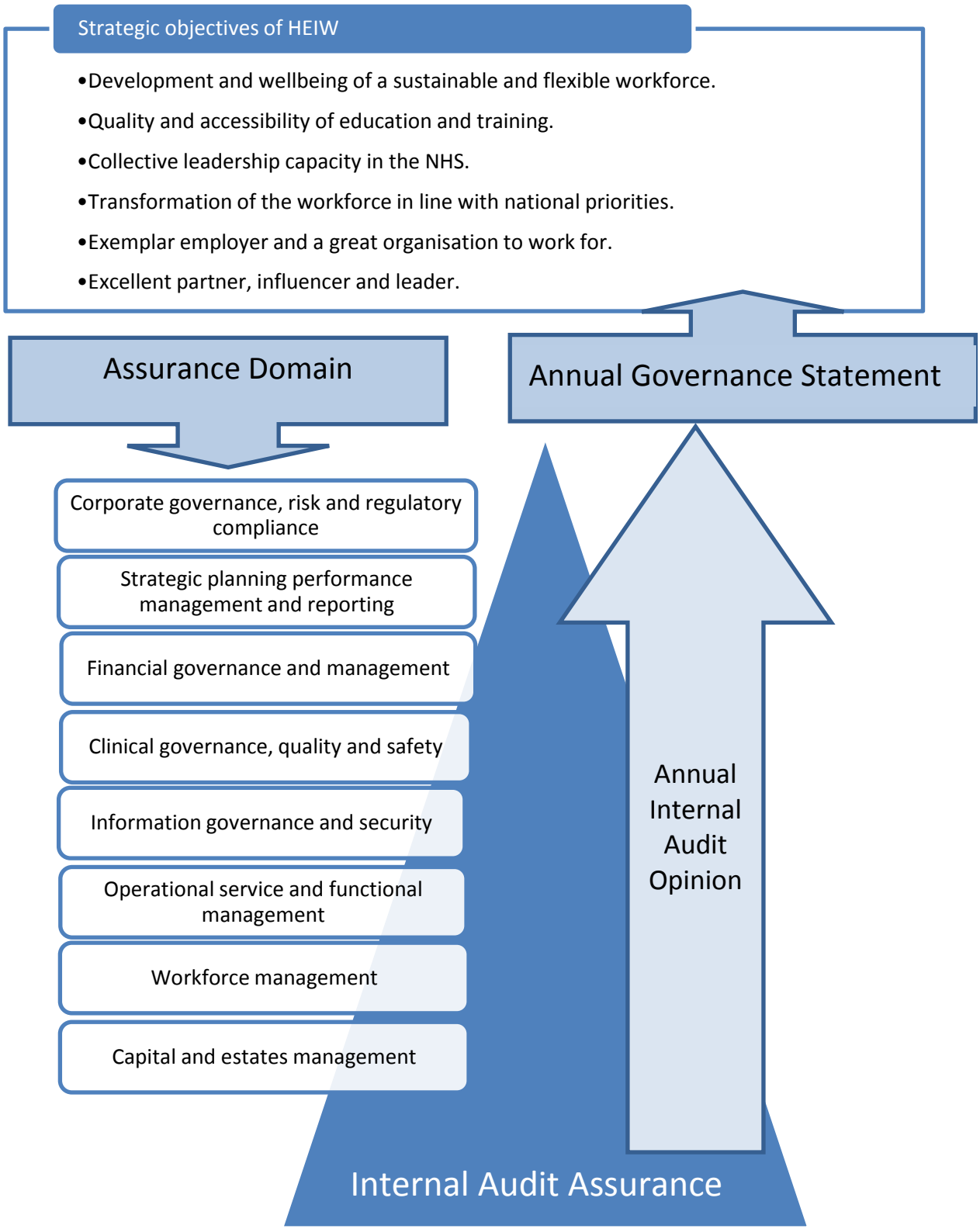
2020/21 is only the second full year of operation for the organisation and as such, it faces different risks and challenges to that of a mature organisation. While systems and processes are in place, they continue to develop and be refined as the organisation matures. Our plan reflects this level of maturity.

While some areas of governance, risk management and control require annual review and some are mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review.

The eight audit domains are shown in figure 1, which also shows how the cumulative internal audit coverage of the domains contributes to the Annual Internal Audit Opinion, which in turn feeds into the Annual Governance Statement, and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion that supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the HEIW systems of assurance

The risk based Internal Audit planning approach integrates with HEIW's systems of assurance. As such, we have considered the following:

- discussions with Directors, the Chair of the Audit and Assurance Committee, and the Chairman of the organisation regarding risks and assurance needs in areas of corporate responsibility;
- risks identified in papers to the Board and its committees;
- legislative requirements to which the organisation is required to comply;
- a review of HEIW's three year Integrated Medium Term Plan (IMTP) for 2020/23;
- planned audit coverage of systems and processes provided through NHS Wales Shared Services Partnership (NWSSP);
- work undertaken by other assurance bodies including that planned by HEIW's Local Counter-Fraud Services (LCFS);
- work undertaken by other review bodies including Wales Audit Office (WAO); and
- the coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement;
- an assessment of the organisation's governance and assurance arrangements and the contents of the corporate risk register;
- key strategic risks identified within the Board Assurance Framework, corporate risk register and assurance processes;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions); and
- new developments and service changes.

2.4 Audit planning meetings

In developing the Plan, in addition to our consideration of the above, the Head of Internal Audit has meet with a number of Executives and the Chair of the Audit and Assurance Committee to discuss current areas of risk and related assurance needs. Our draft plan has been shared with the executive team for comment, and we have met with the:

- Chief Executive;
- Deputy Chief Executive/Director of Workforce and OD;
- Medical Director;
- Board Secretary;
- Chair of HEIW; and
- Chair of the Audit and Assurance Committee.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is informed by the organisation's assessment of risk and assurance requirements captured through its risk management arrangements.

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 control). 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 2020/21

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

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 WAO 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.

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 develop a risk assessment and rolling 3-year audit plan 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.

In addition, the Plan will be periodically reviewed to ensure it aligns with the developing systems of assurance.

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

5. Resource needs assessment

The Plan indicates an indicative resource requirement of 150 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

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 funding passed to NWSSP for Internal Audit is sufficient to meet these audit resource needs.

The Public Sector Internal Audit Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by HEIW 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 2020/21 and:

- approve the Internal Audit Plan for 2020/21;
- 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

Planned output	Audit ref.		Outline scope	Indicative audit days	Lead officers	Outline timing
Corporate governance, risk and regulatory compliance						
Annual Governance Statement	01		Mandatory consideration for Health Organisations. Work undertaken in line with HEIW's reporting cycle. To be undertaken in Q1 2020/21. – No formal report	2	Board Secretary	Q1
Risk management	02		To review the approach to risk within directorates, and how risks are escalated. Also consider how wider strategic risks are managed at a local level.	10	Board Secretary	Q3
Governance arrangements	03		To consider governance arrangements operating at a directorate level. Ensuring that the right information is considered, with an appropriate level of detail.	15	Will depend on which two directorates are reviewed	Q2
Workplace culture	04		To consider the 'tone at the top' and approach to raising concerns. Mindful of the anti-harassment policy.	15	Deputy CEO	TBC
Corporate governance, risk and regulatory compliance domain sub-total				**42 days**		

Planned output	Audit ref.		Outline scope	Indicative audit days	Lead officers	Outline timing
Strategic planning, performance management and reporting						
Communication and engagement strategy	05		To consider the roles, responsibility, ownership, accountability, sign-off process for the strategy. To also consider how stakeholder and other partners have been considered.	15	Deputy CEO	TBC
Performance management	06		To consider the implementation of the performance framework, and the alignment with strategic objectives. We will also consider the performance measures, and the quality of information.	15	Director of Finance & Corporate Services	Q3
Strategic planning, performance management and reporting domain sub-total				**30 days**		
Financial Governance and management						
Financial systems	07		This review is part of a rolling programme of work. Possibly consider budget delegation and budget planning process.	10	Director of Finance & Corporate Services	Q3
Financial Governance and management domain sub-total				**10 days**		

Planned output	Audit ref.		Outline scope	Indicative audit days	Lead officers	Outline timing
Clinical governance quality & safety						
-	-		No specific work identified for 2020/21.	-	-	-
Clinical governance quality & safety domain sub-total				**-**		
Information Governance and security						
Information Governance toolkit review	08		To consider the HEIW self-assessment of information governance arrangements. We will validate and review the action plan. We will be mindful of the Information Governance work being undertaken by HEIW.	10	Director of Finance & Corporate Services	Q3
Cyber security	09		Due to increased scrutiny work to consider how this is addressed within HEIW.	15	Director of Finance & Corporate Services	Q1
Information Governance and security domain sub-total				**25 days**		
Operational service and functional management						
Pharmacy – pre-registration review	10		To consider the implementation of the business case.	15	Medical Director	TBC
Operational service and functional management domain sub-total				**15 days**		

Planned output	Audit ref.		Outline scope	Indicative audit days	Lead officers	Outline timing
Workforce management						
Personal development process	11		To consider if processes are applied appropriately across HEIW. Consideration where staff have come from outside of the NHS.	12	Deputy CEO	Q2
Workforce management domain sub-total				**12 days**		
Capital and Estates						
-	-		No specific work identified for 2020/21.	-	-	-
Capital and Estates domain sub-total				**0 days**		
Audit Contingency				0 days		
Audit management and reporting				16 days		
Indicative total days 2020/21				**150 days**		

The following Key Performance Indicators (KPIs) are used to monitor progress against the Internal Audit programme of work:

KPI	**SLA required**	**Target 2020/21**
Annual Internal Audit plan agreed	✓	By 31 March
Head of Internal Audit opinion	✓	By 31 May
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 2020

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 Health Education and Improvement Wales' (the 'organisation') 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 (the 'organisation') 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.

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.

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.

[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.*

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 the 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.

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.

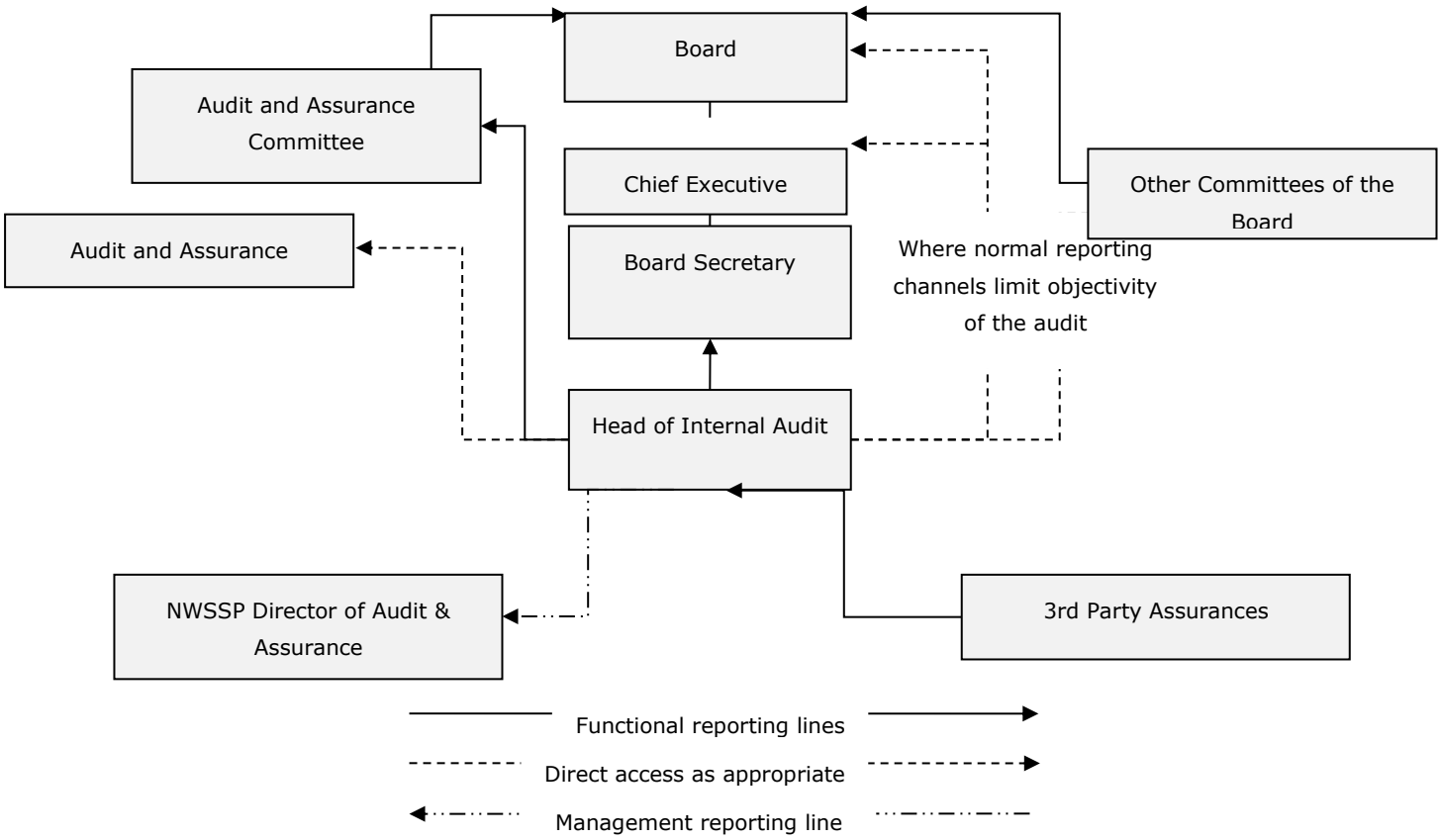
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems that are being operated by organisations outside of the remit of the Accountable Officer, or through a shared or Joint Committee arrangement.

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. 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 (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;
- reviewing arrangements for demonstrating compliance with the Health and Care standards;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Governance and Accountability modular 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 organisations 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. The key stages in this risk based audit approach are illustrated in figure 3.

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 was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards.
- The Head of Internal Audit opinion will:
  - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards.
  - 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.

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.
- 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 Appendix A to this Charter:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive draft reports, which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B to this Charter. 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.
- Internal Audit will issue final reports inclusive of management comments to the relevant Executive Director within 10 working days of management responses being received.
- 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 the 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 2020

Appendix 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.

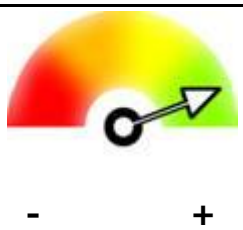
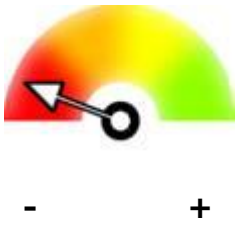
Report finalised by Internal Audit within 10 days of management response.

Internal Audit issues a Final report to the Director/Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive and Board Secretary.

Individual audit reports received by Audit and Assurance Committee.

Final reports are received to the Audit and Assurance Committee at next available meeting and discussed if applicable. The Audit and Assurance Committee identifies their priority areas for Internal Audit to follow up.

Appendix 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,

4/5 Charnwood Court,

Heol Billingsley,

Parc Nantgarw,

CF15 7QZ

Contact details:

Paul Dalton (Head of Internal Audit) – 02921 83 65 65

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

Dyddiad y Cyfarfod	**Dydd Mercher, 1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.3**
Teitl yr Adroddiad	**Diweddariad gan Archwilydd Cyffredinol Cymru i'r Pwyllgor Archwilio a Sicrwydd – Ebrill 2020**		
Awdur yr Adroddiad	Mike Usher, Arweinydd Sector - Iechyd a Llywodraeth Ganolog, Dave Thomas, Cyfarwyddwr, Archwiliad o Berfformiad		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Cyflwynwyd gan	Mike Usher		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Mae'r adroddiad hwn yn rhoi'r wybodaeth ddiweddaraf i'r pwyllgor am y cynnydd a fu mewn perthynas â'n Cynllun Archwilio Dangosol ar gyfer 2020.		
Materion Allweddol	Gofynnir i aelodau nodi nad oes gwelliannau i'r Cynllun Archwilio Dangosol ar gyfer 2020 yn cael eu cyflwyno i'r pwyllgor ar 27 Ionawr 2020, yn cynnwys y ffi arfaethedig sydd bellach wedi cael ei chymedroli gan yr Archwilydd Cyffredinol. Gofynnir i Aelodau nodi cynnydd y gwaith o'i gymharu â'n cynllun ar gyfer 2020. Byddwn ni hefyd rhoi diweddariad llafar i'r Pwyllgor am unrhyw effaith y bydd COVID-19 yn ei gael ar ein rhaglen waith, gan fod hon yn sefyllfa sy'n newid yn gyflym.		
Cam Penodol i'w Gymryd *(un ✓ yn unig)*	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
		x		
Argymhellion	Gofynnir i aelodau wneud y canlynol: • **Nodi fod y Cynllun Archwilio Dangosol ar gyfer 2020 yn parhau'n weithredol.** • **Nodi sut mae'r gwaith yn dod yn ei flaen o'i gymharu â'r Cynllun Archwilio Dangosol ar gyfer 2020.**		

ADRODDIADAU SWYDDFA ARCHWILIO CYMRU

1. CYFLWYNIAD

Mae ein hadroddiad yn rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor am y cynnydd a fu mewn perthynas â'n Cynllun Archwilio Dangosol ar gyfer 2020.

2. CEFNDIR

Cymeradwyodd y Pwyllgor ein Cynllun Archwilio Dangosol ar gyfer 2020 ar 27 Ionawr 2020.

Mae'r cynllun yn amlinellu yn ein gwaith arfaethedig, pryd y bydd yn cael ei wneud, pwy fydd yn ei wneud a ffi arfaethedig.

Roedd y cynllun yn un dangosol oherwydd pan roedden ni'n adrodd, doedden ni ddim wedi cwblhau pob agwedd o asesiad risg ein harchwiliad, ac roedd y ffi arfaethedig o £165,000 yn ddibynol ar gymedroli terfynol gan yr Archwilydd Cyffredinol.

Bellach, rydyn ni wedi cwblhau ein gwaith cynllunio manwl a gallwn gadarnhau nad oes diweddariad i beryglon yr archwiliad ariannol yn Arddangosfa 2 o'r Cynllun Archwilio Dangosol ar gyfer 2020.

Yn ogystal, mae'r Archwilydd Cyffredinol bellach wedi cwblhau ei gymedroli terfynol o'r ffioedd archwilio a does dim newid i'r ffi arfaethedig o £165,500.

Mae'r adroddiad yn rhoi'r wybodaeth ddiweddaraf ynglŷn â'r gwaith o wnaed ers cyfarfod diwethaf y Pwyllgor yn unol â'r cynllun.

Byddwn ni hefyd rhoi diweddariad llafar i'r Pwyllgor am unrhyw effaith y bydd COVID-19 yn ei gael ar ein rhaglen waith, gan fod hon yn sefyllfa sy'n newid yn gyflym.

3. MATERION LLYWODRAETHU A RISG

Dim.

4. GOBLYGIADAU ARIANNOL

Mae ein ffi archwilio arfaethedig ar gyfer 2020 o £165,500 yn parhau'n gyfredol, gostyngiad o 9% ar y ffi a godwyd mewn gwirionedd am ein gwaith archwilio ar gyfer 2019.

5. ARGYMHELLIAD

Gofynnir i aelodau:

- Nodi fod y Cynllun Archwilio Dangosol ar gyfer 2020 yn parhau'n weithredol.
- Nodi sut mae'r gwaith yn dod yn ei flaen o'i gymharu â'r Cynllun Archwilio Dangosol ar gyfer 2020.

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad Cleifion
Amh.
Goblygiadau Ariannol
Ffi archwilio 2020 £165,500.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Amh.
Goblygiadau Staffio
Amh.
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)
Amh.

Hanes yr Adroddiad	Amh.
Atodiadau	Amh.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit and Assurance Committee Update – **Health Education and Improvement Wales**

Date issued: March 2020

Document reference: HEIWAACU202004

Contents

Summary report

About this document

1 This document provides the Audit and Assurance Committee of Health Education and Improvement Wales (HEIW) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered, and information is also provided on the Auditor General's programme of national value-for-money examinations where they may be of interest or relevance to the NHS.

2 We will also provide an oral update to the Committee on any identified impacts of COVID-19 on our work programme, as this is a fast-moving situation.

Financial audit update

Exhibit 1: Financial audit update

Work completed
Annual Accounts
2019-20 Quarterly update meetings with the Chair and Chief Executive have continued throughout the period. **Audit Planning** Our 2019-20 audit planning work commenced in December 2019 and we presented the 2020 Indicative Audit Plan to the Audit and Assurance Committee on 27 January 2020. The plan was indicative as at the time of reporting as we had not completed all aspects of our audit risk assessment, and the proposed fee of £85,500 for financial accounts work was subject to final moderation by the Auditor General. We have now completed our detailed planning work and confirm there is no update to the financial audit risks listed within Exhibit 2 of the 2020 Indicative Audit Plan. Further, the Auditor General has now completed his final moderation of audit fees and there is no change to the proposed fee of £85,500. **Interim Audit** The audit team were onsite for two weeks at the end of February to undertake our interim audit work. This included (but not limited to): - Updating our knowledge of your systems and procedures. - Updating our assessment of the risk of fraud within your financial statements. - Undertaking preliminary work for the identification of related party transactions. - Carrying out substantive testing of expenditure and staff costs for 10 months to 31 Janaury 2020. No issues have been identified to date that require reporting to the Committee. **Final Audit** Draft accounts for audit submission is 5pm on 28 April 2020, our final audit will commence onsite the following day. We will report our audit findings to you on 26 May 2020.

Performance audit update

Exhibit 2: Performance audit update

Work completed				
Topic (year of Audit)	**Key findings**	**Status**	**Executive lead**	**Received at Audit and Assurance Committee / other**
Baseline Review (2019) - informal review of key areas to highlight what's going well and what needs more work	Theme coming through strongly and at the heart of progress so far is HEIW's internal culture and engagement shown by high levels of staff engagement, the collegiate approach to working and strong, supportive leadership. We might have expected more progress on risk and performance management but there are plans in place with developments ongoing and picking up speed. We updated these findings in our Structured Assessment work below.	Complete. Findings discussed in Board Development session 27 June 2019.	Dafydd Bebb	15 July 2019
Structured Assessment (2019)	This work is now complete and asked 'Does HEIW have arrangements in place to support good governance and the efficient, effective and economical use of resources?' Our findings are positive overall with some recommendations mainly around further developing assurance arrangements for risk and performance management and IT governance.	Complete. Report cleared with Executive Team 8/1/20.	Dafydd Bebb	27 January 2020
Work due to start in 2020				
Topic (year of Audit)	**Focus of work**	**Status**	**Executive lead**	**Expected date of final report**
Structured Assessment (2020)	This work will follow up on our 2019 Structured Assessment and focus on those areas still developing.	Not yet started	Dafydd Bebb	January 2021
Local project	We are currently reviewing topics for a local project at HEIW in 2020 to provide useful assurance and support.	Not yet started	TBC	TBC

Other Auditor General studies

The Audit and Assurance Committee may also be interested in the following studies / reports issued since the last Audit and Assurance Committee Update.

Exhibit 3: Other Auditor General Studies and reports

Product	Summary
NHS Wales Finance Data Tool	An interactive tool that lets you look at trends in NHS Finances for the whole of Wales or individual NHS bodies. The tool has been updated for 2019-20 at 31 December 2019 and now includes HEIW. https://app.powerbi.com/view?r=eyJrIjoiNjdmOTViNzQtZWU5OC00OGYwLWE0ZDQtZjk0YTA3NWJiZTRhIiwidCI6ImRmZDY5MmYwLTE2YmYtNDQ0OS04OGUzLWU3NzM1ZGZjY2ZlOCIsImMiOjh9

Good Practice Exchange

The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table in Exhibit 4 lists recent and forthcoming events since the last Audit and Assurance Commitee.

Exhibit 4: Good Practice Exchange

Recent and forthcoming events
Recent events (http://www.audit.wales/events/past-events/)
Future proofing public services. This webinar identified practical examples of services doing things differently to plan for the future and optimise benefits across public services in Wales. (September)
Making an equal Wales a reality. This seminar looked at what public services are doing to contribute to a More Equal Wales. (September).
How technology is enabling collaborative working across public services. This seminar will showcase a range of digital tools and how they can improve collaboration between public services. (October).
Unearth the value in your data *(output coming soon)* This webinar is for organisations that want to transform the way they collect, analyse and use data, at all levels. (January)
Working together to identify and reduce vulnerability *(output coming soon)* This seminar will focus on how to achieve effective governance and accountability in partnership working to deliver efficient public services. (February)
Forthcoming events (http://www.audit.wales/forthcoming-events)
Adverse childhood experiences – alternative delivery models (March 2020)

Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

Wales Audit Office
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

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Structured Assessment 2019 – Management Response to Audit Recommendations – **Health Education and Improvement Wales**

Audit year: 2019

Date issued: January 2020

Document reference: 1662A2019-20

Management response

Introduction

1 We have concluded our 2019 Structured Assessment of Health Education and Improvement Wales. As part of this work, we made a number of audit recommendations to the Authority. These are set out with our findings and conclusions, in our full report which can be found on our website [insert link].

2 This document sets out the Authority's management response and the actions it intends to take to address our 2019 structured assessment recommendations.

3 Any enquiries regarding re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

Health Education and Improvement Wales: management response

The following table sets out the Authority's management response to our 2019 structured assessment audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
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	July 2020	Board Secretary
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.	May 2020	Board Secretary
R3 HEIW should improve its risk management by determining and clearly communicating its risk appetites to ensure a consistent approach to:			

Recommendation	Management response	Completion date	Responsible officer
a) tolerance of risk; b) assessing and scoring of risks; and c) escalation/removal of risks to/from the Corporate Risk Register.	a) HEIW January Board will consider the approval of its approach to managing risk appetite which will include setting tolerance levels for risk. 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.	Jan Board - Completed March Board	Board Secretary Board Secretary
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.	31st March 2020	Director of Workforce and Organisational Development
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	April 2020	Board Secretary / Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
	Asset Register being worked towards initial completion.		
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.	April 2020	Board Secretary
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.	Appointment of Agency staff or consultant – March 2020.	Board Secretary / Director of Workforce and Organisational Development
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	Appointment to permanent role -May 2020	Board Secretary / Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
	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.		
e) documenting a cyber security incident response plan to manage attacks; and	e) This plan will be developed and implemented by the cybersecurity analyst when recruited.	Summer 2020	Board Secretary / Director of Workforce and Organisational Development
f) completing its planned and prioritised actions swiftly.	f) These actions will be completed by the cybersecurity analyst and supported by the process's they implement	Summer 2020	Board Secretary / Director of Workforce and Organisational Development
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, following appointment of new Director of Digital for HEIW	Director of Workforce and Organisational Development
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.	Director recruitment to commence in March 2020	
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	

Recommendation	Management response	Completion date	Responsible officer
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; and b) work with pace to develop KPIs and targets which are clearly linked to strategic objectives, against which the Board can scrutinise performance.	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. 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.	Performance arrangements & expectations to be clarified with staff Feb-April 2020 KPIs aligned to the IMTP will be developed in line with the timescales for implementation	Director of Workforce and Organisational Development

Wales Audit Office
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

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.4**
Teitl yr Adroddiad	**Ymholiadau Archwilio i'r rheini sy'n gyfrifol am Lywodraethiant a Rheolaeth**		
Awdur yr Adroddiad	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Cyflwynwyd gan	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Fel rhan o'r archwiliad o'r cyfrifon statudol, mae gofyn i Swyddfa Archwilio Cymru adolygu'r trefniadau llywodraethu sydd ar waith yn Addysg a Gwella Iechyd Cymru (AaGIC). Er mwyn cyflawni'r cyfrifoldebau hyn, mae Swyddfa Archwilio Cymru wedi ysgrifennu at y 'rheini sy'n gyfrifol am lywodraethiant a rheolaeth' yn AaGIC er mwyn ceisio cael sicrwydd ar nifer o feysydd penodol. Mae'r papur hwn yn amlinellu'r ymateb drafft i'r llythyr hwn, sy'n gorfod cael ei gyflwyno i Swyddfa Archwilio Cymru erbyn 26 Ebrill 2020.		
Materion Allweddol	Mae AaGIC yn gallu darparu sicrwydd priodol mewn perthynas â thwyll, cyfreithiau a rheoliadau, a phartïon cysylltiedig ar gyfer y cyfnod 1 Ebrill 2019 i 31 Mawrth 2020.		
Cam Penodol i'w Gymryd ***(un ✓yn unig)***	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
				✓
Argymhellion	Gofynnir i aelodau wneud y canlynol: • Adolygu'r ymateb drafft i'r llythyr 'Ymholiadau Archwilio i'r rheini sy'n gyfrol ar Lywodraethiant a Rheolaeth' ar gyfer y cyfnod 1 Ebrill 2019 i 31 Mawrth 2020, a chynnig gwelliannau fel bod angen. • Cymeradwyo cyflwyno'r llythyr i Swyddfa Archwilio Cymru		

1. CYFLWYNIAD

Fel rhan o'r archwiliad o'r cyfrifon statudol, mae gofyn i Swyddfa Archwilio Cymru adolygu'r trefniadau llywodraethu sydd ar waith yn Addysg a Gwella Iechyd Cymru (AaGIC).. Er mwyn cyflawni'r cyfrifoldebau hyn, mae Swyddfa Archwilio Cymru wedi ysgrifennu at y 'rheini sy'n gyfrifol am lywodraethiant a rheolaeth' yn AaGIC er mwyn ceisio cael sicrwydd ar nifer o feysydd penodol. Mae'r papur hwn yn amlinellu'r ymateb drafft i'r llythyr hwn.

2. CEFNDIR

Mae'n rhaid i Swyddfa Archwilio Cymru gynnal eu harchwiliadau ariannol yn unol â'r gofynion sydd wedi'u nodi yn y Safonau Rhyngwladol ar Archwilio. Fel rhan o ofynion y Safonau Rhyngwladol ar Archwilio, mae Swyddfa Archwilio Cymru wedi ysgrifennu at AaGIC i ofyn yn ffurfiol am ystyriaeth a dealltwriaeth wedi'u dogfennu ar nifer o feysydd llywodraethiant sy'n effeithio ar archwilio'r datganiadau ariannol.

Yn y llythyr, mae Swyddfa Archwilio Cymru yn nodi bod, "Y prif gyfrifoldeb o ran rhwystro ac atal twyll yn gorwedd gyda'r rheolwyr a'r 'rheini sy'n gyfrifol am lywodraethiant', sef y Pwyllgor Archwilio yn achos yr Awdurdod Iechyd Arbennig."

Y prif feysydd sy'n cael eu hadolygu 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 lywodraethiant:
    - 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 amlinellu'r ddealltwriaeth bresenol o'r safle o ran llywodraethiant yn y sefydliad.

4. GOBLYGIADAU ARIANNOL A MATERION ALLWEDDOL

Does dim goblygiadau ariannol penodol yn codi o'r papur hwn.

5. ARGYMHELLION

Gofynnir i aelodau wneud y canlynol:

- Adolygu'r ymateb drafft i'r llythyr 'Ymholiadau Archwilio i'r rheini sy'n gyfrol ar Lywodraethiant a Rheolaeth' ar gyfer y cyfnod 1 Ebrill 2019 i 31 Mawrth 2020, a chynnig gwelliannau fel bod angen.
- Cymeradwyo cyflwyno'r llythyr i Swyddfa Archwilio Cymru.

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	√			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

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

Atodiadau	Atodiad 1 - Ymholiadau archwilio i'r rheini sy'n gyfrifol am lywodraethiant a rheolaeth yn 2019/20

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Wales Audit Office / Swyddfa Archwilio Cymru

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

Via Email

Reference: HEIW/TCWG 31-03-20
Date issued: 26 February 2020

Dear Eifion, Gill

Health Education and Improvement Wales: Period ended 31 March 2020

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 2020.

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 26 April 2020. 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 5 October 2017 to 31 March 2019	Response for the period 1 April 2019 to 31 March 2020
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 7 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.

Enquiries of management - in relation to fraud		
Question	**Response for the period 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**

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 reports to support their role, including updates provided by the Local Counter Fraud Manager. The Committee is required to meet at least quarterly and since the formation of HEIW has met on:
	  • 2nd October 2018 (Shadow Committee)
	  • 13th November 2018
	  • 12th February 2019
	  • 29th March 2019
	• A comprehensive overview of the counter fraud system and processes relevant to the organisation has been presented at the HEIW corporate induction sessions, giving
		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 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:
		  • 13th May 2019
		  • 29th May 2019
		  • 15th July 2019
		  • 22nd November 2019
		  • 27th 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

Enquiries of management - in relation to fraud		
Question	**Response for the period 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
	all staff an understanding of fraud and how it can be minimised and reported. • A range of Financial Control Procedures have been approved by the Board and are published on the organisation's website. These procedures have been backed up with specific technical briefings. • The organisation is subject to both internal and external audit scrutiny. Internal Audit have completed a review of the financial systems, which was given a 'Reasonable' assurance. Work will continue to maintain and improve this rating.	it can be minimised and reported. Further sessions have been provided to management teams. • 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.

Enquiries of management - in relation to fraud		
Question	**Response for the period 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
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 in 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.	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.
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.	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

Enquiries of management - in relation to fraud		
Question	**Response for the period 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
	The ratification of the Standing Orders and Standing Financial Instructions were announced as part of the Chief Executive update on 18th October 2018 and a link is provided to the documents on the intranet.	provided to specific teams across HEIW during the 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 18th October 2018 and a link is provided to the documents on the intranet. The Standing Orders were revised at Board on 28th November 2019.
5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body for the period ended 31 March 2020?	The Special Health Authority is not aware of any occurrences of fraud within the organisation for the period ended 31 March 2019.	There is one case of suspected fraud currently under investigation. This has been discussed at the Audit & Assurance committee during the year.

Enquiries of management - in relation to fraud		
Question	**Response for the period 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
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 2019.	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.

Enquiries of those charged with governance – in relation to fraud		
Question	**Response for the period 1 October 2018 to 31 March 2019.**	**Response for the period 1 April 2019 to 31 March 2020**
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 Chair of the Audit & Assurance Committee is an Independent Member of the Board.	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 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?	The Audit & Assurance Committee is not aware of any instances of actual, suspected or alleged fraud within HEIW for the period ended 31 March 2019.	There is one case of suspected fraud currently under investigation. This has been discussed at the Audit & Assurance committee during the year.

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 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
1. How have you gained assurance that all relevant laws and regulations have been complied with?	Legal Implications are considered in all reports presented to the Board and the Audit & Assurance Committee. Internal and External audit reviews consider legal and statutory compliance.	Legal Implications are considered in all reports presented to the Board and the Audit & Assurance Committee. Internal and External audit reviews consider legal and statutory compliance.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations since 5 October 2017, with an ongoing impact on the financial statements for the period ended 31 March 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.
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	Further work is to be undertaken in 19/20 in respect of the tax status of contractors.	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 October 2018 to 31 March 2019.**	**Response for the period 1 April 2019 to 31 March 2020**
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.
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 5 October 2017 to 31 March 2019**	**Response for the period 1 April 2019 to 31 March 2020**
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; • 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 • Whenever a new interest arises • 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,	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 • Whenever a new interest arises • 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.	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 3rd March 2020.

Enquiries of the those charged with governance – in relation to related parties		
Question	**Response for the period 1 October 2018 to 31 March 2019.**	**Response for the period 1 April 2019 to 31 March 2020**
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. • 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.	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. 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.

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.5**
Teitl yr Adroddiad	**Yr wybodaeth ddiweddaraf am yr Adolygiad o Gyfarwyddiadau Ariannol Sefydlog**		
Awdur yr Adroddiad	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Cyflwynwyd gan	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Mae'r adroddiad hwn yn rhoi'r wybodaeth ddiweddaraf am sefyllfa bresennol Cyfarwyddiadau Ariannol Sefydlog (SFIs) Addysg a Gwella Iechyd Cymru (AaGIC).		
Materion Allweddol	• Cytunwyd ar Gyfarwyddiadau Ariannol Sefydlog AaGIC ym mis Hydref 2018 ac roeddent i fod i gael eu hadolygu ym mis Hydref 2019. • Sefydlwyd prosiect Cymru gyfan i adolygu'r Cyfarwyddiadau Ariannol Sefydlog ledled GIG Cymru, ac roedd hwn i fod i gael ei gwblhau ym mis Hydref 2019. Mae'r prosiect hwn wedi cael ei ohirio ac felly nid yw'r adolygiad o Gyfarwyddiadau Ariannol Sefydlog AaGIC wedi cael ei gynnal eto. • Mae'r Cyfarwyddwr Cyllid wedi cael dyddiad cwblhau newydd ar gyfer y prosiect, sef mis Gorffennaf 2020. • Os na lynir wrth y dyddiad cwblhau newydd, bydd adolygiad mewnol o'r Cyfarwyddiadau Ariannol Sefydlog yn cael ei gynnal ar ôl i gyfrifon 19/20 gael eu cwblhau.		
Cam Penodol i'w Gymryd *(un ✓ yn unig)*	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
	✓			
Argymhellion	Gofynnir i aelodau wneud y canlynol: • Nodi'r adroddiad			

1. CYFLWYNIAD

Mae’r adroddiad hwn yn rhoi’r wybodaeth ddiweddaraf am sefyllfa bresennol Cyfarwyddiadau Ariannol Sefydlog (SFIs) Addysg a Gwella Iechyd Cymru (AaGIC).

2. CEFNDIR

Yng nghyfarfod cyntaf bwrdd AaGIC ym mis Hydref 2018, cymeradwywyd y Rheolau Sefydlog (SOs) ar gyfer y sefydliad, sy’n cynnwys y Cyfarwyddiadau Ariannol Sefydlog. Yn unol â gofynion y Rheolau Sefydlog, cytunwyd ar ddyddiad adolygu ar gyfer y ddwy ddogfen, sef mis Hydref 2019.

Yn ystod gwanwyn 2019, fe wnaeth grŵp y Cyfarwyddwyr Cyllid, gyda chefnogaeth yr Academi Cyllid, gytuno i ehangu cwmpas prosiect Cymru gyfan a oedd wedi bod yn ailddrafftio adran gaffael y Cyfarwyddiadau Ariannol Sefydlog er mwyn adolygu’r ddogfen lawn. Roedd y prosiect i fod i gyflwyno set o Gyfarwyddiadau Ariannol Sefydlog enghreifftiol ar gyfer GIG Cymru erbyn mis Hydref 2019. Oherwydd bod hyn yn gyson â’r dyddiadau gofynnol yn AaGIC, trefnwyd y byddai’r prosiect hwn yn disodli'r adolygiad mewnol.

Fodd bynnag, oherwydd argaeledd uwch aelodau’r grŵp adolygu a lefel y manylder sydd ei hangen i gael ystyriaeth yn y Cyfarwyddiadau Ariannol Sefydlog, nid yw’r prosiect wedi cael ei gwblhau eto. Dyma statws y gwaith y rhoddwyd gwybod i grŵp y Cyfarwyddwyr Cyllid amdano ar 21 Chwefror:

- Mae'r holl benodau wedi cael eu drafftio;
- Mae’r adran ar gaffael wedi cael ei hailddrafftio ar fformat Harvard;
- Mae Cyfarwyddiadau Ariannol Sefydlog presennol ac arfaethedig wedi cael eu cymharu’n fanwl gan Lywodraeth Cymru fel rhan o’r adolygiad cyfreithiol;
- Mae’r holl benodau wedi cael eu hadolygu gan y prif grŵp a’r grŵp cyfeirio;
- Mae’r ddogfen wedi cael ei rhoi at ei gilydd i greu fersiwn llawn sy’n barod i gael ei adolygu’n derfynol a’i gymeradwyo gan y prif grŵp;

Mae’r Cyfarwyddiadau Ariannol Sefydlog diwygiedig yn mynd drwy’r broses lywodraethu er mwyn cael eu derbyn a’u cymeradwyo’n gyfreithiol gan Lywodraeth Cymru. Rhagwelir y bydd y Cyfarwyddiadau Ariannol Sefydlog diwygiedig yn cael eu cyflwyno gan Lywodraeth Cymru i’w mabwysiadu gan Fyrddau ym mis Gorffennaf 2020. Ar ôl i AaGIC eu derbyn, bydd y Cyfarwyddiadau Ariannol Sefydlog enghreifftiol yn cael eu hadolygu a’u hystyried drwy drefniadau llywodraethu mewnol, yn amodol ar flaenoriaethau’r sefydliad bryd hynny.

3. MATERION LLYWODRAETHU A RISG

Y cyfarwyddiadau sydd ar waith gan AaGIC ar hyn o bryd yw Cyfarwyddiadau Ariannol Safonol a gyflwynwyd gan Lywodraeth Cymru ac felly maent yn cwmpasu’n gynhwysfawr y materion risg a llywodraethiant mae angen i’r sefydliad eu hystyried. Does dim diwygiadau diweddar wedi cael eu cyflwyno gan Lywodraeth Cymru a fyddai’n golygu bod angen newid y ddogfen.

Lle bo archwiliadau mewnol ac allanol wedi cyflwyno argymhellion mewn perthynas â phrosesau a gweithdrefnau AaGIC, mae’r rhain wedi cael eu rhoi ar waith neu maent wrthi’n cael eu rhoi ar waith ar hyn o bryd.

Serch yr hyn a nodir uchod, os bydd oedi pellach yn cael ei nodi yn y prosiect adolygu Cyfarwyddiadau Ariannol Safonol, bydd adolygiad mewnol o'r ddogfen yn cael ei gynnal pan fydd proses diwedd blwyddyn 2019/20 wedi cael ei chwblhau.

4. GOBLYGIADAU ARIANNOL A MATERION ALLWEDDOL

Does dim goblygiadau ariannol penodol yn codi o'r papur hwn.

5. ARGYMHELLION

Gofynnir i aelodau wneud y canlynol:

- Nodi'r adroddiad

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	✓			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	
Ansawdd, Diogelwch a Phrofiad Cleifion				
Nid oes dim effaith ar ansawdd, diogelwch na phrofiad cleifion.				
Goblygiadau Ariannol				
Does dim goblygiadau ariannol uniongyrchol yn codi o'r papur hwn.				
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)				
Does dim goblygiadau cyfreithiol.				
Goblygiadau Staffio				
Does dim goblygiadau uniongyrchol o ran staffio				
Goblygiadau Tymor Hir (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015)				
Does dim goblygiadau tymor hir.				
Atodiadau	Amh.			

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

Dyddiad Cyfarfod	**1 Ebrill 2020**	**Eitem Agenda**	**2.6**
Teitl Adroddiad	**Datganiad Llywodraethu Blynyddol 2019/20**		
Awdur Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Noddwr Adroddiad	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Cyflwynwyd gan	Dafydd Bebb, Ysgrifennydd y Bwrdd		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Gofyn i'r Pwyllgor ystyried y Datganiad Llywodraethu Blynyddol drafft a darparu'r adborth.		
Materion Allweddol	Cafodd yr amserlenni ar gyfer cymeradwyo'r Adroddiad Blynyddol eu hystyried yng nghyfarfod diwethaf y Pwyllgor Archwilio a Sicrwydd. Mae'r Datganiad Llywodraethu Blynyddol drafft, sydd wedi'i atodi yn Atodiad 1, wedi cael ei ddatblygu yn unol â gofynion Llywodraeth Cymru.		
Camau penodol ***(Rhowch un ✓ yn unig)***	**Gwybodaeth**	**Trafodaeth**	**Sicrwydd**	**Cymeradwyo**
		✓		
Argymhellion	Gofynnir i 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 2020..		

DATGANIAD LLYWODRAETHU BLYNYDDOL 2019/2020

1. CYFLWYNIAD

Diben y papur hwn yw gofyn i'r Pwyllgor Archwilio a Sicrwydd ystyried y Datganiad Llywodraethu Blynyddol drafft a rhoi 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

Mae Datganiad Llywodraethu Blynyddol drafft AaGIC, sy'n rhoi manylion am drefniadau llywodraethu'r sefydliad yn ei flwyddyn ariannol lawn gyntaf, wedi'i atodi yn Atodiad 1.

Gofynnir i Aelodau'r Pwyllgor ystyried cynnwys y Datganiad Llywodraethu Blynyddol drafft a rhoi adborth ynghylch yr 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'r cyfrifon "yn gyffredinol fod yn deg, yn gytbwys ac yn ddealladwy ac mae'r swyddog atebol yn cymryd cyfrifoldeb personol amdano a'r dyfarniadau sydd eu hangen ar gyfer penderfynu ei fod yn deg, yn gytbwys ac yn ddealladwy".

5. GOBLYGIADAU ARIANNOL

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

6. ARGYMHELLIAD

Gofynnir i Aelodau:

- drafod cynnwys y Datganiad Llywodraethu Blynyddol drafft a rhoi adborth er mwyn rhoi sicrwydd i'r Bwrdd bod proses lywodraethu gadarn wedi'i gyflawni ar gyfer y cyfnod hyd at 31 Mawrth 2020.

Llywodraethu a Sicrwydd				
Cyswllt ag amcanion corfforaethol (✓ ogydd)	Fel sefydliad newydd sy'n sefydlu AaGIC fel partner gwerthfawr y gellir ymddiried ynddo, sy'n gyflogwr rhagorol ac yn frand ag enw da ac arbenigol	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg ar gyfer y dyfodol.	Gyda Gofal Cymdeithasol Cymru yn siapio'r gweithlu i ddarparu gofal yn agosach i'r cartref ac i gysoni darpariaeth y gwasanaeth yn well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy i'r gweithlu ar gyfer heriau darparu gwasanaethau â blaenoriaeth.
	✓			
	Gwella cyfleoedd i ddefnyddio technoleg a digidoli wrth ddarparu addysg a gofal.	Adfywio'r broses o ddatblygu arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Cymru	Dangos gwerth o fuddsoddi yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad y Claf	
Dim	
Goblygiadau Ariannol	
Does dim goblygiadau ariannol	
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)	
Mae cwblhau'r adroddiad blynyddol yn ddyletswydd statudol i AaGIC	
Goblygiadau Staffio	
Nid oes unrhyw oblygiadau staffio ychwanegol.	
Goblygiadau hirdymor (gan gynnwys effaith Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015.)	
Dim	
Hanes yr Adroddiad	Cyflwynwyd amserlen yng nghyfarfod diwethaf y Pwyllgor Archwilio a sicrwydd ar 27 Ionawr.
Atodiadau	Atodiad 1 – Datganiad Llywodraethu Blynyddol Drafft

GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)

Health Education and Improvement Wales (HEIW)

DRAFT CORPORATE GOVERNANCE REPORT 2019/2020

Signed: Alex Howells …….
(Chief Executive)

Date: ……..

Annual Governance Statement for the Period Ended 31 March 2020

1. Scope of Responsibility

The Board of Health Education Improvement Wales (HEIW) is accountable for governance, risk management and internal control. The Chief Executive (CEO) has responsibility for maintaining appropriate governance structures and procedures, as well as a sound system of internal control which support the achievement of the organisation's policies, aims and objectives, whilst also safeguarding 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 background to HEIW, its functions, 2019/20 Annual Plan and Remit Letter objectives are set out in the Performance Report.

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

During 2019/20 we have continued to develop our system of governance and assurance. Our Board Assurance Framework (BAF) was approved by the Board in September. We will continue to evolve our BAF in 2020/21 through implementing the recommendations arising from the Wales Audit Office Structural Assessment.

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.

1.1 Our System of Governance and Assurance

Through engagement with staff, stakeholders and partners we have developed and agreed our vision: "**Transforming the workforce for a healthier Wales".** We will deliver this vision using 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 have also developed and agreed our values:

- **Respect for all**
- **Together as a Team**
- **Ideas that Improve**

These values are supported by a Values and Behaviours Framework. Further work was undertaken throughout 2019/20 on the development of a People and Inclusion and Organisational Development Strategy.

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 has been rolled out across the organisation. Work continues 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. Tina Donnelly was re-appointed for a term of 4 years from 1 February 2020 taking her term of office to 31 January 2024. Dr Heidi Phillips was re-appointed for a term of three years from 1 February 2020 taking her term of office to 31January 2023. John Hill-Tout was re-appointed for a term of 2 years from 1 February 2020 taking his term of office to 31 January 2022.

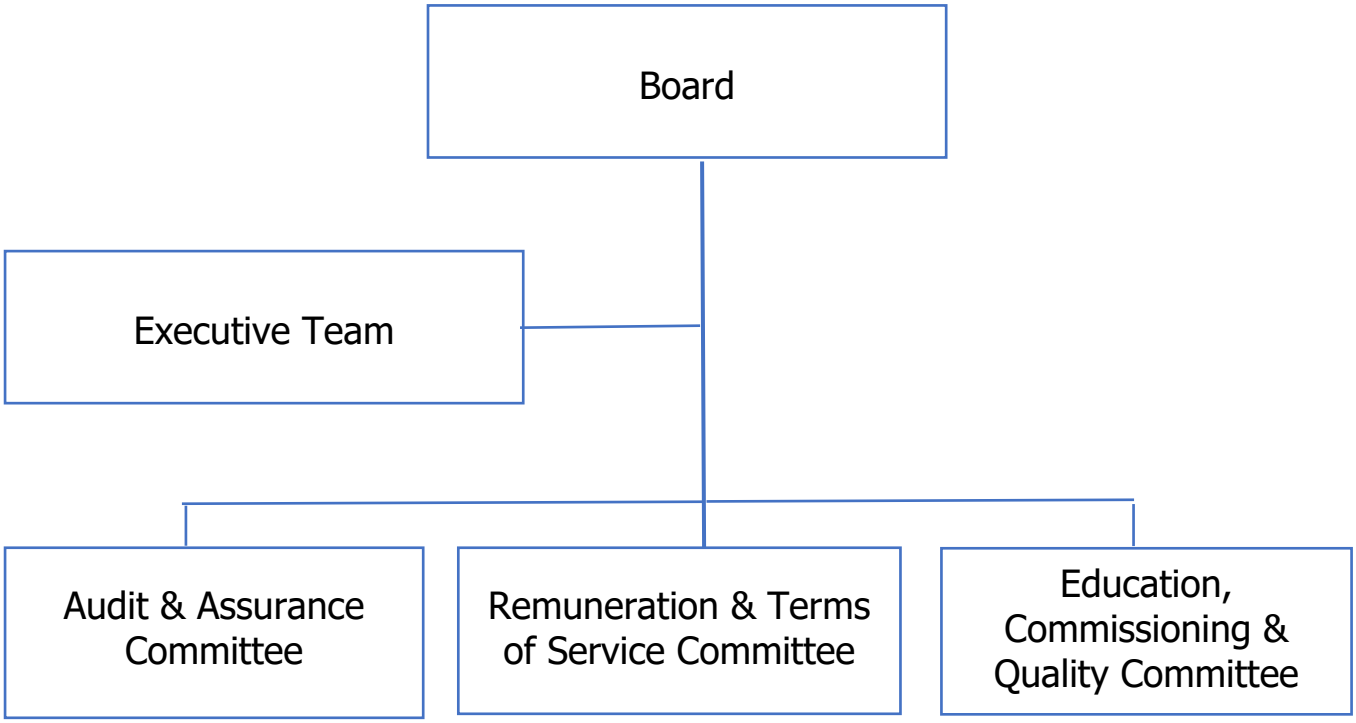
The Director of Finance was appointed on an interim basis in April 2019 and his role was confirmed on the basis of a two year fixed term contract in January 2020.

The new national programme of induction for Board Members, facilitated by Academi Wales, was established in 2019. Three of HEIW's Independent Members attended the first induction programme in December 2019.

During 2019-2020 a number of board development sessions were undertaken which included a focus on the following elements of governance:

- Performance Management Framework;
- Quality and Engagement Bill;
- Board and Sub Committees' Governance Arrangements entitled 'Future Ways of Working';
- Regulation – GMC;
- Risk Appetite;
- Upholding Professional Standards for Independent M Board Members;
- Self-Assessment of Quality Governance Arrangements in response to the HIW and WAO Joint Review at Cwm Taf Morgannwg UHB

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 2019/20 were appropriately constituted with a quorum. The key business and risk matters considered by the Board during 2019/20 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. Following the establishment of the Education Commissioning and Quality Committee a review was undertaken of HEIW's standing orders. The review entitled 'Future Ways of Working' focussed on the roles of the Board and its committees to ensure that decision making was taken at the appropriate level and to avoid any gaps in the governance structure. The paper on Future Ways of Working was approved at September Board and the Standing Orders were updated to reflect the findings of the paper in November. The Board will consider whether any changes are needed during 2020/2021 in line with the Board's governance framework and priorities of the Integrated Medium Term Plan (IMTP) 2020/23.

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, which keeps under review the design and adequacy of HEIW's governance and assurance arrangements and its system of internal control. During 2019-2020, key issues considered by the Audit and Assurance Committee relating to the overall governance of the organisation included:

- Reviewing its terms of reference, which will be kept under regular review;
- Approving the Internal Audit Plan for 2019/20 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 in place;
- Developing the Board's risk management systems and processes and
- Developing arrangements to work with the Wales Audit Office (WAO), and considering, the 2019 Structural Assessment and the WAO's 2020 Audit Plan;
- Providing assurance to the Board in respect of Information Management and Information Governance.

The Committee will undertake a self-assessment for 2019/20 in April 2020. 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 the WAO and Internal Audit. If required, an action plan will be developed.

In March 2019, the Board approved the establishment of the Education, Commissioning and Quality Committee to enable 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 held its first meeting in May 2019 and has considered the following key matters in 2019/20:

- Reviewed its own terms of reference upon establishment;
- 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 2019;
- Reviewed the outcome of the KPMG Strategic Review of Health Professional Education and its 22 recommendations;
- Ensuring the effective management and improvement of the quality of HEIW's education and related research activities;
- Ensuring the effective performance, monitoring, management and value of education and training programmes and contracts;
- Monitoring compliance of education and training activities;
- Providing assurance in respect of risk areas within its area of responsibility and highlight material areas of concern to the Audit and Assurance Committee.

The Committee will undertake a self-assessment for 2019-2020. An evaluation of the results of the self-assessment will be considered by the Committee at its meeting in July 2020.

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 2020, 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.

A report of any proposed changes to the structure and membership of Board committees is approved by the Board. Each 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. Committees are also be required to develop annual reports of their business and activities.

In January 2020, the Education Commissioning and Quality Commission approved the establishment of two advisory groups, the Internal Multi-Professional Education Group (IMPEG) and the External Education Group (EEG).

Table 1
Board and Committee Membership and Attendance since 1 April 2019 to 31 March 2020:

Name	***Position***	***Area of Expertise/ Representation Role***	***Board/ Committee Membership***	***Meeting Attendance 2019/2020***	***Champion Roles***
Chris Jones	*Chair*	• *Primary Care* • *Widening Access* • *Prevention*	• *Board (Chair)* • *RATS Committee (Chair)*	*[?]/7* *7/7*	• *Welsh Language Champion*
John Hill-Tout	*Vice Chair*	• *Performance* • *Governance* • *Finance*	• *Board* • *Audit and Assurance Committee* • *RATS Committee*	*[?]/7* *5/5* *5/7*	• *Primary Care* • *Mental Health Champion*
Tina Donnelly	*Independent member*	• *Leadership* • *Students* • *Workforce* • *Education/ Training*	• *Board* • *RATS Committee* • *Education, Commissioning and Quality Committee*	*[?/]7* *6/7* *4/4*	• *Student/ Trainee Champion* • *Equality and Diversity Champion*
Ruth Hall	*Independent member*	• *Rural Education* • *Quality and Improvement*	• *Board* • *Audit and Assurance Committee* • *RATS Committee* • *Education, Commissioning and Quality Committee (Chair)*	*[?]/7* *5/5* *5/7* *4/4*	• *Rural Champion*

Name	***Position***	***Area of Expertise/ Representation Role***	***Board/ Committee Membership***	***Meeting Attendance 2019/2020***	***Champion Roles***
Gill Lewis	*Independent member*	• *Health & Social Care Workforce*	• *Board* • *Audit and Assurance Committee (Chair)* • *RATS Committee*	*[?]/7* *4/5* *7/7*	• *Health & Social Care Integration Champion*
Ceri Phillips	*Independent member*	• *Workforce Design* • *Value Agenda* • *Digitalisation*	• *Board* • *RATS Committee*	*[?]/7* *6/7*	• *Digital Champion*
Heidi Phillips	*Independent member*	• *Integrated Care* • *Improvement* • *Widening access* • *Education* • *Training*	• *Board* • *RATS Committee*	*[?]/7* *5/7*	• *Quality Improvement Champion* • *Widening Access Champion*
Alex Howells	*Chief Executive*		*Board*	*[?]/7*	
Julie Rogers	*Deputy Chief Executive/ Director of Workforce and OD*		*Board*	*[?]/7*	
Stephen Griffiths	*Executive Director of Nursing*		*Board*	*[?]/7*	
Pushpinder Mangat	*Executive Medical Director*		*Board*	*[?]/7*	
Eifion Williams	*Interim Director of Finance*		*Board*	*[?]/7*	

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.

Table 2

Dates of board and committee meetings held during the period 1 April 2019 to 31 March 2020**.**

Board/ Committee	***Dates Meetings Held***						
Board	***30/05/19***	***18/07/19***	***26/09/19***	***28/11/19***	***19/12/19***	***30/01/20***	***[26/03/20]***
Audit and Assurance Committee	***13/05/19***	***29/05/19***	***15/07/19***	***22/11/19***	***27/01/20***		
Education, Commissioning & Quality Committee	***16/05/19***	***01/07/19***	***21/10/19***	***16/01/20***			
Remuneration and Terms of Service Committee	***25/04/19***	***04/06/19***	***19/06/19***	***18/07/19***	***29/08/19***	***28/11/19***	***19/02/20***

2. The Purpose of the System of Internal Control

HEIW Board's 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 risks to the achievement of policies, aims and objectives. Plus, to evaluate the likelihood of those risks being realised and their impact, and to manage them efficiently, effectively and economically.

The system of internal control for HEIW continues to evolve. Our Board Assurance Framework (BAF) was approve by the Board in September 2019. We use the BAF 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.

Health Education and Improvement Wales Board Control Framework

Leadership | Staff | Systems and Processes | Finances | Technology

Controls and Assurance Mechanisms

High Quality Education

***Controls*: evidenced within**

- Annual Plan
- Commissioning
- Equality Impact Assessment

Assurance: gained via

- Proposed Education Commissioning and Quality Committee
- Senior Leadership Team
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

Controls:

- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports

Assurance: gained via

- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Audit and Assurance Committee
- Proposed Education Commissioning and Quality Committee
- Internal/External Audits

Risk Management

***Controls*:**

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register
- Reports to the Board, Senior Leadership Team and sub committees
- Policies and Procedures
- Scheme of Delegation

Assurance: gained via

- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Audit and Assurance Committee
- Proposed Education Commissioning and Quality Committee

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 and Terms of Service Committee
- Health and Safety Groups, etc.

Findings and/or reports from inspections, annual reporting through to committees

Third line
Independent

- Internal Audit Plan
- Wales Audit Office (Structured Assessment)
- External Audits (eg. Annual Accounts and Annual Report)
- HIW Inspections
- Regulators
- Reviews and Reports by Royal Colleges
- External visits and accreditations
- Independent Reviews

3. Capacity to Handle Risk

We have continued to develop and embed our approaches to risk management and emergency preparedness throughout 2019/20. In July 2019 our Risk Management Policy was approved by the Board. This policy included the requirement to develop an annual risk appetite which was completed and approved by Board in January 2020. This is now being communicated across the organisation, combined with a review of all operational risks. This will ensure a consistent, integrated approach whereby all risks are clearly linked to organisational objectives with a line of sight to the Board Assurance Framework.

The key risks that have been managed during this period include:

- NHS Bursary Terms and Conditions;
- the Strategic Review of Health Professional Education;
- access to Eduroam the dedicated education internet connection for trainers and trainees;
- District Nurse Recruitment; and
- Cyber Security.

One areas of risk receiving priority was in relation to the Interface with Welsh Government. If this interface is not clear this could impact on delivery and reputation, and could undermine a good relationship with the Welsh Government. This risk was downgraded following the successful implementation of the mitigating actions. However, due to its importance it remains a key area of focus.

The Risk Register is continuously updated to capture HEIW's risks as they are identified, and will be further developed in 2020/2021, to align it with the first HEIW IMTP. This will also be incorporated into the continued development of the Board Assurance Framework. The Risk Register will also be updated to include HEIW's Risk Register and recommendations of our internal and external auditors.

3.1 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, regularly 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.

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

The Board is also committed to ensuring staff throughout the organisation are trained and equipped to appropriately assess, manage, escalate and report risk. In June 2019, members of the Senior Leadership team undertook specific risk management training provided by an external consultant on risk. Over forty managers within HEIW have undertaken 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 given by the draft report was one of reasonable assurance for this area. We have drafted our response to this report, which along with the final Internal Audit Report, will be considered by the Audit and Assurance Committee in April 2020.

HEIW has a Crisis Management and Business Continuity policy which was deployed during the flooding near to our headquarters in Nantgarw in February.[The policy was also updated in response to the challenges of the Coronavirus pandemic].

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

4. The Control Framework

NHS Wales organisations are not required to comply with all elements of the corporate governance code for central government departments. However, the main principles of the code stand as they are relevant to all public sector bodies.

The information provided in this governance statement 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. HEIW is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. 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. There have been not 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

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 within our People and OD Strategy together with our Performance Report which is reviewed by the Board every two months.

4.1 Other Control Framework Elements

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

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 with HEIW attending Pride in Cardiff last August.
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.

Our first Strategic Equality Plan 2020-2024 is due for publication on the 1st April 2020. We will be also be publishing our first Annual Equality Report 2019/20 highlighting progress so far.

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.

Annual Quality Statement - As HEIW does not provide direct clinical services it has not completed an Annual Quality Statement in 2019/20.

During 2019/20 HEIW has implemented the following measures to secure quality improvement:

- The establishment of the Education Commissioning and Quality Committee. The Committee's remit includes; assuring the Board on whether effective arrangements are in place to quality manage education systems; to make recommendations in respect of the quality of education and monitoring education quality.
- The work of the Committee in respect of education quality will be further enhanced through the establishment of the two new sub-groups referred to at [page 21] above.
- HEIW has focussed on the quality management process for post graduate medical education. This includes sites within NHS Wales that are in particular need of monitoring.
- HEIW gathers information on student and trainee experiences. This information is used to inform improvements within the education and training provision.
- HEIW monitors 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.
- 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 will 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.

Welsh Language - As HEIW is a relatively new body it has not been named as an organisation that comes under the Welsh Language Measure 2011. Given this the Welsh Language Commissioner's Office has asked HEIW to prepare a Statutory Language Plan as prescribed under the original (1993) Welsh Language Act. Our Welsh language Plan is based on the Welsh Language Standards. The revised Plan is in the process of being drafted and will subject to a public consultation prior to its final submission to the Commissioner at the end of 2020. HEIW also 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 2019-20 we have undertaken extensive communications and engagement activity based on our Board approved Communications and Engagement Strategy to build and strengthen relationships and to help shape our work and services. This has included:

- Regular stakeholder bulletins;
- Social media to inform and update;
- Regular workshops, meetings and virtual working groups to inform and involve everyone in discussions on key topics;
- Continuation of stakeholder workshops across Wales including to inform development of the IMTP;
- Regular stakeholder specific newsletters such as trainee newsletter, dental professionals;
- Participation in national boards and all Wales peer groups;
- Collaboration and co-production of Wales's first Public Body Equality Partnership to develop and delivery Wales' first shared Strategic Equality Plan across public sector bodies;
- Extensive engagement and consultation, with over 1900 contacts, during the development of the Workforce Strategy for Health and Social Care;
- Ongoing widespread engagement and consultation as part of the development of a health and care leadership strategy for Wales;
- Extensive engagement in the strategic review of health professional education
- All Wales conferences and events to focus on key topics, provide access to CPD and support networking.

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. We hosted a four-nations meeting between Health Education England, NHS Scotland and the Northern Ireland Medical and Dental Training Agency earlier this year and are part of a five nations collaborative, on compassionate and collective leadership.

Beginning in early May 2019, we launched the 'HEIW Roadshows' visiting Health Boards and Trusts across Wales to meet with healthcare trainees, students, educators and those responsible for education. The Roadshows enabled us to introduce HEIW and ourselves to students, trainees and colleagues across Wales. It also provided us with an opportunity to listen and gain feedback on education experiences to allow us to inform future provision of healthcare education in Wales. These will be repeated in 2020-21.

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. This position will be reviewed in 2021/21 –

see the Biodiversity and Sustainability section below which details how HEIW will focus on reducing its carbon footprint.

4.2 Ministerial directions

No ministerial directions were received as at year end 31 March 2019.

During the period there were no material lapses in data security and no referrals to the ICO.

4.3 Planning

The Board has received regular reports in respect of the implementation of the 2019/20 Annual Plan through regularly reviewing the Performance Reports.

The Board has played a central role in developing HEIW's Integrated Medium Term Plan (IMTP). Detailed Board discussions to support the development of the IMTP has taken place. This iterative process culminated in the Board approving the IMTP for submission to Welsh Government at its meeting on the 30 January 2020.

5. Review of Effectiveness

As Accountable Officer, the CEO has responsibility for reviewing the effectiveness of the system of internal control. The review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

5.1 Internal Audit

Internal audit provides the CEO, as Accountable Officer and the Board through the Audit and Assurance Committee, with a flow of assurance on the system of internal control. The CEO commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit and Assurance Committee.

The overall opinion by the Head of Internal Audit (HoIA) on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

5.2 The Head of Internal Audit Conclusion:

The scope of the opinion of the HOIA is confined to those areas examined in the risk based audit plan, which has been agreed with senior management and approved, by the Audit and Assurance Committee. The Head of Internal Audit 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

 - + 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.

The audit work undertaken during 2019/20, 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 2019/20. 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** – A **reasonable** assurance report was issued for the review of risk management.
- **Board and Committee Governance arrangements** – Overall **substantial** assurance was issued for this review.

Strategic Planning, Performance Management and Reporting

- **Performance management** – Overall **reasonable** assurance in relation to the work in this area.
- **IMTP Planning** - Overall **substantial** assurance for this review.

Financial Governance and Management

- **Core financial systems** – Overall, **reasonable** assurance was issued for this review.

Clinical Governance Quality and Safety

- **Health and Safety** – Overall **reasonable** assurance for this area of audit work.

Information Governance and Security

- **IT/Digital Review** – TBC
- **Freedom of Information** – Overall **reasonable** assurance for this review.
- **Data Protection (GDPR)** – Overall **reasonable** assurance for this review.

Operational Service and Functional Management

- **Service Review – Medical Training Commissioning** – TBC

Workforce Management

- **Employment status of casual workers Follow Up** – A **reasonable** assurance report for this audit review which was undertaken to follow up on the original **Limited** assurance Internal Audit undertaken in 2018/19.
- **Workforce Review: Values and Behaviours Framework** – Overall **reasonable** assurance for this review.
- **Workforce Strategy Review** - TBC

Capital and Estates Management

- No planned reviews in this domain during 2019/2020.

5.3 External Audit – Wales Audit Office (WAO)

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. The WAO undertakes the external auditor role for HEIW on behalf of the Auditor General. As HEIW was established in October 2018 the WAO undertook a baseline Structured Assessment which was reported in June 2019.

This baseline Structured Assessment fed into the full WAO 2019 Structured Assessment in 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.

The WAO also concluded that HEIW has a clear vision and strategic objectives are in place for 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: The organisation should review Board and committee oversight to ensure the breadth of its work is covered and there are no gaps in scrutiny arrangements.

Board Assurance Framework (BAF) and Risk: The organisation 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 should improve its risk management by determining and clearly communicating its risk appetites to ensure a consistent approach to: tolerance of risk; assessing and scoring of risks; and escalation/removal of risks to/from the Corporate Risk Register.

Performance management framework: HEIW should document its performance management framework, setting out: operational performance management arrangements and lines of accountability; and what is reported to whom and by when, and Board / Committee oversight for performance management.

Information Governance: The organisation should strengthen information governance and cyber security arrangements by: appointing a full-time information governance and data protection manager to complete the GDPR action plan and work towards full compliance; developing and reporting information governance KPIs; achieving certification in cyber security arrangements; establishing effective cyber security resources and expertise to manage risks; documenting a cyber security incident response plan to manage attacks and completing its planned and prioritised actions swiftly.

Digital and IT: HEIW should strengthen its strategic approach to digital and IT by: developing and approving a Digital and IT strategy; considering current capacity to deliver the Head of Digital role and whether it needs to appoint to the post; developing and reporting IT KPIs for challenge and scrutiny.

Monitoring objective against strategic objectives: HEIW has not set out a framework for monitoring performance against its strategic objectives and IMTP and should: formally document arrangements for the oversight and scrutiny of performance against strategic objectives; and work with pace to develop KPIs and targets which are clearly linked to strategic objectives, against which the Board can scrutinise performance.

6. Conclusion – Corporate Governance Report

During the period 1st April 2019 – 31st March 2020 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 2020/21 to further develop these arrangements. It will be important to communicate widely with staff to further embed these arrangements.

Signed by
Chief Executive: ……..

Date: ……

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.7**
Teitl yr Adroddiad	**Adroddiad Blynyddol 2019/2020 y Pwyllgor Archwilio a Sicrwydd**		
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 ddiben Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd yw sicrhau'r Bwrdd bod y system sicrhau yn addas i'r diben ac yn gweithredu'n effeithiol. Mae'r adroddiad yn crynhoi'r prif feysydd busnes a wnaed gan y Pwyllgor yn ystod 2019/2020.		
Materion Allweddol	Mae'r adroddiad hwn yn crynhoi'r prif feysydd busnes a wnaed gan y Pwyllgor yn ystod 2019/2020 ac yn tynnu sylw at rai o'r prif faterion y mae'r Pwyllgor yn bwriadu eu hystyried ymhellach dros y 12 mis nesaf.		
Cam Penodol i'w Gymryd ***(un ✓ yn unig)***	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
				✓
Argymhellion	Gofynnir i Aelodau'r Pwyllgor: - **Cymeradwyo** Adroddiad Blynyddol 2019/2020 i'w gyflwyno i'r Bwrdd ar gyfer sicrwydd.		

Adroddiad Blynyddol 2019/2020 y Pwyllgor Archwilio a Sicrwydd

1. CYFLWYNIAD

Prif ddiben Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd (y 'Pwyllgor') yw sicrhau'r Bwrdd bod y system sicrhau sy'n cael ei darparu gan y Pwyllgor yn addas i'r diben ac yn gweithredu'n effeithiol. Mae'r adroddiad hefyd yn cadarnhau bod y Pwyllgor wedi cyflawni ei Gylch Gorchwyl yn effeithiol.

2. CEFNDIR

Mae'r adroddiad pwyllgor blynyddol hwn wedi cael ei ddatblygu ar ôl adolygu cofnodion a phapurau cymeradwy'r pwyllgor, gan ystyried cylch gwaith y Pwyllgor fel y nodir yn ei Gylch Gorchwyl.

3. ASESU

Mae'r adroddiad hwn yn crynhoi'r gweithgareddau busnes a wnaed gan y Pwyllgor yn ystod 2019/2020 ac mae'n tynnu sylw at rai o'r materion allweddol y mae'r Pwyllgor yn bwriadu eu hystyried ymhellach dros y 12 mis nesaf.

4. MATERION LLYWODRAETHU A RISG

Caiff unrhyw risgiau a materion o ran llywodraethu eu rheoli drwy gyfarfodydd y pwyllgor a bydd adroddiadau ar eithriadau'n cael eu darparu i'r Bwrdd gan y cadeiryddion perthnasol.

5. GOBLYGIADAU ARIANNOL

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

6. ARGYMHELLIAD

Gofynnir i Aelodau'r Pwyllgor:

- **Cymeradwyo** Adroddiad Blynyddol 2019/2020 i'w gyflwyno i'r Bwrdd ar gyfer sicrwydd.

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	✓			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad Cleifion
Mae sicrhau bod y Bwrdd yn cyflawni ei fusnes yn briodol drwy ei Bwyllgorau a'i fod yn cyd-fynd â'i reolau sefydlog yn ffactor allweddol o ran ansawdd, diogelwch a phrofiadau cleifion sy'n cael gofal.
Goblygiadau Ariannol
Nid oes dim goblygiadau ariannol i'r Bwrdd fod yn ymwybodol ohonynt.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Mae'n hanfodol i'r Bwrdd gydymffurfio 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 perfformiad a chyllid tymor byr AaGIC yn ogystal â chanolbwyntio ar y cynaliadwyedd tymor hwy. Nod y strwythur llywodraethu yw adnabod materion yn gynnar er mwyn atal pethau rhag gwaethygu ac mae'r Pwyllgor yn integreiddio i drefniadau cyffredinol y Bwrdd.

Hanes yr Adroddiad	Ystyriwyd gan y Tîm Gweithredol
Atodiadau	Atodiad 1 – Adroddiad Blynyddol y Pwyllgor Archwilio a Sicrwydd 2019/2020

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

Audit and Assurance Committee
Annual Report 2019/2020

Committee Chair's Reflection

The engagement and attendance of all parties has been one aspect of the Audit and Assurance Committee that has improved this year. The agenda setting has improved considerably as have the minutes and action log. The support for the meeting is now much more streamlined and advance notice of agenda items and meeting dates now runs very smoothly.

The continuing challenges as a new organisation will be to pursue and challenge areas of risk and ensure that these are closed down appropriately. The other area of focus going forward is to make sure that there are clear lines of responsibility between the Audit and Assurance Committee, the Education, Commissioning and Quality Committee and the Board.

The Audit and Assurance Committee will receive regular performance reports from the Wales Audit Office and Internal Audit, indicating areas which could merit more detailed examination. Similarly, the financial report could indicate areas for more detailed work. The digital agenda is also a potential area where detailed examination could add value to the Integrated Medium Term Plan (IMTP).

In order to facilitate a better understanding of the Audit and Assurance Committee and its business across the organisation, I think that key links to the minutes of the Committee are important, and making the Annual Report widely available.

1 Introduction and Background

The purpose of the Audit and Assurance Committee is to **advise** and **assure** the Board and the Accountable Officer on whether effective arrangements are in place, regarding the design and operation of Health Education and Improvement Wales's (HEIW) system of governance and assurance. This supports the Board in its decision taking and in discharging its accountabilities for securing the achievement of HEIW's objectives in accordance with the standards of good governance determined for the NHS in Wales.

Membership of the Audit and Assurance Committee:

The membership of the Committee during 2019/20 was as follows:

Chair:	Gill Lewis, Independent Member
Members:	John Hill-Tout, Independent Member
	Dr Ruth Hall, Independent Member

Other officers of HEIW attend to support key matters.

The Committee also has regular attendance from representatives of:

- Wales Audit Office;
- Audit and Assurance, NHS Wales Shared Services Partnership (HEIW's Internal Auditors);
- NHS Counter Fraud

The Committee met on 5 occasions between April 2019 and March 2020.

The Committee wishes to thank all those who have contributed to the Committee discharging its business over the last year.

2 Key Issues and Achievements

2.1 Planning and Review

During 2019/20, the Audit and Assurance Committee has undertaken work to further promote key governance principles and the need for explicit assurance about risk, quality, control and governance within NHS organisations as part of their individual systems of governance and assurance.

The Audit and Assurance Committee has led further work on governance and assurance objectives to ensure good practice is maintained, further improve and embed HEIW's approaches. It has also responded to feedback from Internal Audit reports and the Wales Audit Office Structured Assessment Baseline Review and Structured Assessment for 2019.

In line with good practice, the Audit and Assurance Committee reviewed its own Terms of Reference and also carried out a self-assessment and Committee Evaluation process. As a maturing Committee, it was identified there was a need to focus on the areas of significant organisational risk, control and sound governance.

2.2 Governance and Assurance Development

Policies, Procedures and Plans

The Committee considered the Risk Management Policy and Revisions to the HEIW's Standing Orders and Scheme of Delegation and recommended approval to the Board.

The Committee received and approved:

- Revised Financial Control Procedures for the following areas:
    - Non-Current Assets;
    - Month End Process;
    - General Ledger;
    - Banking.
- Annual Reports for:
    - Wales Audit Office;
    - Internal Audit;
    - Counter Fraud.

- Annual Work Plans for:
    - Internal Audit;
    - External Audit; and
    - Counter Fraud

Following the establishment of the Education, Commissioning and Quality Committee, a review was undertaken of HEIW's standing orders. The review entitled 'Future Ways of Working' focussed on the roles of the Board and its committees to ensure that decision making was taken at the appropriate level and to avoid any gaps in the governance structure. The paper on Future Ways of Working was approved at the Board in September 2019 and the Committee Terms of Reference and Standing Orders were updated to reflect the findings of the paper in November 2019.

Risk Management

The Committee maintained a focus on further developing and embedding risk management processes and work currently in progress to align the Corporate Risk Register to the Integrated Medium Term Plan for 2020/2023. The Risk Management Policy was approved by the Board, and mandatory risk management training has been rolled out to Senior Managers. The Committee recommended that the Board consider its position in relation to Risk Appetite and how it treats risks, and informs wider decision making and provide guidance to staff. In response HEIW's draft Risk Appetite was considered at the Board Development Session in December and the final version of the Risk Appetite was approved at the Board in January 2020.

The Committee considered the draft Board Assurance Framework which outlines HEIW's framework for supporting good governance and ensuring this is supported by robust systems and processes. The Board approved the Board Assurance Framework at its meeting in September 2019.

A risk management internal audit was undertaken between October and December 2019. 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 risk management arrangements. The review sought to provide assurance to the Audit and Assurance Committee that risks material to the system's objectives are managed appropriately. The review concluded that the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls over risk management was reasonable assurance.

Monitoring Progress

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

- Reducing the backlog of **Job Evaluations** and the **Recruitment** into those posts.

- **Compliance with Mandatory Training and PADR** recorded on ESR for core staff. The Committee was assured that focussed work with the Medical Directorate would be undertaken in order to drive improvement in compliance.

- **Information Governance** reporting and the progress against the Work Plan.

- **Procurement Compliance Activity** and **Declarations of Interest Register**: An area of further concern by the Committee generated by this reporting was that further work would need to be undertaken to clarify the process when declarations of interest conflicts arise within the procurement process for cases reported as 'not endorsed'.

- **Audit Recommendation Tracker (the Tracker)**: The Committee approved the mechanism for reporting the progress arising from recommendations from internal and external audit reports. The Tracker contains the current agreed actions in response to the recommendations within Audit reports received from Internal Audit and the Wales Audit Office. The reporting provides the Committee with assurance that those recommendations contained within the Tracker are being progressed, monitored and completed.

3.3 Financial Management Control and Systems Monitoring

The Committee has continued to seek improvements in the financial systems and has approved revised Financial Control Procedures in respect of Non-Current Assets; Month End Process; General Ledger and Banking.

The Committee received the Contracts and Agreements Register and noted the further work to be undertaken to ensure all elements of contract management were being captured.

An update on the current position of the **Strategic Review of Healthcare Education in Wales** was received. The Committee noted that the current contracts were to be extended for 2020/21 and that HEIW was working closely with Legal and Procurement colleagues to finalise the process for the extension with the issuing of a modification notice. The new contracts were to be developed by May 2020 in preparation for the tendering exercise and contract award.

In January 2019, the Committee received a request from the Education, Commissioning and Quality Committee, to scrutinise the remuneration arrangements of the business case for the **Development of a Tariff Arrangement for Secondary Care Training Programme Directors across Wales to support Professionalisation of the Role**. The Committee considered the remuneration package to support the case to implement a tariff arrangement.

3.4 Annual Accounts

In May 2019 the Committee reviewed the draft and audited accounts for 2018-19 and considered reports on the Accounts received from the WAO and 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 2019.

In January 2019, the Committee received the **Annual Accounts Plan and Draft Annual Report Timetable for 2019/20** and noted the changes to the submission deadline dates.

3.5 Wales Audit Office (WAO)

In July 2019 the Committee noted that the WAO was to revisit the preparedness of Wales for a 'no deal' Brexit over the summer, and the increased interest of the Public Accounts Committee (PAC) regarding Counter Fraud arrangements in the Welsh public sector following the Landscape Review undertaken by WAO on behalf of the PAC.

Structure Assessment Baseline Review and Structured Assessment 2019: The report findings highlighted that HEIW had established the necessary arrangements to support good governance, there was more that the organisation needed to do in relation to risk management arrangements; the mapping of key sources of assurance to strengthen the Board Assurance Framework (BAF), and the further development of internal controls to support the Performance Management Framework and Information Governance. The Committee welcomed the report which was positive and recognised the strong leadership and the progress being made in relation to the strategic vision with the development of the first Integrated Medium Term Plan.

3.6 Internal Audit

During the year the Committee considered the following Internal Audit matters:

The **Board and Committee Governance Arrangements Internal Audit Repor**t 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:

- Transitional Management
- Risk Management
- Performance Management
- Values and Behaviours Framework
- Health and Safety
- Freedom of Information

Limited Assurance Report: Workforce Review – Casual Workers: In order to raise compliance levels, a number of actions were being implemented to address the recommendations. Internal Audit undertook a follow up review during September and October 2019 to provide assurance regarding the implementation of the agreed management actions. The follow-up review was assessed with reasonable assurance.

Internal Audit IT Baseline Review: The Committee received the report, noting that this was a review of HEIW's ICT and Information Governance arrangements and was a work in progress. The Committee confirmed that Information Governance was part of its role and remit and was receiving regular Information Governance reports.

[A rounding off statement from the Head of Internal Audit position will be added after the April meeting.]

3.7 Counter Fraud

The Committee agreed the Counter Fraud Strategy and Work Plan.

The Committee received quarterly Counter Fraud Newsletters; the Counter Fraud Report on Sharing Lessons Learnt and the completed Annual Declaration against the Counter Fraud Self Review Tool 2018/19 which had been undertaken as part of the national quality assurance process. The level of assurance and performance rating was an overall score of amber. Further focussed work would be undertaken to raise awareness of fraud, bribery and corruption.

4 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:

5 Key Areas of Focus for the Coming Year

During 2020-2021 the Committee will continue to focus on the following areas:

- 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.

Sponsored by: **Gill Lewis**
Chair of Audit and Assurance Committee

Date: March 2020

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.8**
Teitl yr Adroddiad	**Adroddiad ar Gydymffurfiad AaGIC ym maes Caffael**		
Awdur yr Adroddiad	Helen James, 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	Diben yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio a Risg am y gweithgarwch caffael yn ystod y cyfnod rhwng 18 Ionawr a 20 Mawrth 2020, yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 o'r Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheirianneg) y Cyfarwyddiadau Ariannol Sefydlog.		
Materion Allweddol	Mae esboniad o'r rhesymau, yr amgylchiadau a manylion unrhyw gamau eraill a gymerwyd hefyd wedi'u cynnwys yn yr atodiadau i'r adroddiad.		
Cam Penodol i'w Gymryd *(un ✓ yn unig)*	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
			✓	
Argymhellion	Gofynnir i aelodau wneud y canlynol: • **Nodi**'r adroddiad er sicrwydd		

ADRODDIAD AR GYDYMFFURFIAD AaGIC YM MAES CAFFAEL

1. CYFLWYNIAD

Yn unol â Chyfarwyddiadau Ariannol Sefydlog AaGIC, mae'n rhaid rhoi gwybod i'r Pwyllgor Archwilio a Risg am bob cais am Weithredoedd Dyfynbrisio Unigol (SQA), Gweithredoedd Tendro Unigol (STA), Tendrau Unigol er ystyriaeth yn dilyn cais am Gystadleuaeth OJEU, Ymestyn Contractau a Dyfarnu cyllid ychwanegol y tu allan i delerau'r contract (a weithredwyd drwy Nodyn Newid Contract neu Amrywio Telerau).

2. CEFNDIR

Diben yr adroddiad hwn yw rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor Archwilio am y gweithgarwch caffael yn ystod y cyfnod rhwng 18 Ionawr a 20 Mawrth 2020, yn unol â chyfeirnod 1.2 (Atodlen 2.1.2 o'r Cod Caffael a Chontractau ar gyfer Gwaith Adeiladu a Pheirianneg) y Cyfarwyddiadau Ariannol Sefydlog.

Mae esboniad o'r rhesymau, yr amgylchiadau a manylion unrhyw gamau eraill a gymerwyd hefyd wedi'u cynnwys.

Cyfeirnod SFI	Disgrifiad	Eitemau
3.5	Gweithredoedd Dyfynbrisio Unigol	1
4.2	Gweithredoedd Tendro Unigol	1
5.3	Tendrau Unigol er ystyriaeth yn dilyn cais am Gystadleuaeth OJEU	0
10.8	Ymestyn Contractau	0
14.2	Dyfarnu cyllid ychwanegol y tu allan i delerau'r contract (a weithredwyd drwy Nodyn Newid Contract neu Amrywio Telerau)	1

Ar ben hyn, mae Aelodau Annibynnol wedi gofyn am gadarnhad bod y datganiadau a wneir gan staff sy'n rhan o'r prosesau caffael mewn perthynas â gwrthdaro rhwng buddiannau, yn cael eu gwirio yn erbyn Cofrestr Datgan Buddiannau'r Sefydliad.

Ar ôl adolygu'r gweithdrefnau presennol ym maes Caffael, roedd yn amlwg nad oedd yr arferion hyn yn cael eu dilyn. Fodd bynnag, drwy weithio gyda Thîm Rheoli'r Sefydliad wrth symud ymlaen, gallwn sicrhau'r Pwyllgor Archwilio y bydd yr arferion hyn yn cael eu sefydlu fel rhan o'r broses SQA/STA. Yn ogystal â hyn, yn dilyn yr adolygiad Cymru Gyfan o Reolau Sefydlog a Chyfarwyddiadau Ariannol Sefydlog, argymhellwyd bod y gwiriadau hyn yn cael eu cynnal ar sail ceisiadau sydd wedi'u cymeradwyo'n flaenorol a bydd rhaglen yn cael ei llunio i sicrhau bod hyn yn cael ei gyflawni.

3. GOBLYGIADAU ARIANNOL A RHEOLI

Dylai'r Pwyllgor Archwilio a Risg nodi manylion yr Atodiadau sydd ynghlwm a monitro niferoedd a gwerth y busnes sy'n cael ei gyflwyno i gael cymeradwyaeth ar gyfer Tendr Unigol neu Ddyfynbris Unigol. Mae'r canllawiau cyffredinol ar wario arian cyhoeddus yn nodi y dylai broses wario gael ei chynnal mewn modd teg, tryloyw ac agored, gan sicrhau cystadleuaeth lle bynnag y bo hynny'n bosib. Felly, dylid cael cyn lleied o geisiadau gweithred unigol â phosib.

4. ARGYMHELLIAD

Gofynnir i'r Pwyllgor:

- **nodi**'r adroddiad er sicrwydd.

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol *(rhowch ✓)*	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	✓			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

Ansawdd, Diogelwch a Phrofiad Cleifion
Does dim goblygiadau diogelwch ac ansawdd penodol cysylltiedig â'r gweithgarwch a nodir yn yr adroddiad hwn.
Goblygiadau Ariannol
Mae cyfarwyddiadau ariannol sefydlog, rheolau sefydlog, mesurau rheoli ariannol a systemau cyfrifyddu yn rhoi sylfaen i nifer o fesurau rheoli sefydliadol, sy'n rhan o'r gwaith o gyflawni targedau ariannol a rheolaeth dda. Mae'r canllawiau cyffredinol ar wario arian cyhoeddus yn nodi y dylai broses wario gael ei chynnal mewn modd teg, tryloyw ac agored, gan sicrhau cystadleuaeth lle bynnag y bo hynny'n bosib. Felly, dylid cael cyn lleied o geisiadau gweithred unigol â phosib.
Goblygiadau Cyfreithiol (gan gynnwys asesu cydraddoldeb ac amrywiaeth)
Does dim goblygiadau cyfreithiol penodol cysylltiedig â'r gweithgarwch a nodir yn yr adroddiad hwn.
Goblygiadau Staffio
Does dim goblygiadau staffio penodol cysylltiedig â'r gweithgarwch a nodir 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

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

Health Education Improvement Wales - Audit Committee Report – 1st April 2020

Appendix 1 – Summary Information

Trust	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
HEIW	Medical Directorate	HEIW-SQA-511	March – June 2020	SQA	Clinical Pharmacy Congress (largest gathering for Clinical Pharmacy profession)	Closterstill Media Ltd	£8,985.60	Only event of its kind that provides opportunity to speak with pharmacy professionals.	Endorsed	Procurement to set up meeting with Service to discuss future requirement in July following event to confirm if it is an ongoing requirement.	First Submission
HEIW	Workforce & OD	HEIW-STA-510	March - September 2020	STA	Medical Engagement Scale Survey	Engage to Perform	£82,000	IP is owned by the supplier and have not licenced used of equipment to other suppliers.	Endorsed.	No further action, Service informed that this is the last year for this requirement.	First Submission
HEIW	Dental	HEIW-STA-40225	March 2020	Change Control Notice	Intrepid	HiCOM	£47,180	Increase number of administrative and non-administrative licences required additional fields to support ongoing data repository requirements.	Endorsed.	No further action apart from supporting regular contractual review.	First Submission

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

Health Education and Improvement Wales - Audit Committee Report – 1st April 2020

Appendix 2 - 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	Pharmacy	HEIW/FN/061			Phase 2 Evaluation	Curemed	£13,245.00	Committed to Phase 2 activity when Phase 1 was contracted by Cardiff University.	Not Endorsed.	Procurement to set up meeting in May 2020 to discuss future requirement with Service.	Second submission. First submission was for Phase 1.
HEIW	Pharmacy	HEIW/FN/066	12 months		Cardiff University	10 credit research module	£10,450	Service had followed previous student module registration as they did under Cardiff University to discover that contract now did not cover these students under HEIW.		Service to confirm research module plan to enable procurement to run a competition.	First submission.
HEIW	Secondary Care	HEIW/FN/067	January 2020		BMJ Events	Round 2 speciality training advert	£7,305.50	STA received after contract commitment by Service.		STA is progress for April onwards advertisement. Service requested to extend STA duration to cover all future potential advertising requirement.	Repeat submission. Previous submission in August 2020

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**2.9**
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 argymhellion yr 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 yn cynnwys **8** argymhelliad ar hyn o bryd. Defnyddir proses sgorio Coch; Melyn; Gwyrdd (RAG). Mae'r Adnodd Tracio wedi'i atodi yn Atodiad 1.		
Cam Penodol i'w Gymryd ***(un ✓ yn unig)***	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
				✓
Argymhellion	Gofynnir i'r Pwyllgor Archwilio a Sicrwydd wneud y canlynol: • **Cymeradwyo**'r newidiadau i'r Adnodd Tracio • 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.

Yng nghyfarfod diwethaf y Pwyllgor, cytunwyd y byddai dyddiad targed newydd yn cael ei bennu ar gyfer yr argymhellion hynny roedd eu dyddiad cau wedi mynd heibio, yn ogystal â nodyn yn esbonio pam methwyd y dyddiad cau. Er mwyn ymgorffori'r wybodaeth ychwanegol yn yr Adnodd Tracio, adolygwyd y broses Tracio Archwiliadau gan sefydliadau'r GIG yng Nghymru. Roedd yr adolygiad yn nodi arferion gorau Ymddiriedolaeth Ambiwlans GIG Cymru (WAST) ac, felly, er mwyn gwella'r broses adrodd a pherfformiad, yn ogystal â symleiddio'r broses adrodd, mae Adnodd Tracio Archwiliadau WAST wedi cael ei fabwysiadu ar gyfer AaGIC.

Mae'r Adnodd Tracio'n monitro statws argymhellion Archwiliadau mewnol a'r rheini a gynhelir gan Swyddfa Archwilio Cymru. Mae'r dyluniad newydd yn rhoi 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. Mae hyn yn wahanol i'r adnodd tracio arall, a oedd yn rhoi naratif manylach yng nghyswllt camau a gymerwyd yn erbyn pob un o'r argymhellion.

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

- Adolygiadau Archwilio Mewnol
- Allanol - Adolygiadau Swyddfa Archwilio Cymru ac Adolygiadau Allanol Eraill
- Mewnol wedi cwblhau
- Allanol wedi cwblhau

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**

Mae manylion **8** argymhelliad sy'n deillio o archwiliadau mewnol i'w gweld yn nhab 1 yr adnodd tracio ar hyn o bryd.

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 1 argymhelliad sydd heb gyrraedd y dyddiad cau eto. Fodd bynnag, oherwydd bod y Coronafeirws yn dod yn fwy a mwy o flaenoriaeth, mae rhai camau gweithredu wedi cael eu gohirio nes hysbysir fel arall.

Mae'r 8 argymhelliad yn y tab archwiliad mewnol isod wedi'u rhoi mewn categorïau yn y tabl isod:

Coch	**3**	Yn gwneud cynnydd da, ond tu allan i'r amserlen darged. Fodd bynnag, mae 2 o'r argymhellion wedi cael eu gohirio oherwydd bod y Coronafeirws yn fwy o flaenoriaeth.
Gwyrdd	**4**	Aseswyd bod y cam gweithredu wedi'i gwblhau.
Oren	**1**	Cynnydd sylweddol ond yn dal heb gwblhau'n llwyr, neu dydy'r Cam Gweithredu heb gyrraedd y dyddiad ar hyn o bryd.

Bwriedir tynnu'r 4 cam gweithredu Gwyrdd yr aseswyd eu bod wedi'u cwblhau 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 yn y gronfa ddata yn cael eu cwblhau fel y cytunwyd.

- **Tab 2 – Allanol: Crynodeb o Adroddiadau Swyddfa Archwilio Cymru**

Does dim argymhellion sy'n deillio o Archwiliadau Allanol heb eu cwblhau ar hyn o bryd.

- **Tab 3 a 4 – Argymhellion wedi'u Cwblhau**

Mae gwaith yn cael ei wneud i drosglwyddo'r argymhellion sydd eisoes wedi'u cwblhau i'n cronfa ddata newydd. Bydd hyn yn cael ei wneud wrth gofnodi yn y dyfodol.

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:

- **Cymeradwyo**'r newidiadau i'r Adnodd Tracio
- **Cymeradwyo**'r 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				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	✓			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	
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)				
Does dim goblygiadau cyfreithiol.				
Goblygiadau Staffio				
Does dim goblygiadau o ran 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			

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
26	19/20	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			
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.	Oct-19	Partially complete	Overdue	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. **Current Progress:** The Alcohol & Substance Misuse and Mental Health & Wellbeing Procedures are part of the Corporate Health Standards. Both procedures are due to be presented to the Policy Review Group and Local Partnership Forum anticipated for April 2020.	Apr-20	6				
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	Oct-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				
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.	Dec-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			
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.	Dec-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.	Dec-19	0	Yes			
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	No progress	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. **Current Progress:** The Board planned to undertake its self-assessment as part of a Board Development Session in Q4. However, due to the increased priority of Coronavirus, this has been postponed until further notice.	TBC	TBC				

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 Remuneration and Terms of Service Committee scheduled for Q4 of 2019/20	Mar-20	No progress	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. **Current Progress:** 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.	TBC	TBC				
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	No progress	Not yet due	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. **Current Progress:** 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.	TBC	TBC				

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

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

Dyddiad y Cyfarfod	**1 Ebrill 2020**	**Eitem ar yr Agenda**	**3.1**
Teitl yr Adroddiad	**Disgwyliadau Gafael a Rheoli ar gyfer 2020/21**		
Awdur yr Adroddiad	Martyn Pennell, Pennaeth Cyfrifyddu Ariannol		
Noddwr yr Adroddiad	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Cyflwynwyd gan	Eifion Williams, Cyfarwyddwr Cyllid Dros Dro		
Rhyddid Gwybodaeth	Agored		
Pwrpas yr Adroddiad	Mae'r adroddiad hwn yn rhoi crynodeb o'r Disgwyliadau Gafael a Rheoli ar gyfer 2020/21 sydd i'w hystyried ar draws GIG Cymru.		
Materion Allweddol	• Bydd holl sefydliadau GIG Cymru yn ystyried eu trefniadau gafael a rheoli ar gyfer y flwyddyn ariannol 2020/21. • Ar hyn o bryd mae ymateb ffurfiol yn cael ei baratoi ar gyfer Addysg a Gwella Iechyd Cymru.		
Cam Penodol i'w Gymryd ***(un ✓ yn unig)***	**Gwybodaeth**	**Trafod**	**Sicrhau**	**Cymeradwyo**
	✓			
Argymhellion	Gofynnir i aelodau wneud y canlynol: • Nodi'r adroddiad.			

1. CYFLWYNIAD

Mae’r adroddiad hwn yn rhoi crynodeb o’r Disgwyliadau Gafael a Rheoli ar gyfer 2020/21 sydd i'w hystyried ar draws GIG Cymru.

2. CEFNDIR

Yn fforwm y Cyfarwyddwyr Cyllid ym mis Chwefror 2020, cyflwynodd yr Uned Cyflawni Cyllid (FDU) grynodeb o ganfyddiadau o adolygiad o drefniadau gafael a rheoli a gomisiynwyd ar gyfer sefydliadau’r GIG wedi’u huwchgyfeirio. Nododd y FDU, gyda chefnogaeth Dr Andrew Goodall, y gallai canfyddiadau’r gwaith yma fod yn berthnasol i bob sefydliad ac y gallai gweithredu’r argymhellion arwain at welliant sylweddol i’r sefyllfa ariannol ar draws GIG Cymru. Mae copi o’r cyflwyniad gan yr FDU wedi’i gynnwys yn atodiad 1, sy’n amlinellu’r prif themâu a ddaeth allan o’r adolygiad.

Mewn llythyr dyddiedig 2 Mawrth 2020 at holl Brif Weithredwyr a Chadeiryddion Byrddau Iechyd y GIG (mae copi yn Atodiad 2), gofynnodd Dr Goodall i bob sefydliad ymateb iddo gyda sicrwydd bod y trefniadau ar waith ac yn effeithiol yn eu sefydliad.

Ar hyn o bryd mae Addysg a Gwella Iechyd Cymru (AaGIC) yn ffurfioli ei ymateb i’r llythyr a bwriedir cynnal y cyfarfod cychwynnol ar 31 Mawrth 2020. Rhoddir diweddariad llafar yn amlinellu’r sefyllfa i’r Pwyllgor Archwilio a Sicrwydd.

3. MATERION LLYWODRAETHU A RISG

Bydd yr ymateb i’r llythyr yn nodi’r trefniadau rheoli sydd ar waith yn AaGIC i reoli ac i fonitro ei gyllid.

4. GOBLYGIADAU ARIANNOL A MATERION ALLWEDDOL

Nid oes dim goblygiadau ariannol penodol o ganlyniad i'r papur hwn.

5. ARGYMHELLION

Gofynnir i aelodau wneud y canlynol:

- Nodi’r adroddiad.

Llywodraethu a Sicrwydd				
Cysylltu ag amcanion corfforaethol ***(rhowch ✓)***	Fel sefydliad newydd, sefydlu AaGIC fel partner dibynadwy a gwerthfawr, cyflogwr ardderchog a brand arbenigol ag enw da.	Adeiladu gweithlu iechyd a gofal cynaliadwy a hyblyg i'r dyfodol.	Gyda Gofal Cymdeithasol Cymru, siapio'r gweithlu i ddarparu gofal yn nes at y cartref ac i gysoni darpariaeth gwasanaethau'n well.	Gwella ansawdd a diogelwch drwy gefnogi sefydliadau'r GIG i ddod o hyd i atebion cyflymach a mwy cynaliadwy o ran y gweithlu ar gyfer yr heriau darparu gwasanaethau sy'n cael eu blaenoriaethu.
	√			
	Gwella'r cyfleoedd ar gyfer defnyddio technoleg a digideiddio wrth ddarparu addysg a gofal.	Rhoi hwb i ddatblygiad arweinyddiaeth a chynllunio ar gyfer olyniaeth ar draws iechyd a gofal cymdeithasol mewn partneriaeth â Gofal Cymdeithasol Cymru ac Academi Wales.	Dangos gwerth buddsoddiadau yn y gweithlu a'r sefydliad.	

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

Atodiadau	**Atodiad 1** – Disgwyliadau Gafael a Rheoli 2020/21 cyflwyniad i'r Fforwm Cyfarwyddwyr Cyllid Chwefror 2020. **Atodiad 2** – Llythyr Disgwyliadau Gafael a Rheoli oddi wrth Dr Andrew Goodall, 2 Mawrth 2020.

Grip and Control Expectations for 2020/21

Directors of Finance Forum

21 February 2020

GIG CYMRU NHS WALES | Finance Delivery Unit
Uned Gyflawni Cyllid

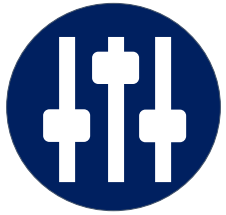
Evidence, Excellence, Insight, Delivery

Session Outline

1. Introduction and Context
2. Minimum Expectations – Budgetary Control Environment
3. Grip and Control Findings
4. Examples and Recommendations

Introduction and Context

- Challenging year despite record levels of investment
- 3 focused pieces of work commissioned including an assessment of grip and control and effectiveness of delivery framework



- Evidence base has identified variation across NHS Wales

- Purpose of this session
  - Share insight
  - Outline minimum expectations and good practice

Minimum Expectations – Control Environment

Business Cases

Clear process for development and approval of business cases (material investments defined in SFIs and approved by Board).

Benefits routinely tracked with corrective action if trajectory not met.

Business cases not delivering to plan escalated with potential consequence that investment ceases or is unwound.

Post implementation reviews take place on systematic basis.

Board Reporting

Financial reports provided to Board that enable members to understand the financial position, evaluate risks and opportunities and use insight to make informed decisions.

Financial reporting integrated with performance reporting.

Reporting balanced between retrospective analysis and prospective action and forecasts.

Accountability and Performance Management

Escalation process in place to manage identified performance issues.

Accountability meetings to focus on understanding of cost drivers of variance and mitigating actions to address overspend and/or choices/decisions that are required.

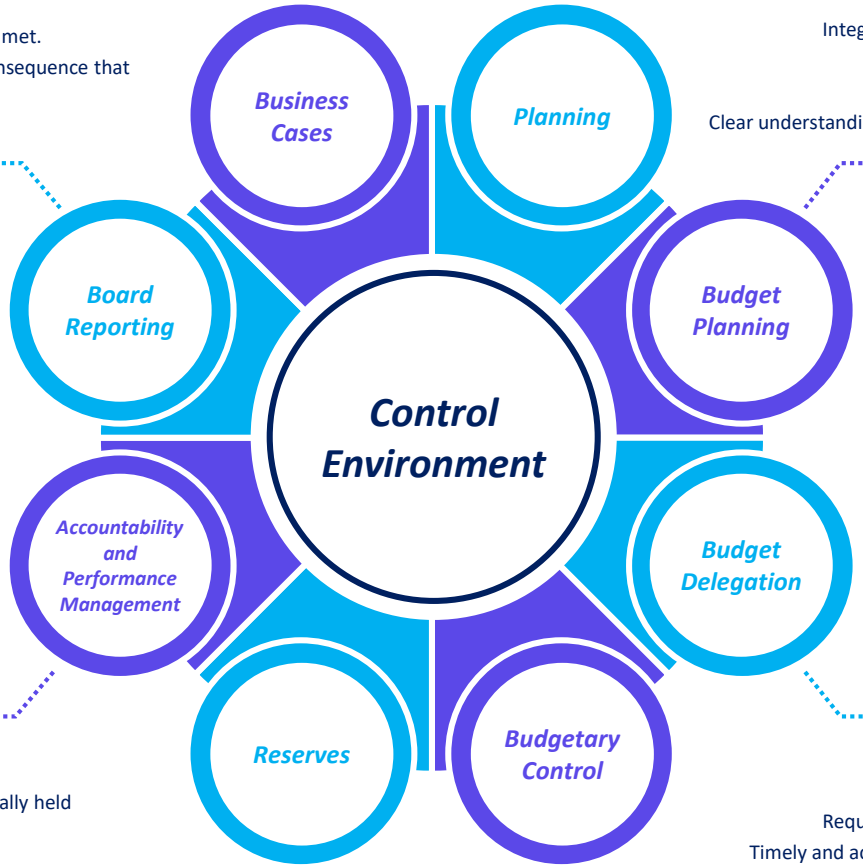
Accountability meetings informed by a range of metrics with improvement trajectories.

Reserves

Appropriate arrangements in place for the management of centrally held reserves.

Reserves held for clearly defined purposes.

Reserves approved and monitored by the Board.



Planning

Clear and robust approach to strategic and operational planning based on population need.

Integrated approach to service, workforce and financial planning.

Evidence based assumptions around cost pressures.

Clearly defined milestones and benefits for investments.

Clear understanding of underlying position (by service and cost area) built into choices.

Budget Planning

Revenue and Capital budgets set in line with organisation's plan and allocation.

Budget plan approved by Board in advance of the new financial year.

Budget holders involved in budget setting process.

Budgets appropriately delegated and profiled.

Budget Delegation

Board delegates budgets to CEO.

CEO formally delegates budgets in writing (per scheme of delegation) – amount, purpose, virements, expected service delivery.

Budget holders formally sign accountability letters.

Clear Financial Control Procedure for budgetary control

Budgetary Control

Only budget holders to commit expenditure.

Requisition and ordering process utilised in accordance with SFIs.

Timely and accurate financial reports with clear expectation of mitigating actions if significant adverse variances.

Budget holders held to account through accountability framework.

Minimum Expectations - Control Environment

Monitoring and Oversight

The Board & appropriate sub-committee should:-

- Approve the organisation's Annual Plan / IMTP, and annual budget plan;
- Monitor performance against the organisation's plan in addition to financial performance;
- Effectively assess and monitor risk to financial delivery including mitigating actions to appropriately manage risk;
- Appropriately approve investments in line with SFIs and scrutinise material planned increases in expenditure; and
- Robustly challenge and support progress with the delivery of savings plans in a timely manner as a key component of the delivery of financial plans.

Grip and Control – General Themes

Scope
The scope of the reviews was limited to include controls that would have a potential immediate impact on financial recovery. In particular, the grip and control work has focused on pay controls, notably variable pay and basic procurement controls.

Findings
The various reports identify a range of controls and functions that can be improved with a view to enhancing organisational responses to financial challenge and delivery.

Consistent Themes – Grip and Control

Organisations are not making the best use of technology solutions for rostering, job planning and rota management

The greatest improvement opportunity lies in pay controls, particularly bank and agency staff.

Approval processes can be enhanced, particularly in organisations with a financial recovery programme.

There are inconsistent controls operating across different sites within the same organisation.

The control environment could be enhanced by the use of data dashboards to visibly demonstrate compliance.

There are limited post implementation reviews of business cases.

Typically controls that are appropriately designed have instances of non-compliance that compromise effectiveness.

Grip & Control Actions - Examples

Bank

Actions

- Temporary Staffing Policy in place.
- Auto enrolment for new starters onto the bank.
- Review pay rates and consider weekly pay as an incentive.
- Admin and clerical bank.

Agency

Actions

- Clear process for agency booking (and compliance).
- Ensure appropriate deduction for agency staff breaks (lunch).
- Review authorisation levels – seniority and consistency across sites.

Rostering

Actions

- E-rostering should be fully deployed.
- Annual leave should be closely managed throughout the year.
- Rosters should be approved six weeks in advance.
- Contracted hours to be fully rostered.

Other pay controls

Actions

- Line managers to notify HR of leaving dates.
- Cease any early finish dates for leavers.
- Enforce compliance with the All Wales Sickness policy.

Medical Locums

Actions

- Implement medical bank.
- Proper process for booking medical agency (no direct approach)
- Ensure appropriate deduction for agency staff breaks (lunch).
- Ensure mileage claims are only for required intra site travel.

Medical Rotas

Actions

- Clear timeline for submission of rotas.
- Ensure alignment of rota to job plans.
- Review additional sessions allocated.
- Monitor medical annual leave.

Waiting List Initiatives

Actions

- Ensure consistent process across organisation.
- Require clear demonstration that existing PAs have been utilised.
- Ensure approval level is appropriate.

Procurement

Actions

- Address clinical preference variation in a targeted manner.
- Review and reduce those able to requisition and order.
- Continue to enforce the 'No PO No Pay' policy.

Grip and Control – Non Compliance Examples

	Example	Expected Control
1	**Agency Bookings** Wards are circumventing the agency booking process with 23% of agency nurse bookings going direct to the nurse and 8% going directly to the agency.	Organisations should have a clear policy and procedure for agency bookings and this should be communicated to all staff. Only bookings made through the appropriate channels e.g. bank office will be paid for.
2	**Leavers Controls** There are delays in notifying HR and payroll of leavers termination dates. Service teams are also agreeing shorter notice periods than those outlined in contracts.	Termination dates should be notified to HR and payroll in a timely manner. Shorter notice periods should only be agreed if it does not adversely impact upon service delivery and does not result in increased expenditure through high cost variable pay.
3	**Rostering** The organisation policy is that rosters are signed off six weeks in advance but in practice, they are signed off four weeks in advance. Shifts are being requested from the bank office before rosters are approved. Agency shifts are being used to fill high cost/unpopular shifts such as nights and long days.	All rosters should be signed off and approved in line with best practice guidance and the policy of six weeks. Shifts should only be requested from the bank office when the roster is signed off and all other options have been explored.
4	**Establishment Controls** There are numerous examples of over-establishment, in some areas by more than 50%.	Appropriate controls should be in place to ensure that staff are only appointed if there is a funded establishment.
5	**Procurement Controls** There is a 'no purchase order : no pay' policy in operation but a high volume of invoices are still on hold.	Goods and services should be procured in line with Standing Financial Instructions and requisitions/orders raised and approved by appropriately authorised individuals.

! Organisations should monitor compliance with key controls and consider disciplinary proceedings for non-compliance.

Next Steps

Finance Delivery Unit Support

- Share the findings (subsequent to this presentation)
- Grip and Control checklist being developed
- Organisation support where required

NHS Wales Response

- How will organisations use the insight/findings?
- How will compliance be demonstrated?
- What further support is required?

Good Practice – Annual Budget Plans

Budget plans which are developed and approved by the Board should as a minimum:

- Outline initial revenue budgets to be delegated for the financial year (to divisions and corporate directorates)
- Outline budgets held in reserve, both planned commitments and any uncommitted reserve
- Approve any budgetary re-provision if appropriate
- Be based on budget setting principles which have already been agreed by the Board
- Clearly outline how the Board will consider or has considered:
  - Developing a sustainable financial position
  - Funding provisions for commitments the Board wants to recognise e.g. pay awards
  - The process for supporting any investment which considers affordability, improved outcomes and benefits, and the organisation's priorities
  - Appropriately balance and prioritise new commitments and confidence in savings delivery
  - Application of efficiency & savings targets in line with opportunities for improvement by service area, and the level of financial challenge faced by budget holders

Good Practice – Annual Budget Plans

- Outline in detail to the Board
  - The organisation's allocation basis, including detail of all new allocations in 2020/21
  - Clarity on the assumed level of savings and efficiency by service / division / unit (including comparison to the assumed opportunity for improvement)
  - Any funding delegation which links to previous Executive & Board choices
  - Any funding delegation for planned 2020/21 new investments which relate to additional allocations or discretionary choices made by the Board
  - Any provisions which are made in budgetary terms, their expected purpose, and process for delegation in the financial year
  - Any reserve value, in addition to the intended use of the reserve with clarity to the Board on how the Board will scrutinise and allocate budgets over the financial year
  - Explicit assumptions in budgetary terms of key big ticket issues which are known material commitments in the organisation's plan, for example Welsh Risk Pool, Treatment Fund, performance improvements, specialised services
- Clearly outline following the above the budget being delegated to each corporate area / division / unit and the reserves being retained centrally
- Clearly outline any further improvements that are required over the financial year, or any known areas with anticipated amendments to delegated budgets

Good Practice – Budget Delegation

Budget delegation to budget holders which are developed and approved by the Board should as a minimum:

- Initiate from the Chief Executive to lead Executive officers as the primary delegated officer for their areas of responsibility
- Form a blueprint and set of principles which support onward delegation to budget holders through the organisations scheme of delegation
- Outline how budgetary management is a key performance requirement and outline how this will be reviewed throughout the financial year
- Be clear on the value and construct of the budget that is delegated
- Outline the budget holder's responsibilities in relation to budgetary control, and ensure awareness of the organisation's financial control procedures, SFI's, Standing Orders
- Outline clear expectations on any further delegation of budgets to budget holders and apply the same principles on any further budget delegation

Good Practice – Budget Delegation

- Outline anticipated future budget delegations within the financial year (including the anticipation of delegating future budgets if the organisations receives additional allocations)
- Outlines delivery expectations in line with delegated budgets
- Outlines the relevant budget training, support, advice, and toolkits available to support budget holders in delivering to available resources
- Outline as appropriate the equivalent level of anticipated delivery of planned outputs and outcomes that align to the delegated budgets – e.g. workforce indicators, key performance indicators, levels of activity, agreed deliverable outcomes associated with specific investment

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

NHS Health Board and Trust Chief Executives and Chairs

Our Ref: AG/AS/SB

2 March 2020

Dear Colleagues

Grip & Control Expectations

You will be aware from discussion at NHS Executive Board, that recent financial planning and delivery support commissioned for organisations in escalation have reported a number of findings in relation to required improvements to organisational grip & control arrangements. Delivery of the necessary actions outlined by these findings will also enable delivery of a material opportunity for financial improvement.

These findings are potentially applicable to all organisations, and as such the Finance Delivery Unit has co-ordinated the key themes from this work into a product for wider use, which is attached to this correspondence.

In addition to considering key grip & control themes, this product also outlines good practice in relation to a minimum expectation of an effective budgetary control environment for NHS organisations having considered good practice across the system.

I expect organisations to review this assessment against their own existing control arrangements, and respond to me with assurance that these arrangements are in place and effective within your organisation.

This is a timely and important requirement in advance of next financial year. If you want to discuss any aspect of this further in undertaking your assessment please contact Hywel Jones, Director of the Finance Delivery Unit, in the first instance.

Yours sincerely

Dr Andrew Goodall CBE

Enc.

cc: Alan Brace
Hywel Jones
Directors of Finance

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 0300 0251182
Andrew.Goodall@gov.wales

Gwefan • website: www.wales.gov.uk

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our Ref: RB/lab Direct Line: 01633 435958 18th March 2020

Dr Andrew Goodall CBE
Director General Health and Social Services/
NHS Wales Chief Executive
Welsh Government
Cathays Park
CARDIFF CF10 3NQ

Dear Andrew

Advice/Proposals from NHS Board Secretaries/Directors of Corporate Governance on COVID-19

Further to the e-mail exchanges over last weekend (14th and 15th March 2020), the all-Wales Board Secretaries Group was asked to consider governance matters in NHS Wales during the period of the COVID-19 Pandemic. The Board Secretaries Group met yesterday via telephone conference and was joined on the call by Sioned Rees from Welsh Government.

The Group emphasised that it was particularly important as the Pandemic is expected to escalate over coming weeks and months that we are clear how we use NHS governance arrangements to enable continued appropriate functioning of NHS organisations and that governance requirements are not be seen as a framework of bureaucracy that hinders agile decision making and taking.

Therefore, we have proposed a number of governance principles to use as a framework, but also maintain a continued focus for NHS organisations on our responsibilities to the public and partners in relation to openness, transparency and accountability and discharging these in the right ways during these unprecedented times.

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys,
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 234234
E-bost: abhb.enquiries@wales.nhs.uk

Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: 01633 234234
Email: abhb.enquiries@wales.nhs.uk

www.aneurinbevanhb.wales.nhs.uk

We have also proposed a number of changes to the ways in which Boards and their Committees operate and have also asked a range of further questions with regard to the coming months and the arrangements for Boards and their membership, decision making and schemes of delegation and also required end of year reporting. The advice and guidance of Welsh Government would be welcomed with regard to the arrangements and your approval to progress with some of these changes for the coming period.

Governance Principles: The Board Secretaries Group has framed a number of governance principles that are designed to help focus consideration of governance matters over coming weeks and months. These are:

- **Public interest and patient safety** - We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking into account the national public health emergency that (COVID-19) presents.
- **Staff wellbeing and deployment** – we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.
- **Good governance and risk management** – we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.
- **Delegation and escalation** – any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing fora will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.
- **Departures** - where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions - these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in how the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.
- **One Wales** – we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is appropriate to do so. We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.
- **Communication and transparency** - we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.

We hope these will be a helpful frame of reference for our management of our organisations and responsibilities and accountabilities.

Proposed changes and amendments to organisational governance arrangements and processes: The Board Secretaries have confirmed that we have already begun to amend our meeting schedules for Boards and Committees. Therefore, our advice is that during the next six months at least, we should continue to focus on key governance requirements, but all other arrangements should be paused. Therefore, it is proposed that we continue to run our Boards as key decision making entities, but that we progressively run these in ways that require a focus on only key decision making only and levels of required assurance, particularly with regard to COVID-19 and quality and patient safety considerations to enable the public to have confidence in our approaches.

In terms of our committees and partnership committees, it is proposed that all these are stood down for the coming period with the exception of our Quality and Patient Safety Committees, which can operate on the basis of a quorum only and also our Audit Committees, which likewise should operate through quorum arrangements, this will be important for end of financial end of year considerations and general assurance with regard to our systems and overall risk management approaches.

Therefore, in terms of how we run our forthcoming Board Meetings and in public Committee Meetings, we discussed three stages prior to having to cancel our meetings all together (and then use the provisions of Standing Orders through Chair's Actions for key decisions, which we could report publically sooner rather than waiting for the next Board). We also recognised that some organisations would decide to get to stage three sooner rather than later and some might wish to start there, which was a view of the majority of Board Secretaries. However, this would need to be agreed with respective Chairs and Chief Executives.

The three proposed levels are:

- **Level One** - to bring the Board together as normal, but with reduced agenda with a focus on key decisions and key elements of assurance, particularly around COVID-19. However, such Board environments need to be set-up in such a way that would allow appropriate distancing between participants. We envision that this option would not be viable for long.

- **Level Two** – use skype or other types of group conference software. Again, with a reduced and focused agenda. It is recognised, that some of these arrangements can be unpredictable and can affect the dynamics of meetings. However, with this option it was also clear that the public would not be able to observe, as the software doesn't allow. Therefore,

the publication of a post Board report and minutes would be an essential way of ensuring a public line of sight for our discussion at Board and committee meetings.

- **Level Three** – was to use the provisions of Standing Orders and run the Board on the basis of a quorum only. Again, to keep the agenda focused to key decisions only and key areas of assurance reporting. This would solve some of the issues that have been experienced with video and audio conferences. It would also keep us business focused. The papers would be shared with all members and they could feed any key comments to the Board Secretary or nominated individual for feeding into Board consideration.

- **The final level** - as mentioned above, would be to cancel Board and committee Meetings and use the provisions of Standing Orders for Chair's Action for key decisions during this time, but not wait to report to the next Board, but publish these immediately and share with Board Members. This would require resilience in our Scheme of Delegation and Authorisation Matrices with clear arrangements for Chair, Vice Chair and a Third (perhaps Chair of Audit) and also this arrangement for other authorised signatories. These approvals could be managed electronically, especially with the required Independent Member signatures i.e. Chair, Vice Chair and IMs).

Therefore, in terms of our Boards, we advise that bringing potentially a group of 24 people together at this time with current national guidance would not be recommended. Recognising that further social distancing and shielding measures are likely to come in at the weekend, especially with the age profile of some of our Boards, that the first level is no longer viable.

In all instances, it was agreed that we should not at this time invite the public in to observe these meetings as it would be in their own public interest not to attend (and this might be taken out of our hands soon anyway). However, if at all possible we should seek to webcast or Facebook live, for instance. If this is not possible, either due to technology restraints or recognising that support for this would come from communications staff who are currently hard pressed.

Therefore, it is recommended that we discharge our public responsibilities by producing a news from the Board communication in quick order after the Board (perhaps within three working days) and publish it and also produce the minutes quickly after the meeting for publishing.

In the current circumstances we find ourselves it was considered this was the most reasonable approach to seek to discharge our responsibilities. We would explain this in our public notices and ask members of the public not to attend due to current circumstances and give them the details of the alternative arrangements we have established. Board Secretaries have developed common wording for our public notices to ensure consistency and standardisation across NHS Wales.

It was considered that the public and interested parties would understand this and consider this prudent for their and others safety. We would of course always publish our papers beforehand, which would be in the public domain. However, it was recognised that there might need to be some flexibility around publication timelines given the capacity of organisations to produce papers etc in what are very fluid and challenging conditions currently. Therefore advice from Welsh Government on this would be welcomed.

The Board Secretaries Group is clear that Standing Orders provide us with a clear framework for decision taking in these circumstances and that they should be used effectively during this time. However, we also recommend that Welsh Government consider a potential future requirement for the suspension of Standing Orders or a range of the provisions and expectations within Standing Orders to reduce the bureaucratic burden on organisations. The Board Secretaries Group would welcome the opportunity to support Welsh Government colleagues in consideration of this point.

The Group also considered a number of other associated areas and these are outlined below, where advice and permission is sought for further changes.

End of Year Reporting: Further advice is sought from Welsh Government with regard to our end of year reporting requirements and arrangements. We are aware of the requirement for our accounts and public disclosure statements to inform Welsh Government Accounts and the requirement of HM Treasury, but further advice is sought with regard to any relaxation of requirements and timelines with regard to these arrangements, especially the range of public disclosure statements that are required i.e. Accountability Report, Annual Governance Statement, Performance Report, Annual Quality Statement and Annual Report.

Particularly with the Annual Report and our Annual General Meetings. We are aware that Welsh Government, in line with HM Treasury requirements, have sought to reduce the timeline for reporting. However, Annual Reports and AGMs are now required by the end of July each year, when historically they were required by the end of September each year. We would like to

request that consideration is given to returning to the September date for the Annual Report and AGM requirement for 2020.

Wales Audit Office: We are aware that Welsh Government colleagues are already in conversation with Wales Audit Office colleagues on a number of matters. Therefore, it would be helpful for an early determination with regard to audit programmes for NHS Wales and also any relaxation of commitments that we have currently made for actions from recommendations from key audits such as the Structured Assessment.

NHS organisations is already in conversation with our Internal Audit colleagues with regard to our own programmes, but of course the Head of Internal Audit opinion is a key element of our end of year reporting and we need to ensure that our programmes are completed enough to ensure that they can form an opinion from the work they have completed.

Consultations: The Group are seeking clarity with regard to consultations for service change during this time. We will as organisations need to change the configuration and location of our services at short notice as part of our response to the Pandemic. Therefore, advice with regard to any relaxation of the requirement for consultation at this time would be welcomed. However, we will continue to liaise with our Community Health Councils, but any revised guidance to both the NHS and CHCs would be helpful.

Mental Health Act and Mental Health Act Managers: The Group is seeking clarity on our responsibilities under the Mental Health Act and required reporting. We also require further consideration and guidance on the continued role of Mental Health Act Managers, as again the age profile of many of these individuals might mean they have to isolate or shield themselves. Therefore, we will need to have advice with regard to continued requirements and also any proposals for alternative arrangements. Further guidance on this area from Welsh Government would be helpful.

Appointment and Tenure of Board Members: Many organisations are currently undertaking recruitment activity to replace Board Members. It is anticipated that this will be difficult to conclude over coming months. Therefore, guidance on whether or not this recruitment should be paused would be welcomed or if appointments awaiting approval could be expedited. Also, consideration at this time if there is an option to extend the tenure of existing members who might have reached the end of their 8 year term, as this would assist with resilience.

The Board Secretaries Group hope the above considerations are helpful at this time. We will always seek to communicate openly and transparently and ensure that good governance principles and are applied and

maintained, but we recognise that some arrangements will require to be adapted or amended in coming weeks and months and we will of course want to play our part in ensuring this can be done effectively and appropriately. Grateful in the interim for the advice of Welsh Government on some of the questions and requested that we have highlighted above.

If you need any further information or clarification on any of the points made, please do not hesitate to contact me.

Yours sincerely

Richard

Richard Bevan
Chair of the Board Secretaries Group
Signing for and on behalf of the Members of this Group.

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Richard Bevan
Chair of Board Secretaries Group and
Board Secretary
Aneurin Bevan University Health Board
St Cadoc's Hospital
Caerleon
Newport, NP19 3XQ

Your Ref : RB/lab

26 March 2020

Dear Richard

Dear Richard

Advice/Proposals from NHS Board Secretaries/Directors of Corporate Governance on Covid-19

I am writing in response to your letter to Andrew Goodall of 18 March 2020 regarding governance matters in NHS Wales whilst responding to the Covid-19 pandemic. I wish to thank you and the Board Secretaries/Directors of Corporate Services for co-ordinating a consistent approach and proposals across the NHS for us to consider.

Since we have received your letter the UK and Welsh Government have announced further restrictions that I realise will have resulted in your organisations having moved rapidly through the proposed levels for ensuring that Board and Committee key decisions can be made. We have taken this into account when considering the appropriate response which is provided to the key points below. In responding consideration has been given to the need to try to ensure that we do not need to revisit these principles, but as we are all very aware this is an ever changing situation.

As indicated in your letter, it is important to ensure a continued focus for NHS organisations on their governance responsibilities to the public and partners in relation to openness, transparency and accountability but it is accepted the ways these have traditionally been discharged will need to change whilst responding to this pandemic. The ability to communicate electronically with the public does allow organisations to share copies of Board and Committee papers electronically and the suggestion of providing an update as soon as possible after the meeting will also aid with communication and openness.

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 03000628078
Jo-anne.daniels@gov.wales
Gwefan • website:
www.cymru.gov.uk

The Governance Principles as laid out appear to be appropriate, whilst paying due regard to the need to ensure that legal responsibilities are discharged especially where they are designed to protect the health, safety and welfare of staff, patients and service users. This will require Boards to ensure good risk management based on effective and dynamic risk assessment.

A response to the individual points you raised seeking advice and permission on future changes is provided below:

1) Where the proposals are appropriate and require amendment of the Model Standing Orders this will be forthcoming subject to the agreement of the Minister for Health and Social Services and advice will be prepared to this effect. This advice recognises that:

   a) Whilst the Board is responsible for establishing the Committee structure that it determines best meets its needs as a minimum it will establish Committees which cover the following aspects of Board business:
      - Quality and Patient Safety;
      - Audit;
      - Information Governance;
      - Charitable Funds;
      - Remuneration and Terms of Service; and
      - Mental Health Act requirements.

   The proposal that these meetings are stood down during this time, with the exception of Quality and Patient Safety Committee and the Audit Committee, requires amendment or agreement to move away from your own Standing Orders and Terms of Reference of these Committees. It does not require us to amend the Model Standing Orders as it only requires the establishment of the Committees. Each organisation is required to agree its own Standing Orders under the appropriate Regulations and Model Standing Orders regarding the operation of these Committees.

   Your Boards are able to vary or suspend their own Standing Orders, providing that the Board is able to satisfy that it complies with the relevant regulations. This will require approval by the Audit Committee (or relevant committee) and that it has given notice of the motion.

   The Quality and Patient Safety Committee has a critical role during this public health emergency and the challenging decisions needed to ensure actions are quality and risk assessed and organisations act in the best interest of the public and staff.

   b) Level 3 advises that the Board and Committees will operate within the quorum, focusing agendas on key decisions only. The Standing Orders and Terms of Reference of Boards and Committees make provision for this. The quorum for each Board is specified within the respective Regulations, whereas the quorum for Committees is determined by each individual organisation. As Committee membership, with the exception of the Remuneration and Terms of Service Committee, is taken only from Independent Members/Non-Executive Directors, providing they are themselves able to fulfil their duties this should not present too much of a

challenge. Organisations will obviously be considering very carefully the items for discussion to ensure that unnecessary pressure is not placed on the executive or officers of the organisation whilst they are responding to the pandemic.

c) The proposal to stand down partnership groups is also acknowledged but the need to ensure continued communication and dialogue with staff and stakeholders during this time, whilst the Forums are not meeting should be recognised.

d) 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. The UK and Welsh Government has stopped public gatherings of more than two people and it is therefore not possible for you to hold your meetings in public whilst these restrictions are in place. I note that technological solutions are being considered and it will be necessary to ensure that any decisions that are taken at this time could not be held over until it is possible to resume the requirement to meet in public.

e) With regard to the ability to introduce a future requirement to suspend or vary the Model Standing Orders or a range of provisions within them to reduce bureaucratic burden on organisations – as you will be aware when the Model Standing Orders were issued in September 2019 Appendix 1 advised of those areas which were:

- In accordance in legislation, or
- Issued under direction as part of the Model Standing Orders

When determining whether or not it is possible to reduce bureaucratic burden it will be necessary to consider the sections of the Model Standing Orders that are referred to. If they do not relate to requirements specified in legislation or a section issued under Direction the individual organisation does already have the ability to vary or suspend the relevant sections as detailed in a) above. I am content for officials to further discuss with you if your needs involve the suspension or variation related to a section issued under Direction as this would require a specific amendment and the re-issuing of the Model Standing Orders when and if the occasion arose.

2) **End of Year Reporting**: It is acknowledged that the end of year reporting requirements will need to change and consideration has been given to this. A detailed schedule will be issued to Directors of Finance but in the interim the dates are as follows:

- Draft accounts, Annual Governance Statement, Statement of Directors Responsibilities and Remuneration Report – 22 May 2020
- Final accounts , Annual Governance Statement, Statement of Directors Responsibilities and Remuneration Report - 30 June 2020
- All other sections of the Annual Report, includes Performance Report and the Accountability Report (excluding the Annual Governance Statement and the Remuneration Report – 31 August 2020

- Annual Quality Statement - 30 September 2020

This revised timescale will inform the date for the holding of the Annual General Meeting and the Model Standing Orders will be amended requiring this to be held before the 30 November 2020.

3) **Wales Audit Office:** It will be for the Auditor General for Wales to consider the impact of Covid-19 on the requirements placed upon him. This in turn will inform the requirements placed upon NHS organisations in Wales and the determination of the subsequent audit programme. I can assure you from a Welsh Government perspective we will be considering progress against previous audit actions, such as the structured assessments taking account of the current needs and priority to respond to the pandemic and our planning for recovery.

   With regard to Internal Audit programmes and the Head of Internal Audit's ability to provide an annual opinion, this will need to be considered on an organisation by organisation basis as this will be dependent on the progress made against the annual plan before the current pandemic started to have an impact.

4) **Consultations:** There is provision within Regulation 27 (5) of the Community Health Council (Constitution, Membership and Procedures (Wales) Regulations 2010 for service change to be made without prior consultation where the relevant health service body is satisfied that, in the interests of the health service or because of the risk to safety or welfare of patients or staff, a decision has to be taken without allowing for consultation, this does state that *in such a case, the relevant Local Health Board, Strategic Health Authority, Primary Care Trust and NHS Trust must notify the Council immediately of the decision taken and the reason why no consultation has taken place.* It will be important for you all to constructively engage with the Community Health Councils on the changes you are making in response to the pandemic. I acknowledge that the current guidance and local protocols agreed may not be appropriate for the challenges we now face and the pace of decision making and service change which may be required in response to this pandemic. I have, therefore asked colleagues to develop an addendum to the guidance to help the NHS and CHCs.

5) **Mental Health Act and Mental Health Act Managers:** As you may now be aware the Coronavirus Act includes provision for temporary emergency changes to the Mental Health Act which will only be switched on **if** the mental health sector is experiencing unprecedented resource constraints, which are resulting in patients' safety being put at significant risk. Welsh Government is engaging with key partners to determine the conditions that would make it appropriate for the powers to be exercised locally – and further information and guidance will follow in due course. The Mental Health Incident Group will consider the need for further guidance.

6) **Appointment and Tenure of Board Members:** A decision has been taken regarding current and future recruitment campaigns and this was communicated to you on the 19 March 2020 by the Public Appointments Unit. This will have an impact on NHS organisations which will be discussed with you individually. There is still the requirement to comply with the Governance Code and to inform

the Commissioner for Public Appointments where a decision is made to extend an appointment as outlined in the previous correspondence. The matter of allowing individuals to serve for a total of more than eight years will, for Local Health Boards and Public Health Wales NHS Trust require an amendment to Regulations and I have asked colleagues to take this forward. There is currently no upper limit for Velindre NHS Trust and the Welsh Ambulance Service NHS Trust but the Model Standing Orders will require amendment subject to agreement by the Minister for Health and Social Services.

I hope the above provides clarification on the matters you raised and provides assurance that we are acting and providing you with the support required during these challenging times. The Governance team will be in contact regarding progress on the work being taken forward.

Yours sincerely

Jo-Anne Daniels
Cyfarwyddwyr Iechyd Meddwl, Grwpiau Agored I Niwed a Llywodraethu'r GIG
Director of Mental Health, Vulnerable Groups and NHS Governance

Copy: Board Secretaries and Heads of Corporate Governance, Local Health Boards, NHS Trusts and Health Education and Improvement Wales
Committee Secretaries, Welsh Health Specialised Services Committee, Emergency Ambulance Committee and NHS Wales Shared Services Partnership
Andrew Goodall, Director General and Chief Executive NHS Wales

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

To Chief Executives

Our Ref: AG/SE/SB

30 March 2020

Dear Colleagues

COVID-19 – Decision Making & Financial Guidance

I want to take this opportunity to thank you and your teams for your support and commitment during these unprecedented times. The challenges associated with COVID-19 are significant, and delivering the necessary solutions are the priority for us all.

In these exceptional and unprecedented circumstances, I recognise that organisations and teams are required to make potentially difficult decisions at pace. These decisions may at times be without a full evidence base, or be without the support of key individuals who would ordinarily support business as usual processes and advice.

In taking urgent and exceptional decisions in this challenging environment, I recognise that there is a disruption to our usual financial discipline and authorisation processes. However, this continues to be within the context of needing to ensure appropriate use of public money. It is vital therefore, that within this disrupted environment, individual and collective decision-making is effective and stands the test of scrutiny when our services and systems return to a normalised position in the future. Once we return to a normalised position, the NHS will be called to account for its stewardship of public funds.

Across Welsh Government, the First Minister has asked all departments of government to both prioritise resources to deal with the COVID-19 pandemic and to ensure those resources are deployed effectively on the actions that will make the biggest difference. It is within that context that I am writing this letter to you.

I would urge organisations to ensure that in making decisions at this time the following applies:

- Due consideration is given to regularity in relying on legal powers, propriety and meeting the standards of 'Managing Welsh Public Money', and value for money supported by an assessment of the realistic options available to you at the time

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 0300 0251182
Andrew.Goodall@gov.wales

Gwefan • website: www.wales.gov.uk

- Decisions taken must be rational and justifiable with due consideration of all options and risk. If approval is required then it should be sought, and justification for decisions should be recorded, if not at the time then subsequently. Ultimately, we need to ensure the decisions we are taking are defendable to the patients and public we serve, and this should provide a clear and consistent test to our actions.

- Individuals and organisations should ensure that our decision making conduct is in line with Nolan Principles, and integrity is at the heart of what we do, with no conflict of interest affecting or appearing to affect decisions. If a decision is planned which is particularly novel, contentious, or repercussive, my officials are on hand to provide advice and guidance to inform any decision making.

- During emergencies such as these, organisations inevitably are more vulnerable to a risk of fraud, and unfortunately, some will try to take advantage of this situation for personal gain. That is why at times like these a continued focus on good governance and potential fraud is key.

- If you have any concerns in any aspects of your decision making process and revised governance arrangements, in addition to seeking advice of officials, you should ensure the continual involvement of Wales Audit Office in your activities to re-focus your decision making processes.

In keeping with the principles and spirit of this correspondence, and the indication set out by the Minister to step back from routine monitoring arrangements, our routine financial arrangements need to adapt on an interim basis. I therefore attach guidance to organisations on expectations from a financial management and reporting perspective at this time. This outlines the minimum expectation in this area, and aims to ensure a supportive and balanced focus in forthcoming months on ensuring core minimum requirements are in place to support all organisations at this challenging time.

Once again, thanks to you and your teams for everything that you do. My officials continue to be available to provide support on the issues I have outlined above. If there are any areas for further clarification or where additional advice and guidance is required, let me know.

Yours sincerely

Dr Andrew Goodall CBE

COVID-19 - Financial Guidance to NHS Wales' organisations

Given the immediate challenges presented by the COVID-19 pandemic, it is recognised that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis.

In this environment, there is a need to ensure that:

- There are clear and pragmatic financial arrangements in place which minimise any disruption to the system
- Business continuity arrangements are effective
- Frameworks to support effective decision making are clear
- Core financial assumptions and positions are clear and monitored, but with a light touch approach whilst maintaining sufficient clarity on minimum key measures

This guidance has been developed to support organisations and provide clarity on expectations for this disrupted period and until organisations return to business as usual arrangements.

Principles

This document has been developed with the following guiding principles:-

- Finance will not be a barrier to delivering the operational needs of the service in response to the COVID-19 pandemic but needs to be managed and monitored in a structured manner;
- Funds will flow to and from NHS Wales' organisations in a timely manner;
- Organisations are expected to work together to ensure that services are not disrupted during this period as a result of cross-border flows and commissioning;
- Requests for COVID-19 funding will be facilitated through a simplified process that balances financial governance and operational need; and
- Organisations will track both the additional costs arising from COVID-19, and reductions in expenditure due to COVID-19 (i.e. reduced elective activity) in a structured and transparent manner.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS Wales response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Welsh Public Money and other related guidance. Any financial mismanagement during this period should be managed in exactly the same way as at any other time.

NHS Wales organisations should undertake an urgent and timely review of financial governance arrangements to ensure decisions to commit resources in response to COVID-19 are robust and appropriate. Value for money is expected to remain a consideration when making decisions with a significant financial impact.

Specifically, organisations are expected to ensure that systems are in place to support decision-making at pace whilst maintaining appropriate controls and governance. This relates in particular to:

- Ensuring an appropriate scheme of delegation is in place and compliance with SFIs. This should include ensuring effective authorisation and signatory systems are in place to minimise any disruption
- Financial information should be collected in support of COVID-19 which is auditable and evidenced and supported by good documentation of key decisions

- Delegation limits and approvals should be documented and followed, having been approved by the Board. The arrangements should also be sufficiently robust and flexible to ensure that authorisation and decisions can take place in the absence of key staff.

No new revenue or capital business investments should be progressed unless related to the response to COVID-19 or otherwise expressly approved by Welsh Government.

From a governance perspective, organisations are also expected to ensure that any proposed service delivery solution in response to COVID-19 have appropriate NHS Indemnity arrangements and advice from Welsh Risk Pool as required.

Core Financial Systems & Processes

NHS Wales Shared Services Partnership has outlined the business continuity arrangements in respect of key financial processes including payroll, procurement and accounts payable. These systems are able to operate via remote working with limited disruption. The systems are, however, dependent upon the ongoing exercise of controls within NHS Wales' organisations. In particular, organisations are asked to ensure that purchase to pay arrangements are appropriately effective and timely, and any payroll adjustments are communicated at an early stage. This will ensure timely payments to suppliers and maintaining cash flow, and ensuring no impact on the pay of our staff.

Organisations should ensure that robust business continuity arrangements are in place covering core financial systems, monitoring and reporting. This should include ensuring procedures, and rules for key systems are available and accessible to all appropriate staff, in a common place (both hard copy and electronically) to support staff required to undertake roles outside of their normal duties.

Business continuity plans should be kept under constant review, tested to ensure they remain effective, shared with all staff members, and updated on a timely basis where required with clear and timely communication.

Standing Financial Instructions require clear quotations and tender processes, which in the current situation, may not be possible. In ensuring appropriate use of public money, where this is not possible any new arrangements must be clearly documented, and decision making justifiable in the context of future scrutiny and accountability.

Organisations should ensure that control is maintained over inventory and stocks which will be critical should supply chains be under pressure. Organisations should therefore consider whether more frequent stock checks are required, and have clear processes in relation to products in high demand and optimise product distribution to ensure the right items are available at the times for patient care.

If inventory is moved to other NHS organisations, then records will need to be kept of where these items are being sent to ensure that they are appropriately accounted for and are not lost or wasted.

NHS Wales' organisations are required to continue to pay suppliers and other NHS bodies (including NHS England providers) on a timely basis.

Counter Fraud

During emergencies and crises, organisations are inevitably more vulnerable to a risk of fraud. There is already emerging evidence of increased phishing e-mails and other fraudulent activity. There are particular risks around invoice and procurement fraud.

We would encourage organisations to remain vigilant to this heightened risk of fraud and to take the following actions:-

- Maintain basic and fundamental financial controls around authorisation and segregation of duties; and
- Engage with your local counter fraud service if you require any guidance or note any suspicious activity.

Revenue & Capital Allocations and Cash

NHS Wales organisations have received clear allocations for 2020/21, and all organisations should always utilise the funding available within their agreed allocation. It is anticipated that reductions in planned care activity as part of the response to COVID-19 will free up resources (finance and workforce) to be diverted to the COVID-19 response.

Welsh Government recognises the importance of liquidity and cash management at this time. The NHS Financial Management Team will prioritise the distribution of cash to support NHS Wales' organisations. Welsh Government will ensure that cash is paid to NHS Wales' organisations on a regular and timely basis to facilitate key financial activities such as payroll, procurement and accounts payable.

If additional allocations and/or requests for funding are approved through the processes outlined in this document, Welsh Government will communicate approval and issue the allocation in a timely manner, including converting into cash allocations on a timely basis.

It is acknowledged that organisations will incur additional costs in relation to COVID-19 and outline arrangements for monitoring and reimbursement below.

Ring-fenced Allocations (excluding DEL/AME Non Cash Depreciation)

During this period, it is recognised that there may be under-utilisation or re-direction of ring-fenced services for their traditional purpose with therefore a reduced expenditure level against the baseline ring-fenced allocation. During this period there will be no claw-back of ring-fenced allocations therefore any under-spend against the allocation is an appropriate offset against increased COVID-19 expenditure.

Cost Reimbursement – Revenue Costs

In many instances, the operational costs of the COVID-19 response will be met from within existing funding, as resources are re-directed from planned elective activity or other planned commitments. Further, costs of significant programmes and actions co-ordinated on a Once for Wales basis will be funded centrally as part of the national co-ordinated response.

Where an organisation has a need to incur specific additional costs associated with the local response, or where an organisation has a national leadership role, then Welsh Government will consider making additional revenue funding available. This will require a submission to Welsh Government explaining the nature of the additional cost, the likely timeframe it will be incurred and why it cannot be met from within the existing allocation. This will ensure an audit trail to support business critical decisions and support enabling allocation processes.

In order to facilitate a swift response, requests for funding support should be submitted to the central mailbox at NHSFinancialManagement@gov.wales

Implementation of identified actions and appropriate procurement should not be delayed whilst waiting for funding confirmation from Welsh Government.

Financial Reporting & Monitoring

Organisations need to ensure they will be able to track their financial position on an ongoing basis, and capture the impact of the COVID-19 pandemic. Welsh Government is revising existing monitoring arrangements to ensure routine monitoring is focussed on the bare minimum requirements to sustain clear financial reporting and integrity at this time. At a high level, this monitoring will describe the following:-

- Baseline position pre COVID-19 as per previous plans;
- Year to Date & Forecast outturn position
- Risks
- Allocation & Income assumptions (recognising that this is a fast changing environment)
- Cash flow & Capital assumptions
- Additional COVID-19 expenditure incurred; and
- Planned expenditure or investments that was not incurred due to COVID-19;

Organisations should build this approach into reporting and forecasts, and establish appropriate mechanisms to facilitate tracking of any additional expenditure in relation to COVID-19.

Welsh Government acknowledges that organisations' efforts will be wholly directed towards the COVID-19 response, which will affect the pursuit of savings and efficiencies at this time. It is recognised that delivering savings will not be prioritised unless they are supportive of the current situation and challenges. Organisations should review and identify which programmes will, and will not, be maintained or ceased, and progress to date documented and closed down to allow progress when the system returns to a normalised position. Organisations are expected to provide a clear assessment of their forecast outturn position having considered non-delivery of planned savings and the other variables outlined above.

Welsh Government is re-developing monitoring guidance for 2020-21, which will be issued in due course. This is being developed in line with the principles above and in the spirit of the challenges associated with COVID-19. Monitoring will therefore adopt a 'light-touch' approach with key areas of focus around COVID-19 reporting, and with sufficient flexibility for organisations to describe the financial impact of COVID-19 clearly. This will reflect both planned impacts on expenditure, and unplanned financial impacts of COVID-19.

Capital

The principles of ensuring clarity on assumed allocations, forecast expenditure, and COVID-19 impact outlined within this guidance applies to Capital in addition to Revenue expenditure. Capital support will be provided for:

- Testing equipment and facilities
- Inpatient facilities, to include compliance issues with existing isolation rooms and conversion to negative pressure where required
- Inpatient facilities, expansion of isolation rooms numbers to meet the requirements of WHC (2018) 033
- Critical care facilities and equipment
- Diagnostics

- Works and equipment required to cohort patents not requiring critical care, including those in non NHS owned facilities where required
- Digital equipment
- Other capital requirements not covered by the above as required

As per reimbursement of revenue costs, organisations are asked to outline where additional capital funding is required above approved Capital Resource Limits (CRLs) and Capital Expenditure Limits (CELs), organisations should make submissions to Welsh Government outlining the detail of the costs, and timeframe it will be occurred. Implementation of identified actions and appropriate procurement should not be delayed whilst waiting for funding confirmation from Welsh Government

Routine capital monitoring will be reflected in the revised Monitoring Returns; however, given the challenges of COVID-19, Capital Projects progress reports are not required until at least the end of Quarter 1, when the position will be reviewed.

Given the exceptional circumstances of the current situation, for 2019/20 due to the ongoing uncertainty about year-end deliveries for both COVID and non COVID equipment and delay in construction schemes CRLs/CELs will continue to be amended for one week after 31st March, with the intention of closing them on 8 April 2020.

Depreciation funding requirements above baseline, will be obtained via the Non Cash Estimate Exercise in early August and refined in November (the June exercise will not be undertaken in 2020/21).

Purchase of enhanced discharge support services / Partnership arrangements

Timely discharge and community care wrap around packages will be essential to release bed capacity within hospitals. Discharge to Recover and Assess packages are anticipated to be enhanced and will include community response team ('CRT') support, intermediate care beds (in a community hospital or care home) and domiciliary care.

Within existing partnership arrangements Welsh Government anticipates that additional costs will be incurred by both the local authorities involved and healthcare bodies. It is also envisaged that organisations collectively will be repurposing existing funding streams such as the Integrated Care Fund as an appropriate resourcing mechanism in these circumstances. Any additional planned expenditure which requires funding support should comply with the revenue cost reimbursement model outlined above within this guidance.

Cross-Border Flows

It is essential that NHS Wales organisations collaborate effectively and minimise any disruption on the system during this period. All Welsh commissioners are expected to deploy the same approach as English commissioners and agree block contract arrangements with English providers in line with NHS England guidance. The NHSE guidance reflects that this arrangement should be in place to 31 July 2020 but we anticipate that this period will be extended and organisations should ensure that they are able to respond swiftly to any extension. It is recognised that this arrangement may have a disproportionate impact on those organisations with a high reliance on English providers and who cannot re-deploy internal resources to offset this financial pressure. This will be considered directly with specific impacted organisations.

An approach to Long Term Agreements for quarter 1 during the COVID-19 pandemic period has been developed by Deputy Directors of Finance, which is endorsed by Welsh Government as both a pragmatic and sensible approach. It is vital that organisations ensure stability, and no disruption in the system at this time.

Actions being taken and led directly by Welsh Government on a system wide basis as part of the response to COVID-19 will be resourced directly with no anticipated impact on any individual organisation.

It is anticipated that Welsh organisations will have similar pragmatic reciprocal arrangements with English commissioners as appropriate on any activity for English residents treated in Welsh providers.

Primary Care Contractors

From 1 April, it is anticipated that Primary Care contractors are enabled to prioritise their workload according to what is necessary to prepare for and manage the outbreak, and therefore as a principle organisations should ensure that income will be protected as per existing contractual arrangements if other routine contracted work has to be substituted. Health Boards should plan to continue to make payments on this basis and ensure timely cash flow to independent contractors. Welsh Government will reimburse any additional costs in relation to COVID-19 as part of the reimbursement processes outlined in this guidance. Specific developments on a national basis may result in further guidance and support in relation to actions being taken by Primary Care contractors and this will be issued by policy leads in due course.

It is also intended that, during the outbreak, payments made under the Premises Cost Directions will be maintained. This will be in the event that premises are not able to open or where the use of premises is diverted away from GMS to support other COVID activities.

Summary

This guidance is intended to provide clear minimal expectations and be a supportive framework for organisations to consider what is or is not maintained in the current situation.

Given the pace and urgency of the current situation and environment, there may be additional areas for clarification that has not been addressed by this guidance. Any queries in relation to this can be directed at NHSFinancialManagement@gov.wales or directly with either Steve Elliott, Hywel Jones, Andrea Hughes, or Val Whiting in the first instance who will support you as required.