Pwyllgor Archwilio a Sicrwydd Lechyd a Gofal Digidol Cynni

Mon 04 July 2022, 09:00 - 12:15

Virtual

Agenda

09:00 - 09:05
5 min

1. MATERION RHAGARWEINIOL

1.1 Croeso a Chyflwyniadau

I'w Nodi *Cadeirydd*

1.2 Ymddiheuriadau absenoldeb

I'w Nodi *Cadeirydd*

1.3 Datganiadau o Fuddiannau

I'w Nodi *Cadeirydd*

09:05 - 09:10
5 min

2. AGENDA GYDSYNIO

2.1 Cofnodion heb eu cadarnhau o'r cyfarfod

I'w Cymeradwyo *Cadeirydd*

- 3 Mai 2022
- 24 Mai 2022
- 14 Mehefin 2022

2.1i AA-MDA-PUBLIC DRAFT CYM.pdf (21 pages)
2.1ii AA-MDA-PUBLIC DRAFT CYM.pdf (7 pages)
2.1iii AA-MDA-PUBLIC DRAFT CYM.pdf (7 pages)

2.2 Adroddiad Sicrwydd Pwyllgor Partneriaeth Cydwasanaethau GIG Cymru

Information *Cyfarwyddwr Gweithredol Cyllid*

2.2 Audit and Assurance NWSSPdocx.pdf (4 pages)
2.2i SSPC Assurance Report 19 May 2022.pdf (6 pages)

2.3 Adroddiad Cryno Cadeirydd y Pwyllgor Archwilio Cymru Gyfan

I'w Nodi *Cadeirydd*

2.3 ARAC Update re AWACC 19.05.2022 FINAL.pdf (5 pages)

2.4 Blaengynllun Gwaith

I'w Nodi *Ysgrifennydd y Bwrdd*

2.4 Forward Workplan.pdf (4 pages)
2.4i Audit & Assurance Committee Forward Workplan v8.pdf (2 pages)

09:10 - 09:10
0 min

3. BUSNES Y CYFARFOD

3.1 Cofnodion Gweithredu

I'w Nodi *Cadeirydd*

- 3.1 Action logv3.pdf (1 pages)

09:10 - 10:30
80 min

4. ARCHWILIO AC ATAL TWYLL

4.1 Adroddiad Cynnydd yr Archwiliad Mewnol

I'w Nodi *Archwilio Mewnol PCGC*

- 4.1 Internal Audit Progress Update.pdf (4 pages)
- 4.1i Internal Audit Update Report - July 2022.pdf (5 pages)

4.2 Adroddiadau Adolygiad Archwilio Mewnol

Ar gyfer Sicrwydd *Archwilio Mewnol PCGC*

- Y Gweithlu
- Adolygiad o'r Gyfarwyddiaeth

- 4.2 Audit Reports.pdf (4 pages)
- 4.2i Final DHCW 2122-13-Workforce report_.pdf (13 pages)
- 4.2ii - FINAL Directorate Review Internal Audit Report.pdf (15 pages)

4.3 Diweddariad Pwyllgor Archwilio Cymru

Ar gyfer Sicrwydd *Archwilio Cymru*

- 4.3 Audit Wales Update Report (July 2022).pdf (4 pages)
- 4.3i 2901A2022 DHCW AC Update (July 2022).pdf (10 pages)
- 4.3ii Structured Assessment 2022 Briefing Note FINAL.pdf (7 pages)

4.4 Cofnodion Gweithredu Archwilio

I'w Nodi *Pennaeth Gwasanaethau Corfforaethol*

- 4.4 Audit Action Log-v2.0.pdf (6 pages)
- 4.4i DHCW Audit Action Log Jun 22.pdf (8 pages)

4.5 Adroddiad Blynyddol y Gwasanaeth Atal Twyll Lleol 2021/2022

I'w Gymeradwyo *Gwasanaethau Atal Twyll Caerdydd a'r Fro*

- 4.5 DHCW CF Annual Report Cover Sheet.pdf (4 pages)
- 4.5i DHCW Annual Report 21-22 FINAL.pdf (11 pages)

4.6 Cynllun Blynyddol Atal Twyll Lleol 2022/2023

I'w Gymeradwyo *Gwasanaethau Atal Twyll Caerdydd a'r Fro*

- 4.6 DHCW CF Annual Plan Cover Sheet.pdf (4 pages)
- 4.6i DHCW Annual Plan FINAL.pdf (26 pages)

4.7 Adroddiad Diweddaru Atal Twyll Lleol

I'w Nodi *Gwasanaethau Atal Twyll Caerdydd a'r Fro*

- 4.7 DHCW Quarter Progress Report Cover Sheet.pdf (4 pages)
- 4.7i DHCW Period 1 2022 Progress Report Final.pdf (7 pages)
- 4.7ii Appendix A.pdf (1 pages)
- 4.7iii Appendix B.pdf (1 pages)

4.7iv Appendix C.pdf (2 pages)

Egwyl – 15 munud

10:30 - 12:15
105 min

5. ADRODDIADAU LLYWODRAETHU

5.1 Adroddiad Rheoli Risg a Sicrwydd y Bwrdd

I'w Drafod *Ysgrifennydd y Bwrdd*

5.1 Risk Management Report.pdf (7 pages)
5.1i Appendix A REP-BAF Dashboard.pdf (10 pages)
5.1ii Appendix B DHCW Corporate Risk Register.pdf (9 pages)
5.1iii Appendix C DHCW Risk and BAF Milestone Plan V6.pdf (2 pages)

5.2 Cylchlythyr Iechyd Cymru – Adroddiad Blynyddol

I'w Nodi *Rheolwr Llywodraethu Corfforaethol*

5.2 Welsh Health Circular - Annual Report.pdf (4 pages)
5.2i 2.5 WHC 2021-22.pdf (1 pages)

5.3 Cydymffurfiaeth â'r Gymraeg a Fframwaith Gwella

Ar gyfer Sicrwydd *Rheolwr y Gymraeg*

5.3 Welsh Language Assurance Report.pdf (6 pages)
5.3i Appendix A Welsh Language Action Plan - Audit and Assurance May 2022.pdf (2 pages)
5.3ii Appendix B FRA-DHCW Welsh Language Compliance and Improvement Framework.pdf (12 pages)

5.4 Adroddiad Safonau Ymddygiad

I'w Nodi *Rheolwr Llywodraethu Corfforaethol*

5.4 Standards of Behaviour Report.pdf (5 pages)
5.4i Appendix A Declarations of Interest Register 22_23.pdf (6 pages)
5.4ii Appendix B DHCW Gifts & Hospitality Declarations v1-0.pdf (1 pages)

5.5 Adroddiad Archeb Prynu Gwerth Uchel a Chronnus

I'w Nodi *Cyfarwyddwr Cyswllt Cyllid*

5.5 High Value Purchase Orders 4th July Final F-01.pdf (5 pages)
5.5i Appendix A - High Value Purchase Orders Tracker June 16th.pdf (3 pages)
5.5ii Appendix B - Cumulative High Value Transactions Tracker June 16th.pdf (3 pages)

5.6 Diweddariad am Golledion a Thaliadau Arbennig – Ar Lafar

I'w Nodi *Cyfarwyddwr Cyswllt Cyllid*

5.7 Cyfarwyddyd Ariannol Sefydlog ac Adolygiad Cydymffurfio

I'w Nodi *Cyfarwyddwr Cyswllt Cyllid*

5.7 Audit and Assurance SFI Review_F-02.pdf (6 pages)
5.7i Appendix A - Standard Financial Instructions Review.pdf (3 pages)
5.7ii Appendix B -Standard Financial Instructions Compliance Review.pdf (6 pages)

5.8 Adroddiad Cydymffurfiaeth Caffael a Chynllun Dirprwyo

I'w Nodi *Pennaeth Gwasanaethau Masnachol*

5.8 Strategic Procurement.pdf (4 pages)
5.8i Appendix A DHCW Single Tender single quotation and change notice activity June 22.pdf (3 pages)

5.9 Adroddiad Diweddaru Cydymffurfiaeth Ansawdd a Rheoleiddio

I'w Nodi *Pennaeth Dros Dro Ansawdd a Rheoleiddio*

5.9 DHCW Quality and Regulatory Update Report 04 July 2022.pdf (6 pages)

5.10 Adolygiad Blynyddol Ansawdd a Rheoleiddio

I'w Nodi *Pennaeth Dros Dro Ansawdd a Rheoleiddio*

5.10 DHCW Annual Quality Report - June-22.pdf (21 pages)

5.11 Adroddiad Cynllun Gweithredu'r Adolygiad Llywodraethu Sylfaenol

I'w Nodi *Ysgrifennydd y Bwrdd*

5.11 Baseline Governance Review Action Report.pdf (4 pages)
5.11i Appendix A Baseline Governance Review Action Plan v2.pdf (3 pages)

5.12 Adroddiad Ystadau a Chydymffurfiaeth

I'w Nodi *Pennaeth Gwasanaethau Corfforaethol*

5.12 Estates Enviornmental HS Report-v2.0.pdf (6 pages)
5.12i APPENDIX A External Estates Compliance Report -May 2022.pdf (20 pages)
5.12ii APPENDIX B WG Emissions Return.pdf (10 pages)

12:15 - 12:15
0 min

6. MATERION I GLOI

6.1 Eitemau ar gyfer Adroddiad y Cadeirydd i'r Bwrdd

I'w Drafod *Cadeirydd*

6.2 Unrhyw Faterion Brys Eraill

I'w Drafod *Cadeirydd*

Dyddiad y cyfarfod nesaf: 18 Hydref 2022

I'w Nodi *Cadeirydd*

Pwyllgor Archwilio a Sicrwydd - CYHOEDDUS

COFNODION, PENDERFYNIADAU A CHAMAU GWEITHREDU I'W CYMRYD

09:00 – 13:00 03/05/2022

Galwad Teams

Cadeirydd	Marian Wyn Jones

Yn Bresennol (Aelodau)		Teitl	Sefydliad
Marian Wyn Jones	MW-J	Aelod Annibynnol, Cadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru
Ruth Glazzard	RG	Aelod Annibynnol, Is-gadeirydd y Bwrdd	Iechyd a Gofal Digidol Cymru
David Selway	DS	Aelod Annibynnol	Iechyd a Gofal Digidol Cymru
Yn bresennol			
Julie Ash	JA	Pennaeth Gwasanaethau Corfforaethol	Iechyd a Gofal Digidol Cymru
Stephen Chaney	StC	Dirprwy Bennaeth Archwilio Mewnol	Archwilio Mewnol PCGC
Simon Cookson	SC	Cyfarwyddwr Archwilio a Sicrwydd	Archwilio Mewnol PCGC
Nathan Couch	NC	Arweinydd Archwilio Perfformiad (Iechyd)	Archwilio Cymru
Mark Cox	MC	Cyfarwyddwr Cyswllt Cyllid	Iechyd a Gofal Digidol Cymru
Chris Darling	CD	Ysgrifennydd y Bwrdd	Iechyd a Gofal Digidol Cymru
Gareth Davies	GD	Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau Digidol	Iechyd a Gofal Digidol Cymru
Paul Evans	PE	Rheolwr Ansawdd (Cydymffurfiaeth Reoleiddio)	Iechyd a Gofal Digidol Cymru

Julie Francis	JF	Pennaeth Gwasanaethau Masnachol	Iechyd a Gofal Digidol Cymru
Meirion George (ar gyfer eitem 3.2)	MG	Cyfarwyddwr Cynorthwyol ar gyfer ADS	Iechyd a Gofal Digidol Cymru
Darren Griffiths	DG	Rheolwr Archwilio (Perfformiad)	Archwilio Cymru
Carwyn Lloyd-Jones	CL-J	Cyfarwyddwr TGCh	Iechyd a Gofal Digidol Cymru
Gareth Lavington	GL	Arbenigwr Atal Twyll Lleol Arweiniol	Atal Twyll Lleol Caerdydd a'r Fro
Martyn Lewis	ML	Archwiliwr	Archwilio Mewnol PCGC
Claire Osmundsen-Little	CO-L	Cyfarwyddwr Gweithredol Cyllid	Iechyd a Gofal Digidol Cymru
Julie Robinson	JR	Cydlynydd Llywodraethu Corfforaethol	Iechyd a Gofal Digidol Cymru
Michelle Sell	MS	Cyfarwyddwr Cynllunio a Pherfformiad a Phrif Swyddog Masnachol	Iechyd a Gofal Digidol Cymru
Mike Whiteley	MW	Rheolwr Archwilio	Archwilio Cymru
Ymddiheuriadau			
Grace Quantock	GQ	Aelod Annibynnol, Is-gadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru
Ifan Evans	IE	Cyfarwyddwr Gweithredol Strategaeth	Iechyd a Gofal Digidol Cymru
Dave Thomas	DT	Cyfarwyddwr Archwilio	Iechyd a Gofal Digidol Cymru
Derwyn Owen	DO	Cyfarwyddwr Archwilio	Iechyd a Gofal Digidol Cymru
Sophie Fuller	SF	Rheolwr Llywodraethu Corfforaethol a Sicrwydd	Iechyd a Gofal Digidol Cymru

Acronymau			
Iechyd a Gofal Digidol Cymru	Iechyd a Gofal Digidol Cymru	NWIS	Gwasanaeth Gwybodeg GIG Cymru

SHA	Awdurdod Iechyd Arbennig	AS	Archwilio a Sicrwydd
DPA	Dangosyddion Perfformiad Allweddol	PCC	Pwyllgor Cyfrifon Cyhoeddus
RhS	Rheolau Sefydlog	CAS	Cyfarwyddiadau Ariannol Sefydlog
AaGIC	Addysg a Gwella Iechyd Cymru	FCP	Gweithdrefnau Rheoli Ariannol
ADS	Cymhwyso, Datblygu a Chefnogi		

Rhif yr Eitem	Eitem	Canlyniad	Cam Gweithredu
1	MATERION RHAGARWEINIOL		
1.1	Croeso a chyflwyniadau Croesawodd y Cadeirydd bawb i'r Pwyllgor Archwilio a Sicrwydd. Rhoddwyd croeso arbennig i Gareth Lavington, yr Arweinydd newydd ar Atal Twyll, Mike Whiteley a Nathan Couch o Archwilio Cymru, Meirion George, Cyfarwyddwr Cynorthwyol ADS (Iechyd a Gofal Digidol Cymru) a Gareth Davis, Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau (Iechyd a Gofal Digidol Cymru). Mynegodd y Cadeirydd gydymdeimlad diffuant y Pwyllgor â theulu a ffrindiau Konrad Kujawinski, Pennaeth Ansawdd a Rheoleiddio, a oedd yn bresennol yn rheolaidd yn y cyfarfod hwn, ar ei farwolaeth ddiweddar. Cadarnhaodd y Cadeirydd ei bod eisoes wedi cyfarfod ymlaen llaw ag Archwilio Mewnol ac Allanol i ystyried y papurau a diolchodd iddynt am eu hamser. Cynhaliwyd y cyfarfod trwy Microsoft Teams ac atgoffwyd y rhai a oedd yn bresennol bod y cyfarfod yn cael ei gofnodi ac y byddai'n cael ei bostio ar wefan Iechyd a Gofal Digidol Cymru yn dilyn y cyfarfod.	Nodwyd	Dim i'w nodi
1.2	Ymddiheuriadau am Absenoldeb Nodwyd ymddiheuriadau am absenoldeb gan: • Grace Quantock, Is-Gadeirydd Archwilio a Sicrwydd, Aelod Annibynnol • Ifan Evans, Cyfarwyddwr Gweithredol Strategaeth • Dave Thomas, Archwilio Cymru • Derwyn Owens, Archwilio Cymru	Nodwyd	Dim i'w nodi

	• Sophie Fuller, Rheolwr Llywodraethu Corfforaethol a Sicrwydd		
1.3	**Datganiadau o Fuddiannau** Datganodd y Cadeirydd ddiddordeb yn eitem 4.3 ar yr agenda, yr adroddiad Cydymffurfiaeth â'r Iaith Gymraeg, oherwydd ei bod yn cadeirio Grŵp Gorchwyl a Gorffen 'Mwy na Geiriau' ar y Fframwaith Strategol y Gymraeg. Roedd y grŵp yn datblygu cynllun gweithredu a grybwyllwyd yn yr adroddiad. **Penderfynodd** y Pwyllgor: **Nodi**'r Datganiad o Fuddiannau	Nodwyd	Dim i'w nodi
2	BUSNES Y CYFARFOD		
2.1	**Cofnodion cyfarfod 18 Ionawr 2022 heb eu cadarnhau - Cyhoeddus** Nododd y Cadeirydd na chafwyd unrhyw sylwadau ynghylch cywirdeb y cofnodion. **Penderfynodd** y Pwyllgor: **Gymeradwyo**'r cofnodion fel cofnod cywir o'r drafodaeth a byddent yn cael eu gwneud yn gyhoeddus.	Cymeradwywyd	Dim i'w nodi
2.2	**Cofnodion cyfarfod 18 Ionawr 2022 heb eu cadarnhau – Preifat** Cadarnhaodd Ruth Glazzard, Aelod Annibynnol (RG) pryd bynnag y cynhaliwyd sesiwn breifat byddai'n cael ei herio a ddylid cynnal yr eitem yn breifat ai peidio, er mwyn sicrhau bod cymaint o'r busnes â phosibl yn cael ei gynnal yn gyhoeddus. Nododd y Cadeirydd na chafwyd unrhyw sylwadau ynghylch cywirdeb y cofnodion. **Penderfynodd** y Pwyllgor: **Gymeradwyo'r** cofnodion fel cofnod cywir o'r drafodaeth a'u cyhoeddi ar wefan y Bwrdd Iechyd Arbennig.	Cymeradwywyd	Dim i'w nodi
2.3	**Log gweithredu** Gwahoddwyd Chris Darling, Ysgrifennydd y Bwrdd (CD) i gyflwyno'r Log Gweithredu. Nododd y Pwyllgor fod pedwar cam gweithredu wedi'u nodi yng nghyfarfod diwethaf y pwyllgor, ac roedd pob un o'r pedwar wedi'u cwblhau gyda'r camau a gymerwyd wedi'u dogfennu yn y Log Gweithredu. Nodwyd bod cam gweithredu pellach **20211005-A03** wedi'i gwblhau ers cyhoeddi'r papurau a byddai'n cael ei adolygu ym	Nodwyd	Dim i'w nodi

	Mhwyllgor mis Gorffennaf. Roedd dau gam gweithredu pellach ar y gweill a byddent yn cael eu hadrodd i gyfarfod mis Gorffennaf. **Penderfynodd** y Pwyllgor: **NODI**'r log gweithredu.		
2.4	**Blaengynllun Gwaith** Amlygodd CD yr eitemau a symudwyd i'r cynllun ar gyfer Pwyllgor mis Gorffennaf fel:- • Diweddariad yr Uned Seibergadernid • Adroddiad dilynol System Wybodaeth Gofal Cymunedol Cymru (WCCIS). • Adolygiad Blynyddol Ansawdd a Rheoleiddio **Penderfynodd** y Pwyllgor: **NODI** Blaengynllun Gwaith y Pwyllgor.	Nodwyd	Dim i'w nodi
3	ARCHWILIO AC ATAL TWYLL		
3.1	**Adroddiad Cynnydd yr Archwiliad Mewnol** Cyflwynodd Simon Cookson, Cyfarwyddwr Archwiliad Mewnol Partneriaeth Cydwasanaethau GIG Cymru (SC) y Cynllun Cynnydd yr Archwiliad Mewnol. Ymunodd ei gydweithwyr, Stephen Chaney a Martyn Lewis, ag SC. Roeddent yn bresennol i gyflwyno'r pedwar adroddiad archwilio a gwblhawyd. Cadarnhaodd SC fod dau archwiliad ar gynllun 2021/22 heb eu cymeradwyo eto ac y byddent yn cael eu cyflwyno i gyfarfod mis Gorffennaf y Pwyllgor. Yn ogystal, roedd barn y Pennaeth Archwilio Mewnol bellach wedi'i drafftio a byddai'n cael ei chyflwyno i'r Pwyllgor ym mis Gorffennaf, a oedd yn nodi canlyniad cadarnhaol yn gyffredinol o ran sicrwydd rhesymol cryf. Dywedodd Claire Osmundsen-Little, Cyfarwyddwr Gweithredol Cyllid (CO-L) fod yr archwiliadau wedi'u cyflawni er bod y rhan fwyaf ohonynt wedi'u cynnal tua diwedd y flwyddyn a bod hyn yn dangos cryfder y berthynas waith rhwng Archwilio Mewnol ac Iechyd a Gofal Digidol Cymru. Roedd trafodaethau wedi'u cynnal i lunio cynllun 2022/23 a sicrhau rhaglen waith fwy llyfn h.y. bydd adroddiadau'n cael eu cyflwyno i'r cyfarfodydd wedi'u dosbarthu'n gyfartal ar draws y flwyddyn. **Penderfynodd** y Pwyllgor: **NODI**'r diweddariad Archwilio Mewnol ar gyfer sicrwydd.	Ar gyfer Sicrwydd	Dim i'w nodi
3.2	**Adroddiadau Adolygiad Archwilio Mewnol**	Ar gyfer	**Camau**

	Prosiect Symud y Ganolfan Ddata Derbyniodd yr adolygiad sgôr Sicrwydd ***Sylweddol*** cryf. Amlinellodd Martin Lewis, Archwilydd (ML) y gwaith a wnaed yn yr adolygiad a oedd yn edrych ar y trefniadau llywodraethu sydd ar waith ar gyfer symud y Ganolfan Ddata. Canfu'r archwiliad strwythur prosiect a oedd yn destun llywodraethu da gyda fframwaith monitro ac adrodd yn eu lle. Cwblhaodd y prosiect yr holl amcanion. Nid oedd unrhyw ganfyddiadau o'r adroddiad gan ei fod yn sicrwydd sylweddol. Estynnodd y Pwyllgor Archwilio eu llongyfarchiadau i CL-J a'i dîm ar symud y Ganolfan Ddata yn llwyddiannus. **Trefniadau Llywodraethu (Rhan 2)** Derbyniodd yr adolygiad archwilio sgôr Sicrwydd ***Rhesymol.*** Cyflwynodd Stephen Chaney, Rheolwr Archwilio, Partneriaeth Cydwasanaethau GIG Cymru (StC) yr adroddiad archwilio Trefniadau Llywodraethu, sef ail ran cyfres gyffredinol o adolygiadau llywodraethu. Roedd yr adolygiad yn adolygiad cyfunol o gynllunio, rheoli perfformiad a rheoli risg. Roedd yr adolygiad wedi derbyn sicrwydd rhesymol cryf gyda rhai meysydd i'w gwella ac adlewyrchwyd y rhain yn yr argymhellion. Amlygodd StC y negeseuon allweddol o'r adolygiad. Cadarnhaodd CD mewn perthynas â Risg a Fframwaith Sicrwydd y Bwrdd fod hon yn broses barhaus i'r sefydliad ac roedd camau gweithredu wedi'u cynllunio a fyddai'n helpu i olrhain cynnydd ar yr agweddau hyn o'r gwaith. Cadarnhaodd Michelle Sell, Cyfarwyddwr Cynllunio a Pherfformiad a Phrif Swyddog Masnachol (MS) yr aethpwyd i'r afael â rhai o'r camau gweithredu oedd yn ymwneud â'r Cynllun Tymor Canolig integredig (IMTP), fod yr adroddiad perfformiad yn parhau i gael ei fireinio a bydd yn cael ei ailosod ar gyfer y Cynllun Tymor Canolig Integredig newydd a bydd amcanion yn cael eu gosod. Rhoddwyd sicrwydd i'r Pwyllgor fod nifer o Safonau Gofal Iechyd yn llai perthnasol i'r sefydliad gan nad oedd Iechyd a Gofal Digidol Cymru yn darparu gofal yn uniongyrchol, fodd bynnag, byddai'r safonau a oedd yn berthnasol i Iechyd a Gofal Digidol Cymru yn cael eu hadolygu a'u hymgorffori yn yr adroddiad perfformiad. Cadarnhaodd CD y byddai nifer y safonau cymwys yn cynyddu wrth i Iechyd a Gofal Digidol Cymru symud mwy i faes dyfeisiau meddygol a byddai hyn yn cael ei fonitro. **CAM GWEITHREDU:20220503-A01** Dolen i'r Ganolfan	Sicrwydd	**Gweithredu:** Dolen i'r Ganolfan Gwasanaethau Cyhoeddus Digidol (CDPS) sydd â Phennaeth Safonau newydd yn ei le, i'w ddarparu drwy RG a chynnal trafodaeth y tu allan i'r cyfarfod. Bydd RG yn cysylltu â'i thîm Safonau Gofal Iechyd a thîm Iechyd a Gofal Digidol Cymru.

Gwasanaethau Cyhoeddus Digidol (CDPS) sydd â Phennaeth Safonau newydd yn ei le, i'w ddarparu trwy RG a chynnal trafodaeth y tu allan i'r cyfarfod. Bydd RG yn cysylltu â'i thîm Safonau Gofal Iechyd a thîm Iechyd a Gofal Digidol Cymru.

Datblygu Systemau

Derbyniodd yr adolygiad archwilio sgôr Sicrwydd ***Rhesymol***.

Cyflwynodd ML yr adolygiad Datblygu System a oedd wedi edrych ar y gweithdrefnau a'r canllawiau, yr hyfforddiant a'r sgiliau sydd ar waith.

Y risgiau posibl a gynhwyswyd fel rhan o'r adolygiad oedd:-

- nid oedd y system yn bodloni anghenion y defnyddwyr;
- dogfennaeth annigonol yn arwain at golli gwybodaeth sefydliadol ac yn effeithio ar gymorth a chynnal a chadw; a
- gwendidau diogelwch yn arwain at fynediad amhriodol at ddata neu golli swyddogaeth.

Darparodd Meirion George, Cyfarwyddwr Cynorthwyol ADS (MG) sicrwydd bod 23% yn fwy o staff mewn swydd yn ADS na'r llynedd, fodd bynnag yr anhawster oedd cadw i fyny â chylch gwaith ehangach Iechyd a Gofal Digidol Cymru. Amlinellodd MG rai o'r mesurau sydd yn eu lle i fynd i'r afael â'r diffyg staff fel a ganlyn:

- roedd gwaith yn cael ei wneud gan y Gweithlu i fynd i'r afael â chynllunio capasiti yn y dyfodol.
- Roedd Iechyd a Gofal Digidol Cymru yn defnyddio mwy o drydydd partïon a chyflenwyr strategol i gynorthwyo gyda'r diffyg adnoddau.
- Adolygu'r buddion di-dâl fel rhan o'r cynnig ac ymddengys fod hyn yn llwyddiannus i raddau.
- Roedd cyllid ar gyfer hyfforddiant wedi'i gynyddu.

Cadarnhaodd MG y byddai'n gweithio gyda'r Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau newydd i fynd i'r afael â'r argymhellion yn yr adroddiad.

Roedd DS yn falch o nodi bod mwy o ddefnydd o gyflenwyr strategol a'r cynnydd yn y cyfrif pennau, ond cydnabuwyd nad oedd yr Agenda ar gyfer Newid yn gystadleuol o'i gymharu â'r farchnad agored.

Gwybodaeth Ariannol Graidd

Derbyniodd yr adolygiad archwilio sgôr Sicrwydd ***Rhesymol***.

Cyflwynodd StC yr adolygiad Ariannol Craidd a gafodd sgôr resymol gref. Cadarnhaodd StC yr aethpwyd i'r afael â rhai o'r argymhellion eisoes ac amlygodd rai o'r pwyntiau perthnasol

	yn yr adroddiad. Cadarnhaodd CO-L fod yr adolygiad wedi bod yn ddefnyddiol i Iechyd a Gofal Digidol Cymru fel sefydliad newydd a chydnabuwyd bod angen iddo fod yn fwy cyson mewn rhai o ddadansoddiadau adrodd a rhannu tueddiadau'r Gyfarwyddiaeth. Roedd safle SharePoint yn cael ei ddatblygu i ddangos cysondeb ar draws Cyfarwyddiaethau a gwaith gyda'r Cyfarwyddiaethau i sicrhau bod deiliaid cyllidebau yn gyfarwydd â'r offer ac yn gallu gweld y tueddiadau a'r dadansoddiadau. Roedd Power BI yn offeryn cymharol newydd roedd Iechyd a Gofal Digidol Cymru yn ei hyrwyddo o fewn y timau cyllid digidol. Cytunodd Mark Cox, Cyfarwyddwr Cyswllt Cyllid (MC) fod yr archwiliad wedi bod yn ddefnyddiol iawn o ran gweithredu Power BI fel y dangosfwrdd a'r mecanwaith adrodd o ddewis. Roedd RG yn hapus gydag ymateb y rheolwyr ac o weld bod yr elfen proses gaffael tendr unigol wedi derbyn sicrwydd sylweddol ond holodd a oedd deiliaid cyllidebau yn draddodiadol yn rheoli eu cyllidebau eu hunain neu a oedd yn cael ei adael i'r adran gyllid. Cadarnhawyd bod adolygiadau cyllidebol rheolaidd yn cael eu cynnal a bod deiliaid y gyllideb yn cymeradwyo'r cyllidebau y cytunwyd arnynt ganddynt ar ddechrau'r flwyddyn ariannol. Rhoddwyd sicrwydd i'r Pwyllgor fod nifer o gamau gweithredu ar y gweill mewn perthynas â'r canfyddiadau a oedd yn sail i bwysigrwydd archwiliadau. Diolchodd y Pwyllgor i Archwilio Mewnol am y modd y cynhaliwyd yr archwiliadau ganddynt. **Penderfynodd** y Pwyllgor: **DDERBYN** y pedwar adroddiad ar gyfer **SICRWYDD**.		
3.3	**Cynllun Archwilio Mewnol 2022/23** Cadarnhaodd SC fod dau archwiliad arall o gynllun 2021/22 a fyddai'n cael eu cyflwyno i'r Pwyllgor ym mis Gorffennaf, ynghyd â Barn y Pennaeth Archwilio Mewnol. Roedd y broses sicrwydd yn broses barhaus a chyflwynwyd y cynllun ar gyfer y flwyddyn i ddod i'w gymeradwyo. Amlygodd SC fod y cynllun mewn tair rhan ac yn unol â Safonau Archwilio Mewnol y Sector Cyhoeddus. Roedd y cynllun yn nodi'r meysydd a nodwyd ar gyfer 2022/23 a oedd yn gysylltiedig â risgiau corfforaethol ac allweddol i'r sefydliad. Cadarnhaodd MW-J y bu trafodaethau helaeth ynghylch y cynllun. Gofynnodd MS am fân newid yn Atodiad A mewn perthynas â'r	I'w Cymeradwyo	Dim i'w nodi

	Strategaeth Ystadau; fe'i neilltuwyd i'r Prif Swyddog Gweithredol, fodd bynnag, Cyfarwyddwr Gweithredol Cyllid oedd yn gyfrifol am Ystadau ddylai fod y swyddog cyfrifol. **Penderfynodd** y Pwyllgor: **GYMERADWYO**'r Cynllun a'r Siarter Archwilio Mewnol a **NODI** bod gan Archwilio Mewnol yr adnoddau i gwblhau'r gwaith.		
3.4	**Trosolwg o DPA Archwilio Mewnol** Cyflwynodd SC y Trosolwg o DPA a oedd yn nodi'r dangosyddion perfformiad allweddol a ddefnyddir ar hyn o bryd a nifer o newidiadau a fyddai'n cael eu hystyried i fesur effaith y gwaith a wneir gan Archwilio Mewnol yn well. I gefnogi'r gwaith hwn roedd Archwilio Mewnol yn edrych ar dri maes:- • Y Traciwr Archwilio – canran yr argymhellion sydd wedi'u gweithredu ac effaith yr argymhellion h.y. a yw wedi cryfhau llywodraethu, lleihau risg, gwella rheolaethau ac ati. • Roedd PCGC yn gwneud gwaith ar yr ymgysylltu â chwsmeriaid a mesur ansawdd. • Derbyniwyd nifer o adroddiadau lle'r oedd themâu a materion cyffredin wedi'u nodi, byddai mwy o waith yn cael ei wneud ar hyn i rannu arferion da a chanfyddiadau cyffredin. Byddai adroddiad pellach yn cael ei gyflwyno yn ystod y flwyddyn i roi'r wybodaeth ddiweddaraf am gynnydd. Ychwanegodd SC fod Archwilio Mewnol wedi penodi Rheolwr Cymorth Busnes yn ddiweddar a fyddai'n gallu cysylltu ag Ysgrifennydd y Bwrdd a thynnu'r themâu a'r llinynnau cyffredin ar draws y bwrdd gan y bydd themâu digidol a TG gan sefydliadau eraill. Croesawodd y Pwyllgor y darn hwn o waith a diolchodd i Archwilio Mewnol am fod yn gyfaill beirniadol da yn ystod blwyddyn gyntaf Iechyd a Gofal Digidol Cymru ac am ddarparu rhywfaint o bersbectif allanol. **Penderfynodd** y Pwyllgor: **NODI** cynnwys yr adroddiad DPA.	I'w Drafod	Dim i'w nodi
3.5	**Adroddiad Diweddaru Pwyllgor Archwilio Cymru** Aeth Darren Griffiths, Rheolwr Archwilio Archwilio Cymru (DG) â'r Pwyllgor drwy adrannau'r adroddiad a chadarnhaodd nad oedd unrhyw ddiweddariad perfformiad gan ei fod wedi'i adrodd a'i gwblhau yn yr Adolygiad Llywodraethu Sylfaenol.	Ar gyfer Sicrwydd	Dim i'w nodi

Aeth DG yn ei flaen, o ran y rhaglen Cyfnewid Arferion Da, na fu unrhyw ddigwyddiadau ers mis Ionawr ond bod rhaglen newydd o'r enw Persbectifau Covid 19 wedi'i lansio. Roedd cyfweliadau wedi'u cynnal gyda chydweithwyr ar draws y sector cyhoeddus i'w gwahodd i rannu eu profiadau o'r effaith a gafodd Covid 19 ar y ffordd y mae gwasanaethau cyhoeddus yn cael eu llywodraethu a'u darparu. Roedd Ysgrifennydd y Bwrdd o Iechyd a Gofal Digidol Cymru wedi cytuno i gael ei gyfweld a byddai'r ddolen i'r cyfweliad hwn yn cael ei rhannu â'r Pwyllgor cyn gynted ag y byddai ar gael.

Roedd crynodeb o adroddiad Cenedlaethol ar Weithio ar y Cyd gyda'r Gwasanaethau Brys wedi'i gynnwys yn yr adroddiad er gwybodaeth.

Roedd llythyr diweddaru drafft ynghylch System Wybodaeth Gofal Cymunedol Cymru wedi'i baratoi a'i rannu â chydweithwyr Iechyd a Gofal Digidol Cymru. Byddai'n cael ei anfon ymlaen i'r Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus, unwaith y byddai wedi'i ystyried gan y Pwyllgor hwnnw byddai'n cael ei gyflwyno i'r Pwyllgor Archwilio a Sicrwydd.

Darparodd Mike Whiteley, Rheolwr Archwilio, Archwilio Cymru (MW) uchafbwyntiau allweddol o'r adran archwilio ariannol.

- Derbyniwyd y cyfarwyddyd cyfrifon gan Lywodraeth Cymru a oedd yn cadarnhau'r cyfrifon 15 mis o 31 Rhagfyr 2020 i 31 Mawrth 2022.
- Nid oedd yr archwiliad o gyllid a chydbwysedd trosglwyddiadau o Felindre wedi canfod unrhyw broblemau.
- Gwnaethpwyd gwaith i sicrhau bod balansau agoriadol yn cael eu hadlewyrchu'n gywir yn y cyfriflyfr.
- Roedd y cyfrifon drafft wedi'u derbyn cyn y dyddiad cau. Holodd RG a oedd y cyfweliadau ôl-Covid yn nodi'r argyfwng costau byw a fydd yn dechrau cael effaith ar staff, yn enwedig y rhai ar gyflogau is, yn ogystal â'r cyhoedd sy'n defnyddio'r GIG ehangach.

Cadarnhaodd DG fod y cyfweliadau Covid 19 wedi'u cynllunio i gwmpasu ystod eang o bynciau ac y byddai dadansoddiad lefel uchel yn cael ei gynnal ar y themâu allweddol. Roedd Archwilio Cymru hefyd wedi bod yn ymgynghori ar raglen waith yr Archwilydd Cyffredinol ar gyfer yr ychydig flynyddoedd nesaf. Roedd y rhaglen waith wedi mynegi awydd i edrych ar anghydraddoldebau a thlodi felly roedd posibilrwydd y gellid archwilio'r rhain yn fanylach.

Penderfynodd y Pwyllgor:

DDERBYN adroddiad Archwilio Cymru ar gyfer **SICRWYDD**

3.6	**Cynllun Archwilio 2022 Archwilio Cymru** Cyflwynodd DG y Cynllun Archwilio a oedd yn nodi'r rhaglen waith yn ystod 2022 mewn perthynas ag archwilio datganiadau ariannol Iechyd a Gofal Digidol Cymru yn ogystal ag adolygu trefniadau'r sefydliad ar gyfer sicrhau effeithlonrwydd ac effeithiolrwydd economi. Cadarnhaodd DG y byddai'r cynllun yn ymgymryd â thri darn o waith archwilio perfformiad a rhoddodd fanylion pellach. Cyflwynodd MW yr adran ar y gwaith archwilio ariannol gan amlygu rhai o'r risgiau yn y tabl Risgiau Ariannol yn arddangosyn 1. Diolchodd y Pwyllgor i Archwilio Cymru am y diweddariad ac edrychodd ymlaen at y diweddariad terfynol yn y cyfarfod nesaf. **Penderfynodd** y Pwyllgor: **GYMERADWYO** Cynllun Archwilio Cymru ar gyfer 2022.	I'w Cymeradwyo	Dim i'w nodi
3.7	**Adolygiad o Themâu Adroddiad Archwilio Iechyd a Gofal Digidol Cymru** Cadarnhaodd CD y cynhaliwyd yr adolygiad fel ymateb i gais gan y Pwyllgor ym mis Hydref i nodi themâu archwiliadau yn ystod y flwyddyn. Ar adeg ysgrifennu nid oedd yr holl Archwiliadau Mewnol wedi'u cwblhau, fodd bynnag, wrth symud ymlaen, cynigiwyd bod gwaith yn cael ei wneud gyda'r Pennaeth Gwasanaethau Corfforaethol i sicrhau bod y traciwr archwilio yn nodi themâu a'u cynnwys ar y traciwr. Cytunodd y Pwyllgor ei fod yn ddarn defnyddiol o waith a fyddai'n dod yn fwy defnyddiol fyth wrth i ragor o archwiliadau gael eu cynnal. Nodwyd y pwysigrwydd bod y Pwyllgor yn defnyddio unrhyw themâu sy'n dod i'r amlwg nid yn unig o adroddiadau archwilio, a bod angen meddwl sut y defnyddiwyd yr wybodaeth hon o ran sicrwydd a chraffu h.y. archwiliad dwfn. **CAMAU GWEITHREDU: 20220503-A02** Cytunodd Ysgrifennydd y Bwrdd y dylid rhannu'r Themâu Archwilio â'r Grŵp Dysgu a Datblygu. **Penderfynodd** y Pwyllgor: **NODI** Adolygiad Themâu'r Adroddiad Archwilio.	I'w Nodi	**Camau Gweithredu:** Y Themâu Archwilio i'w rhannu gyda'r Grŵp Dysgu a Datblygu
3.8	**Traciwr Camau Gweithredu Archwilio** Cadarnhaodd Julie Ash, Pennaeth Gwasanaethau Corfforaethol (JA) fod 23 o gamau gweithredu wedi'u hadolygu yn y cyfarfod diwethaf lle cafodd 17 eu cau gan adael cyfanswm o 6 cham gweithredu agored. Derbyniodd y Pwyllgor dri adroddiad	Nodwyd	Dim i'w nodi

	newydd yn y cyfarfod diwethaf a oedd yn cynnwys 10 cam gweithredu newydd. Roedd y rhain wedi'u hychwanegu at y cofnod sydd bellach yn cynnwys cyfanswm o 16 o gamau gweithredu agored. Roedd JA yn falch o adrodd bod 13 o'r 16 hynny wedi'u cwblhau a thri ar y trywydd iawn i gael eu cwblhau erbyn eu dyddiad targed. **Penderfynodd** y Pwyllgor: **NODI**'r camau gweithredu oedd yn weddill a'r gwaith arfaethedig oedd ar y gweill i gau'r camau gweithredu.		
3.9	**Adroddiad Diweddaru Atal Twyll Lleol** Cyflwynodd Gareth Lavington, Swyddog Atal Twyll Arbenigol Arweiniol, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro (GL) yr adroddiad Diweddaru ar Atal Twyll Lleol ar gyfer y chwarter yn diweddu 31 Mawrth ac amlygodd y prif bwyntiau. Holodd RG a oedd angen unrhyw beth arall gan y Pwyllgor i symud y darn addysg a chyflwyniad yn ei flaen h.y. a ddylai'r Pwyllgor gynyddu ei ymgysylltiad nawr bod y tîm Atal Twyll wedi'i recriwtio'n llawn iddo. Cadarnhaodd GL ei fod yn cyflwyno'r hyn roedd yn teimlo oedd angen ei ddarparu i Iechyd a Gofal Digidol Cymru o ran addysg/cyflwyniadau a'i fod yn awyddus i gael lefel o ddealltwriaeth gyda chydweithwyr yn Iechyd a Gofal Digidol Cymru yn ogystal ag Archwilio Mewnol lle cafwyd y risgiau cynhenid. Cadarnhaodd CO-L ei bod wedi cyfarfod â GL a'u bod wedi trafod y cynllun, sut y gellid alinio adnoddau i gefnogi cyflawni'r cynllun a sut i godi proffil Atal Twyll. Cadarnhaodd GL y byddai'n cysylltu ag MC ynghylch sesiynau twyll a sut y byddai'r rhain yn cael eu darparu'n effeithiol. **Penderfynodd** y Pwyllgor: **NODI**'r Adroddiad Diweddaru Atal Twyll	Nodwyd	Dim i'w nodi
4	ADRODDIADAU CORFFORAETHOL		
4.1	**Diweddariad am y Cyfrifon Blynyddol** Cyflwynodd MC y sefyllfa bresennol i'r Pwyllgor a'r amserlen ar gyfer y dyfodol:- • Gweithgareddau a gynhaliwyd ers cyhoeddi'r adroddiad: roedd tudalen 2 o adran 1.5 yn nodi'r dyddiadau cau ar gyfer adrodd yn allanol ar gyfer y sefydliad. Roedd y dyddiad cau cyntaf yn adlewyrchu cyflwyniad ariannol diwrnod 5. Roedd Eitem 2 yn nodi bod Iechyd a Gofal Digidol Cymru wedi bodloni ei ofynion adrodd statudol o ran ei sefyllfa adennill	Nodwyd	Dim i'w nodi

	costau. • Roedd y cyfrifon drafft wedi'u cyflwyno. • Mae tîm Cyllid Iechyd a Gofal Digidol Cymru yn cysylltu ag Archwilio Cymru bob wythnos i ddarparu tryloywder. • Roedd dwy elfen o golledion a thaliadau arbennig a oedd angen sylw arbennig yn y nodiadau a'r naratif a oedd yn cyd-fynd â'r cyfrifon. • Roedd datgeliad 16 Safonau Adrodd Ariannol Rhyngwladol (IFRS) yn rhan o'r trafodaethau cyffredinol gydag Archwilio Cymru. **Penderfynodd** y Pwyllgor: **NODI** diweddariad y Cyfrifon Blynyddol ar gyfer **SICRWYDD.**		
4.2	**Rheoli Risg gan gynnwys y Gofrestr Risgiau Corfforaethol** Amlygodd CD y sefyllfa proffil risg bresennol i'r Pwyllgor: - • Roedd 21 o risgiau ar y gofrestr, 10 y manylwyd arnynt yn y log ac 11 a oedd yn ymwneud â Seiberddiogelwch a chawsant eu hystyriwyd yn y Pwyllgor Llywodraethu a Diogelwch Digidol yn y sesiwn breifat. • Roedd nifer o risgiau wedi'u hychwanegu ac yn ymwneud yn gyffredinol â risgiau seiber ond hefyd roedd nifer wedi'u tynnu a'u rhestru yn yr adroddiad gyda'r rhesymau dros eu tynnu neu eu cau. Rhoddodd CD ddiweddariad ar y tair risg a neilltuwyd i'r Pwyllgor:- • **DHCW0259 Swyddi Gwag** Roedd y risg yn cael ei hadolygu'n rheolaidd. Roedd nifer sylweddol o staff newydd wedi ymuno ag Iechyd a Gofal Digidol Cymru yn ystod y 12 mis diwethaf. Roedd strategaeth adnoddau Masnachol wedi'i datblygu a byddai'r Grŵp Tasglu Recriwtio yn cael ei dynnu'n ôl a byddai grŵp ariannol/masnachol/recriwtio yn ei le. • **DHCW0208 Cydymffurfio â'r Iaith Gymraeg** Nid oedd y risg wedi newid. Daeth Rheolwr Gwasanaethau'r Gymraeg i'w swydd yn gynharach yn y flwyddyn ac mae wedi adolygu'r safonau a chydymffurfiaeth Iechyd a Gofal Digidol Cymru yn eu herbyn. • **DHCW0273 Gwasanaeth Testun Dwy Ffordd Cymraeg**	Trafodwyd	Dim i'w nodi

	Roedd disgwyl i'r gwasanaeth testun dwy ffordd gael ei gwblhau a chytunwyd gyda Llywodraeth Cymru y byddai'n mynd yn fyw o ran y mesurau lliniaru i sicrhau bod apwyntiadau testun dwyieithog dwy ffordd yn cael eu hanfon erbyn mis Mehefin. Roedd y dyddiad wedi symud o ddechrau mis Mai wrth i Lywodraeth Cymru bennu blaenoriaethau ar gyfer rhaglen Imiwneiddio Cymru. Gwahoddodd CD CL-J i roi trosolwg o'r gwaith a wnaed ar y risgiau seiber. Rhoddodd CL-J esboniad pam fod nifer y risgiau meddalwedd wystlo wedi cynyddu o un risg. Roedd y risg generig wedi'i rhannu'n risgiau penodol yn unol â chyngor gan gwmni ymgynghori a oedd wedi gwneud gwaith ar risgiau seiber. Darparwyd diweddariadau ar y risgiau oedd yn weddill: • 0261 oedd y risg amhenodol wreiddiol, roedd bellach wedi cau. • 0257 byddai'r risg hon yn cael ei chau yn fuan, roedd newidiadau'n cael eu monitro. • 0283 roedd mater masnachol wedi'i ddatrys ac roedd y risg bellach wedi'i gau. Derbyniodd y Pwyllgor sicrwydd gan DS, Is-Gadeirydd y Pwyllgor Llywodraethu a Diogelwch Digidol a gadarnhaodd fod cynnydd da yn cael ei wneud o ran risgiau meddalwedd wystlo. Roedd Cadeiryddion y ddau Bwyllgor yn awyddus i beidio â dyblygu gwaith, felly nid oedd y risg seiber yn cael ei thrafod mewn sesiwn Breifat o'r Pwyllgor hwn. **Cynllun carreg filltir** Hyfforddwyd staff Iechyd a Gofal Digidol Cymru ar Sicrwydd Risg a Bwrdd yn ystod y ddau fis diwethaf a chynlluniwyd sesiwn Fframwaith Sicrwydd Bwrdd (BAF) ar ddiwrnod Datblygu'r Bwrdd ar 5 Mai 2022. Y nod oedd mynd â'r Fframwaith Sicrwydd Bwrdd i'r Bwrdd yng nghyfarfod mis Mai i'w gymeradwyo. O ran y risg Swyddi Gwag, awgrymodd DS y dylid canolbwyntio mwy ar raglen hyfforddi staff fewnol i uwchsgilio staff mewnol drwy'r rhaglenni datblygu priodol. **Penderfynodd** y Pwyllgor: **NODI'**r Adroddiad Rheoli Risg gan gynnwys y Gofrestr Risgiau Corfforaethol a'r Cynllun Carreg Filltir		
4.3	**Cydymffurfio â Safonau'r Gymraeg** Esboniodd CD fod Iechyd a Gofal Digidol Cymru wedi ymrwymo	Ar gyfer Sicrwydd	Dim i'w nodi

	i ddod yn sefydliad dwyieithog, ac fel corff statudol newydd, darparwyd amcangyfrif o ba adnoddau Cymraeg y byddai eu hangen. O safbwynt cyfieithu, rhoddwyd Cytundeb Lefel Gwasanaeth ar waith gyda Phartneriaeth Cydwasanaethau GIG Cymru (PCGC) am y cyfnod 2021/22, fodd bynnag, mae mwy na dwywaith yr adnodd y cytunwyd arno wedi'i ddefnyddio. Roedd y Rheolwr Iaith Gymraeg newydd ei benodi wedi adolygu'r cynllun gweithredu ac wedi gwneud rhai diwygiadau fel y nodir yn eitem 4.3i yn yr agenda. Mae Iechyd a Gofal Digidol Cymru wedi drafftio Cynllun Iaith Gymraeg penodol i Iechyd a Gofal Digidol Cymru ac wedi cysylltu â swyddfa Comisiynydd y Gymraeg i ddatblygu'r cynllun. Roedd y Cynllun Iaith Gymraeg wedi'i gyflwyno i'w gymeradwyo Cadarnhaodd CD y byddai'r adroddiad Cydymffurfio â Safonau'r Gymraeg yn cael ei gyflwyno eto fel eitem sefydlog i'r Pwyllgor adolygu cydymffurfio â'r Gymraeg. Cadarnhaodd y Cadeirydd mai hi yw hyrwyddwr Bwrdd yr Iaith Gymraeg a'i bod yn falch o nodi'r newid cadarnhaol roedd y Rheolwr Iaith Gymraeg wedi'i gychwyn ac roedd yn edrych ymlaen at dderbyn yr adroddiad ffurfiol cyntaf yn y cyfarfod nesaf. **Penderfynodd** y Pwyllgor: **NODI'**r Adroddiad Cydymffurfio â Safonau'r Gymraeg ar gyfer **SICRWYDD**.		
4.4	**Adroddiad Datganiadau o Fuddiannau, Rhoddion a Lletygarwch** Dywedodd CD yng nghyfarfod diwethaf y Pwyllgor bod yr holl ddatganiadau o fuddiannau wedi'u cofnodi ar gyfer Aelodau'r Bwrdd ar gyfer 2021/22. Gwelodd y gofrestr derfynol ar gyfer 2021/22 gyfradd gydymffurfio o 87% o uwch reolwyr band 8a ac uwch, yn ymateb ac yn cael eu hychwanegu at y gofrestr. Gan weithio gyda'r tîm Cyfathrebu, y gobaith oedd gwella ar y ffigwr hwn ar gyfer 2022/23 a chodi ymhellach ymwybyddiaeth unigolion o'u cyfrifoldeb i adrodd am unrhyw ddatganiad a pholisi Safonau Ymddygiad. Tynnodd CD sylw'r Pwyllgor at dri datganiad o letygarwch, cafodd y tri eu derbyn a'u cymeradwyo gan y Prif Weithredwr gyda dim wedi'u gwrthod. Dywedodd CD ei fod yn ymwybodol o un datganiad lletygarwch nad oedd wedi'i gynnwys ar y gofrestr a bydd yn cael ei gofnodi'n ôl-weithredol a'i gyflwyno yn y cyfarfod nesaf. Nododd y Pwyllgor y rhodd gwerth £56.49 a dderbyniwyd yn wreiddiol, a gafodd ei gwrthod yn ddiweddarach oherwydd	Sicrwydd	Dim i'w nodi

	gwerth y rhodd. Cadarnhaodd RG fod y gofrestr yn unol â'r disgwyl a phwysleisiodd fod cydweithwyr yn defnyddio'r gofrestr os cynigir unrhyw roddion neu letygarwch iddynt. **Penderfynodd** y Pwyllgor: **DDERBYN** Adroddiad Datganiadau Buddiannau, Rhoddion a Lletygarwch ar gyfer **SICRWYDD**.		
4.5	**Adroddiad Archebion Prynu Gwerth Uchel** Rhoddodd MC fanylion y pum archeb dros y trothwy o £750k a drafodwyd yn ystod y cyfnod adrodd. O ran y contractau cronnus sydd wedi cyrraedd dros £750k fel yr adlewyrchir yn Nhabl 2 roedd un o'r rhain yn ymwneud â phrydlesu cerbydau parhaus ar gyfer staff, tynnwyd yr eitemau hyn o gyflogres staff, felly nid ydynt yn arwain at unrhyw gost i Iechyd a Gofal Digidol Cymru. Nodwyd bod newid mawr wedi bod i geir trydan ar gyfer ceir ar brydles i staff yn y chwarter olaf. Ychwanegodd MC y byddai'n ymarfer diddorol i adolygu a gwerthuso ddiwedd y flwyddyn i weld a ellid cyflawni unrhyw arbedion economaidd. **CAM GWEITHREDU 20220503-A03** Gwasanaethau Caffael i barhau i edrych ar batrymau a thueddiadau a nodi unrhyw gyfleoedd contractio gwahanol. **Penderfynodd** y Pwyllgor: **NODI'R** Adroddiad Archebion Prynu Gwerth Uchel.	Nodwyd	**Cam Gweithredu:** Caffael i barhau i edrych ar batrymau a thueddiadau a nodi unrhyw gyfleoedd contractio gwahanol.
4.6	**Diweddariad am Golledion a Thaliadau Arbennig** Cadarnhaodd MC mai dyma'r tro cyntaf i adroddiad ar Golledion a Thaliadau Arbennig ddod gerbron y Pwyllgor ac roedd yr adroddiad yn manylu ar ddwy eitem: • Taliad ex-gratia (7e: Setliad) 15.0 (swm a dalwyd mewn £'000) • Taliadau iawndal eraill a wnaed o dan rwymedigaeth gyfreithiol 1,158.4 (swm a dalwyd mewn £'000). Gwnaethpwyd yr eitem hon o dan gyfarwyddyd Llywodraeth Cymru ac fe'i cefnogwyd gan y cyllid priodol. Roedd y Pwyllgor yn falch o nodi'r adroddiad a oedd yn rhoi sicrwydd iddynt fod y prosesau priodol ar waith. **Penderfynodd** y Pwyllgor: **NODI'r** Colledion a'r Taliadau Arbennig ar gyfer **SICRWYDD.**	Nodwyd	Dim i'w nodi

4.7	**Adroddiad Cydymffurfiaeth Caffael a Chynllun Dirprwyo** Cyflwynodd Julie Francis, Pennaeth Gwasanaethau Masnachol (JF) yr adroddiad a gofynnodd i'r Pwyllgor nodi'r trosolwg canlynol: • Roedd tri Cham Gweithredu Tendr Unigol (STA) a chwe nodyn newid. • Bu gostyngiad yn nifer y Camau Gweithredu Tendr Unigol ers y cyfarfod diwethaf. • Mae'r Camau Gweithredu Tendr Unigol a'r nodiadau newid i gyd yn cwmpasu ystod o weithgareddau i sicrhau bod gwasanaethau gweithredol yn parhau. • Gweithredwyd pob Cam Gweithredu Tendr Unigol yn unol â chyfarwyddiadau ariannol sefydlog. **Penderfynodd** y Pwyllgor: **NODI** cynnwys yr Adroddiad Cydymffurfiaeth Caffael a Chynllun Dirprwyo	Nodwyd	Dim i'w nodi
4.8	**Adroddiad Diweddaru Cydymffurfiaeth yr Uned Ansawdd a Rheoleiddio a Seibergadernid** Cyflwynodd CO-L yr adroddiad a rhoddodd yr uchafbwyntiau allweddol i'r Pwyllgor:- • Roedd 2021/22 wedi dod i ben yn gadarnhaol gydag archwiliadau ISO 9001 ac ISO 14001. Roedd y ddau archwiliad yn llwyddiannus ac ni chodwyd unrhyw achosion newydd o ddiffyg cydymffurfio a chaewyd yr holl achosion blaenorol o ddiffyg cydymffurfio. • Cwblhawyd y Cynllun Tymor Canolig Integredig gan gynnwys mabwysiadu'r i-pasbort a'r porth ansawdd. • Ymgymerwyd â datblygu'r adroddiad rheoli ansawdd misol ar gyfer y grŵp Ansawdd a Rheoleiddio a pharhaodd y gwaith ar gydymffurfiaeth dyfeisiau meddygol. • Cyflwynwyd y cynllun Blynyddol Seiberddiogelwch i Gyfarwyddwyr y Grŵp Cymheiriaid Digidol a'i ddilysu gan Lywodraeth Cymru. • Roedd archwiliadau ar y gweill ar gyfer Chwarter 1 2022/23. • Roedd rhaglen archwilio mewnol seiliedig ar risg wedi'i datblygu. I grynhoi, cafwyd perfformiad cryf gan y Tîm Ansawdd ac roedd ansawdd yn cael ei ymgorffori ar draws Cyfarwyddiaethau.	Nodwyd	Dim i'w nodi

	Penderfynodd y Pwyllgor: **NODI** Adroddiad Diweddaru Cydymffurfiaeth yr Uned Ansawdd a Rheoleiddio a Seibergadernid.		
4.9	**Adroddiad Cynllun Gweithredu'r Adolygiad Llywodraethu Sylfaenol** Dywedodd CD fod yr Adolygiad Llywodraethu Sylfaenol a gynhaliwyd wedi cynhyrchu cyfleoedd ar gyfer gwella a oedd yn cael eu monitro gan y Bwrdd Rheoli. Amlinellodd CD y meysydd cynnydd allweddol o fewn y cynllun gweithredu. Byddai diweddariad pellach yn cael ei ddarparu i gyfarfod Archwilio a Sicrwydd mis Gorffennaf a byddai cynnydd yn parhau i gael ei fonitro. Ychwanegodd CD unwaith y byddai'r Asesiad Strwythuredig wedi'i gwblhau y byddai'n cael ei adrodd yn ôl trwy'r traciwr Archwilio ffurfiol. Rhoddodd DS drosolwg i'r Pwyllgor o'r cynnydd a'r trafodaethau a gynhaliwyd yng nghyfarfod diwethaf Rhwydwaith Digidol Aelodau Annibynnol Cymru Gyfan. **Penderfynodd** y Pwyllgor: **NODI** Cynllun Gweithredu'r Adolygiad Llywodraethu Sylfaenol	Ar gyfer Sicrwydd	Dim i'w nodi
4.10	**Adroddiad Ystadau a Chydymffurfiaeth** Cyflwynodd JA yr uchafbwyntiau canlynol o'r adroddiad: • **Cynllun Cyflenwi Strategol Datgarboneiddio Iechyd a Gofal Digidol Cymru** Roedd Iechyd a Gofal Digidol Cymru wedi dod yn aelod o Grŵp Newid Hinsawdd Cymuned o Arbenigwyr Llywodraeth Cymru. • **Ardystiad ISO 14001** Mae ardystiad Rheolaeth Amgylcheddol IS0 14001 wedi'i gynnal yn llwyddiannus ers 2014. • **Ystadegau Cydymffurfiaeth** Roedd ystadegau cydymffurfiaeth ystadau yn 93% a oedd yn uwch na'r targed o 90%. • **Ystadegau Iechyd a Diogelwch** Ychydig iawn o ddigwyddiadau oedd i'w hadrodd. 6 digwyddiad yn ystod y flwyddyn a gafodd eu hadrodd a'u rheoli yn unol â thargedau. **Penderfynodd** y Pwyllgor: **NODI'**r Adroddiad Ystadau a Chydymffurfiaeth.	Nodwyd	Dim i'w nodi

4.11	**Gweithdrefn Weithredu Safonol ar gyfer Ymestyn Contract** Cyflwynodd JF y Weithdrefn Weithredu Safonol ar gyfer Ymestyn Contract a gynhyrchwyd mewn ymateb i gais gan Gadeirydd y Pwyllgor Archwilio a Sicrwydd. Hysbyswyd y Pwyllgor fod Gweithdrefn Weithredu Safonol a diagram llif cysylltiedig o'r broses wedi'u datblygu er mwyn ymdrin â chontractau y tu allan i werth neu dymor gwreiddiol eu contract i gydymffurfio ac yn unol â'r Rheoliadau Caffael. **Penderfynodd** y Pwyllgor: **NODI**'r Weithdrefn Weithredu Safonol ar gyfer Ymestyn Contract	Nodwyd	Dim i'w nodi
4.12	**Adroddiad Diweddaru ar yr Ymchwiliad i COVID-19** Derbyniodd y Pwyllgor, er gwybodaeth, yr wybodaeth ddiweddaraf am yr Ymchwiliad i COVID-19 a nododd y byddai gan yr Ymchwiliad ran allweddol i'w chwarae wrth baratoi ar gyfer Ymchwiliad y DU a'r gwersi a ddysgwyd. Cadarnhaodd CD fod Iechyd a Gofal Digidol Cymru wedi cyfarwyddo gwasanaethau Cyfreithiol a Risg PCGC yn ddiweddar i ddarparu cymorth wrth baratoi ar gyfer yr Ymchwiliad, er ei bod yn anodd ar hyn o bryd i gwmpasu goblygiadau adnoddau y gallai hyn ei gael ar Iechyd a Gofal Digidol Cymru. Ychwanegodd MS ei bod yn annhebygol y byddai Iechyd a Gofal Digidol Cymru yn cael ei alw fel cyfranogwyr craidd, ond bod y ffocws wedi bod ar sicrhau bod llwybr archwilio a bod yr holl ddogfennaeth mewn un lleoliad canolog. Cytunodd y Pwyllgor y dylent dderbyn mecanwaith diweddaru rheolaidd ar yr Ymchwiliad i COVID-19. **CAM GWEITHREDU 20220503-A04** Cytuno ar fecanwaith adrodd ar gyfer rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor am yr Ymchwiliad i COVID-19. MS i ddod â'r wybodaeth ddiweddaraf yn ôl i'r pwyllgor ar barodrwydd yr Ymchwiliad a ddarparwyd gan y Cyfreithwyr. Rhoddodd CD yr wybodaeth ddiweddaraf i'r Pwyllgor fod y Byrddau Iechyd a chydweithwyr yn y GIG wedi recriwtio timau penodedig i weithio ar yr Ymchwiliad ac er y cydnabuwyd bod eu sefyllfa'n wahanol i Iechyd a Gofal Digidol Cymru, mae staff yn Iechyd a Gofal Digidol Cymru yn ymateb i'r Ymchwiliad hwn yn ogystal â busnes fel arfer. **Penderfynodd** y Pwyllgor: **NODI'r** Adroddiad Diweddaru ar yr Ymchwiliad i COVID-19 .	Nodwyd	**Cam Gweithredu:** Cytuno ar fecanwaith adrodd ar gyfer rhoi'r wybodaeth ddiweddaraf i'r Pwyllgor am yr Ymchwiliad i COVID-19 MS i ddod â'r wybodaeth ddiweddaraf yn ôl i'r pwyllgor ar barodrwydd yr Ymchwiliad a ddarparwyd gan y Cyfreithwyr

4.13	**Adroddiad Adolygu Blynyddol o'r Rheolau Sefydlog** Cyflwynodd CD adroddiad Adolygiad Blynyddol o'r Rheolau Sefydlog gan nodi ei fod eisoes wedi'i gyflwyno i'r Bwrdd a rhoddodd y diweddariadau allweddol: • Rheolau Sefydlog, ychydig iawn o newidiadau a wnaed ar gyfer y flwyddyn ariannol hon. Roedd y newidiadau wedi'u nodi yn yr adroddiad gyda'r prif newid i'r Cylch Gorchwyl. • Cydymffurfio â'r Rheolau Sefydlog, yn ystod 2021/22 ni fu angen dod ag unrhyw achos o ddiffyg cydymffurfio â'r Rheolau Sefydlog i'r Pwyllgor hwn. Cadarnhaodd CO-L fod adolygiad o'r Cyfarwyddiadau Ariannol Sefydlog (SFI) wedi'i gwblhau a nododd ddau faes lle y gwnaed newidiadau yn ystod y flwyddyn ariannol. **CAM GWEITHREDU: 20220503-A05** Cytunodd CO-L i ddod â'r adolygiad o Gyfarwyddiadau Ariannol Sefydlog i gyfarfod nesaf y Pwyllgor Archwilio a Sicrwydd. **Penderfynodd** y Pwyllgor: **NODI** adroddiad Adolygiad Blynyddol y Rheolau Sefydlog ar gyfer **SICRWYDD**	Ar gyfer Sicrwydd	**Cam Gweithredu:** Cytunodd CO-L i ddod â'r adolygiad o Gyfarwyddiadau Ariannol Sefydlog i gyfarfod nesaf y Pwyllgor Archwilio a Sicrwydd
4.14	**Adroddiad Sicrwydd Pwyllgor Partneriaeth Cydwasanaethau GIG Cymru** Cyflwynodd SL yr uchafbwyntiau canlynol o'r adroddiad: • Mewn perthynas â chostau ceir a phrydlesi, roedd PCGC wedi gwneud addasiadau i'r rhestr i gefnogi'r rhaglen ddatgarboneiddio. • Roedd perfformiad yn gyffredin â materion recriwtio yn Iechyd a Gofal Digidol Cymru. • Chwyddiant ynni – roedd PCGC yn allweddol i leihau effaith y cynnydd mewn prisiau cyfleustodau. **Penderfynodd y Pwyllgor:** **NODI** Adroddiad Sicrwydd Partneriaeth Cydwasanaethau GIG Cymru	Nodwyd	Dim i'w nodi
4.15	**Adroddiad Cryno Cadeirydd y Pwyllgor Archwilio** Darparodd y Cadeirydd gefndir yr adroddiad a gynhaliwyd ymhlith Cadeiryddion Archwilio ac a oedd yn bennaf ar gyfer rhannu arferion da. Bwriedir cynnal y cyfarfod nesaf yn ddiweddarach y mis hwn a	Ar gyfer Sicrwydd	Dim i'w nodi

	byddai'r adroddiad yn cael ei gyflwyno i Bwyllgor mis Gorffennaf. **Penderfynodd** y Pwyllgor: **NODI** Adroddiad Cryno Cadeirydd y Pwyllgor Archwilio ar gyfer **SICRWYDD.**		
5	MATERION I GLOI		
5.1	**Adroddiad Crynhoi Cynnydd y Pwyllgor i'r Bwrdd** Nododd y Cadeirydd yr eitemau a gymeradwywyd, a gefnogwyd ac a drafodwyd i'w cynnwys yn adroddiad y Cadeirydd i'r Bwrdd. Nodwyd bod y Pwyllgor hwn yn dangos arferion da.	Trafodwyd	Dim i'w nodi
5.2	**Unrhyw Faterion Brys eraill** Dim i'w nodi.	Nodwyd	Dim i'w nodi
5.3	**Dyddiadau ac Amserau'r Cyfarfodydd Nesaf:** • 24 Mai 2022 (adolygiad o gyfrifon) 10.00am • 14 Mehefin 2022 cyfrifon a archwiliwyd 10.00am • 5 Gorffennaf, 2022, 09:00am	Nodwyd	Dim i'w nodi

Pwyllgor Archwilio a Sicrwydd Eithriadol - CYHOEDDUS

COFNODION, PENDERFYNIADAU A CHAMAU I'W CYMRYD

10:00 – 11:00 24/05/2022

Galwad Teams

Cadeirydd	Marian Wyn Jones

Yn Bresennol (Aelodau)		Teitl	Sefydliad
Marian Wyn Jones	MW-J	Aelod Annibynnol, Cadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru
Ruth Glazzard	RG	Aelod Annibynnol, Is-gadeirydd y Bwrdd	Iechyd a Gofal Digidol Cymru (DHCW)
David Selway	DS	Aelod Annibynnol	Iechyd a Gofal Digidol Cymru (DHCW)
Grace Quantock	GQ	Aelod Annibynnol, Is-gadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru (DHCW)
Presennol			
Simon Cookson	SC	Cyfarwyddwr Archwilio a Sicrwydd	Archwilio Mewnol PCGC
Mark Cox	MC	Cyfarwyddwr Cyswllt Cyllid	Iechyd a Gofal Digidol Cymru (DHCW)
Chris Darling	CD	Ysgrifennydd y Bwrdd	Iechyd a Gofal Digidol Cymru (DHCW)
Gareth Davis	GD	Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau Digidol	Iechyd a Gofal Digidol Cymru (DHCW)
Ifan Evans	IE	Cyfarwyddwr Gweithredol Strategaeth	Iechyd a Gofal Digidol Cymru (DHCW)
Paul Evans	PE	Rheolwr Ansawdd	Iechyd a Gofal Digidol Cymru

		(Cydymffurfiaeth Reoleiddio)	(DHCW)
Julie Francis	JF	Pennaeth Gwasanaethau Masnachol	Iechyd a Gofal Digidol Cymru (DHCW)
Sophie Fuller	SF	Rheolwr Llywodraethu a Sicrwydd Corfforaethol	Iechyd a Gofal Digidol Cymru (DHCW)
Claire Osmundsen-Little	CO-L	Cyfarwyddwr Gweithredol Cyllid	Iechyd a Gofal Digidol Cymru (DHCW)
Julie Robinson	JR	Cydlynydd Llywodraethu Corfforaethol	Iechyd a Gofal Digidol Cymru (DHCW)
Michelle Sell	MS	Cyfarwyddwr Cynllunio a Pherfformiad a Phrif Swyddog Masnachol	Iechyd a Gofal Digidol Cymru (DHCW)
Mike Whiteley	MW	Rheolwr Archwilio	Archwilio Cymru
Siân Williams	SW	Pennaeth Gwasanaethau Ariannol	Iechyd a Gofal Digidol Cymru (DHCW)
Ymddiheuriadau			
Julie Ash	JA	Pennaeth Gwasanaethau Corfforaethol	Iechyd a Gofal Digidol Cymru (DHCW)
Stephen Chaney	StC	Dirprwy Bennaeth Archwilio Mewnol	Archwilio Mewnol PCGC
Nathan Couch	NC	Arweinydd Archwilio Perfformiad (Iechyd)	Archwilio Cymru
Darren Griffiths	DG	Rheolwr Archwilio (Perfformiad)	Archwilio Cymru
Gareth Lavington	GL	Arbenigwr Atal Twyll Lleol Arweiniol	Atal Twyll Lleol Caerdydd a'r Fro
Helen Thomas	HT	Prif Weithredwr	Iechyd a Gofal Digidol Cymru (DHCW)

Acronymau			
DHCW	Iechyd a Gofal Digidol Cymru	NWIS	Gwasanaeth Gwybodeg GIG Cymru
AIA	Awdurdod Iechyd Arbennig	AS	Archwilio a Sicrwydd
SoCNW	Datganiad o Wariant Net Cynhwysfawr	WHC	Cylchlythyr Iechyd Cymru

Rhif yr Eitem	Eitem	Canlyniad	Cam gweithredu
1	MATERION RHAGARWEINIOL		
1.1	Croeso a chyflwyniadau Croesawodd y Cadeirydd bawb i'r Pwyllgor Archwilio a Sicrwydd Arbennig a gafodd ei gynnull i dderbyn y cyfrifon drafft ar gyfer 2021/22. Cynhaliwyd y cyfarfod drwy Microsoft Teams ac atgoffwyd y rhai a oedd yn bresennol fod y cyfarfod yn cael ei recordio ac y byddai'n cael ei bostio ar wefan DHCW yn dilyn y cyfarfod. Dywedodd y Cadeirydd wrth y Pwyllgor fod eitem 2.2 ar yr agenda wedi'i derbyn fel papur hwyr, fodd bynnag, roedd hyn wedi'i adolygu a'i drafod gydag Ysgrifennydd y Bwrdd a chytunwyd y gallai'r Pwyllgor gyflawni ei rôl wrth graffu ar y papur. Cynghorodd y Cadeirydd y byddai'r eitem agenda yn cael ei hadolygu'n fanwl yn ystod y cyfarfod.	Nodwyd	Dim i'w nodi
1.2	Ymddiheuriadau am Absenoldeb Nodwyd ymddiheuriadau am absenoldeb gan: • Helen Thomas, Prif Weithredwr, DHCW • Julie Ash, Pennaeth Gwasanaethau Corfforaethol, DHCW • Stephen Chaney, Dirprwy Bennaeth Archwilio Mewnol, PCGC • Gareth Lavington, Pennaeth Atal Twyll, Caerdydd a'r Fro • Nathan Couch, Arweinydd Archwilio Perfformiad, Archwilio Cymru • Darren Griffiths, Rheolwr Archwilio, Archwilio Cymru	Nodwyd	Dim i'w nodi
1.3	Datganiadau o Fuddiannau Nid oedd unrhyw Ddatganiadau o Fuddiannau i'w nodi.	Nodwyd	Dim i'w nodi
2	BUSNES Y CYFARFOD		
2.1	Cyflwyno Cyfrifon Drafft 2021/2022 Cyflwynodd Claire Osmundsen-Little, Cyfarwyddwr	Nodwyd	Dim i'w nodi

Gweithredol Cyllid (CO-L) y Cyfrifon Drafft a darparodd rywfaint o gyd-destun y gwaith yr oedd DHCW wedi'i wneud dros y flwyddyn ddiwethaf ers ei sefydlu fel Awdurdod Iechyd Arbennig (AIA). Roedd DHCW wedi ymgymryd â'r gwaith llywodraethu cywir ac wedi sicrhau ei fod yn cydymffurfio â'i Ddyletswyddau a Gofynion Statudol.

Rhoddodd Mark Cox, Cyfarwyddwr Cyswllt Cyllid (MC) gyd-destun pellach ar sut y lluniwyd y datganiadau ariannol;

- nid oedd unrhyw gymaryddion fel y gwelir yn arferol, gan mai hon oedd y set gyntaf o gyfrifon;
- bod gofyniad wedi bod am set o gyfrifon 15 mis;
- yn nodi'r ffordd y cafodd trafodion eu trin cyn 1 Ebrill 2021

Tynnodd Sian Williams, Pennaeth Gwasanaethau Ariannol (SW) sylw at naw o'r 34 nodyn yn y cyfrifon a nododd y prif bwyntiau.

Cadarnhaodd MC y bydd DHCW yn cyfarfod ag Archwilio Cymru ar 1 Mehefin ac yn cytuno ar y cyfrifon terfynol a fydd yn galluogi'r cyfrifon i gael eu hadolygu gan y cyfarfod Archwilio a Sicrwydd ar 14 Mehefin, a'u cymeradwyo gan y Bwrdd cyn eu cyflwyno ar 15 Mehefin i Lywodraeth Cymru.

Cyflwynodd yr aelodau eu sylwadau ar y cyfrifon drafft. Gofynnodd Ruth Glazzard, Aelod Annibynnol (RG) am eglurhad ar un o'r nodiadau a amlinellwyd yn gynharach a oedd yn cyfeirio at 'ragdaliadau eraill' ac a ellid eu diffinio'n glir i ddangos tystiolaeth o'r hyn y cyfeiriwyd ato fel 'arall'.

Cadarnhaodd MC ei fod yn arsylwad o gyfres gyntaf DHCW o gyfrifon nad oedd natur ei fusnes yn gweddu i'r templedi a gyhoeddwyd. Fodd bynnag, mae'n rhaid i Lywodraeth Cymru ddarparu templedi cyson a'u bod wedi'u pwysoli tuag at Fyrddau Iechyd ac Ymddiriedolaethau nad oedd yn rhoi unrhyw hyblygrwydd i DHCW.

Dywedodd RG, wrth i DHCW fynd ymlaen, y bydd perygl y bydd mwy a mwy o eitemau mewn categorïau 'arall' nad fyddai'n ymddangos yn dryloyw iawn.

Cadarnhaodd CO-L mai dymuniad DHCW oedd sicrhau bod y cyfrifon yn dryloyw ac yn glir i bawb ac roeddent yn ceisio, fel rhan o'r Cyfarfod Cyffredinol Blynyddol, ategu'r set o gyfrifon gyda chyflwyniad arloesol i alluogi unrhyw un yng Nghymru i ddeall y cyfrifon a sut mae DHCW yn defnyddio eu cyllid i gefnogi gwasanaethau digidol ar draws y GIG Cymru. Nid yw'r gofyniad statudol yn galluogi hyblygrwydd nac arloesedd yn y ffordd y cyflwynir y cyfrifon felly dylai'r cyflwyniad hwn ddod â'r cyfrifon yn fyw i'r cyhoedd.

Ategodd David Selway, Aelod Annibynnol (DS) ei ddiolch i'r tîm ariannol am eglurder y cyflwyniad, a gofynnodd am bwynt o

	eglurhad mewn perthynas â'r asedau anniriaethol a'r gwerth a neilltuwyd i feddalwedd a ddatblygwyd yn fewnol. Holodd a oedd cyfanswm gwerth y feddalwedd wedi'i gynhyrchu hyd yma neu a oedd yn werth yn ystod y flwyddyn i'r hyn a ychwanegwyd at y sylfaen asedau. Cadarnhaodd MC mai cyfanswm y gwerth ydoedd, yn amodol ar gyfanswm y gost, cost cyflogi'r staff yn seiliedig ar eu cyflogau a'r costau uniongyrchol sy'n gysylltiedig ag adeiladu pob ased unigol neu ddatblygu meddalwedd. Mae asedau anniriaethol yn cael eu hamorteiddio tra bydd dibrisiant yn cael ei gymhwyso ar yr asedau sefydlog diriaethol. Canmolodd Grace Quantock, Is-gadeirydd Archwilio a Sicrwydd ac Aelod Annibynnol (GQ) y tîm cyllid am ddadnasoddi'r cyfrifon a'u gwneud yn ddealladwy. Gofynnodd GQ a oedd y problemau gyda chostau byw yn cael eu hystyried o ran Polisi Taliadau'r Sector Cyhoeddus i sefydliadau nad ydynt yn rhan o'r GIG a oedd ar hyn o bryd yn 97% ac 82% ar gyfer sefydliadau'r GIG. Cadarnhaodd CO-L yr hoffai weld 97% ar gyfer sefydliadau nad ydynt yn rhan o'r GIG a sefydliadau'r GIG fel ei gilydd. Bydd yr agwedd hon yn cael ei thargedu ond fel rhan o'r ymarferion caffael yr oedd y tîm Masnachol yn eu cynnal, oedd hyrwyddo ac archwilio busnesau o Gymru yn rhagweithiol fel bod yr arian yn cael ei wario yng Nghymru ac yn cefnogi economi Cymru lle bynnag y bo'n briodol. Diolchodd y Cadeirydd i'r Tîm Cyllid am yr holl waith a wnaed i ddarparu cyfres mor glir o gyfrifon. **Penderfynodd** y Pwyllgor: **Nodi'r** Cyfrifon Blynyddol Drafft 2021/2022		
2.2	**Iechyd a Gofal Digidol Cymru – Ymholiadau Archwilio i'r rhai sy'n gyfrifol am Lywodraethu a Rheoli ar gyfer y cyfnod a ddaeth i ben 31 Mawrth 2022** NododdMark Cox, Cyfarwyddwr Cyswllt Cyllid (MC) y prif bwyntiau o Atodiadau 1-3 a oedd yn mynd i'r afael â'r tri maes mewn perthynas â: - • Nodi ymholiadau sy'n ymwneud â thwyll, • Sut mae'r rheolwyr yn cael sicrwydd y cydymffurfiwyd â'r holl gyfreithiau a rheoliadau perthnasol; a • Thrydydd partïon, pa brosesau sydd gan DHCW ar waith sy'n sicrhau bod cysylltiadau trydydd parti yn cael eu monitro a'u hadrodd. Asesodd DHCW y risg yn isel y gallai'r datganiadau ariannol gael eu cam-ddatgan yn sylweddol oherwydd twyll. Amlinellodd MC y trefniadau sydd ar waith i roi gwybod i'r	Trafodwyd	Dim i'w nodi

	Pwyllgor Archwilio a Sicrwydd am unrhyw faterion a risgiau twyll a lliniaru'r risgiau hynny. Atgoffodd RG yr Aelodau fod y Pwyllgor hwn wedi trafod yr argyfwng 'cost byw' o'r blaen a'r hyn y gallai ei wneud i'r proffil risg pan ddaw i dwyll. O ran nodi ac ymateb i risg, cafwyd camau cadarnhaol o ran y dull blaengar. **Penderfynodd y Pwyllgor:** **NODI** Ymholiadau Archwilio Iechyd a Gofal Digidol Cymru i'r rhai sy'n gyfrifol am Lywodraethu a Rheoli ar gyfer y cyfnod a ddaeth i ben ar 31 Mawrth 2022.		
2.3	**Diweddariad Archwilio Cymru** Rhoddodd Mike Whiteley Rheolwr Archwilio, Archwilio Cymru (MW) drosolwg cyffredinol o'r archwiliad a oedd yn mynd rhagddo yn ôl y disgwyl a diolchodd i'r tîm cyllid am eu cymorth a'u hymatebion amserol. Roedd y tîm Archwilio wedi rhoi eu hadborth ac roedd y cyfan yn mynd yn dda o'u safbwynt nhw. Amlinellodd MW yr ISA260 a'r hyn y gellid ei ddisgwyl yn y cyfarfod ym mis Mehefin; y Farn Archwilio arfaethedig ar y cyfrifon, y Llythyr Cynrychiolaeth ac unrhyw argymhellion, a oedd yn ofyniad safonol o dan safonau archwilio. Yn achos unrhyw gamddatganiadau wedi'u haddasu, byddai'r rhain yn cael eu cynnwys yn y Llythyr Cynrychiolaeth. Byddai sesiynau'n cael eu cynnal rhwng DHCW ac Archwilio Cymru ar y gwersi a ddysgwyd o'r flwyddyn gyntaf o gyfrifon ac archwilio cyfrifon i adolygu'r hyn a aeth yn dda a'r hyn y gellid gwella arno. Tynnodd MW sylw'r Pwyllgor at yr eitem flaenorol ar yr agenda a dywedodd fod twyll, o safbwynt Archwilio Cymru, hefyd yn cynnwys camadrodd ariannol bwriadol. Cadarnhaodd MW ei fod yn hyderus y gallai'r cyfrifon archwiliedig terfynol gael eu cyflwyno i Lywodraeth Cymru ar 15 Mehefin a bod amser i ddatrys unrhyw faterion cyn y dyddiad hwn. Estynnodd y Cadeirydd ei gwerthfawrogiad i'r tîm a'r ffordd yr oedd y cyfrifon wedi cael eu cyflwyno a'u harchwilio ar gyfer blwyddyn gyntaf DHCW. **Penderfynodd** y Pwyllgor: **NODI** diweddariad Archwilio Cymru.		
3	MATERION I GLOI		

3.1	**Unrhyw Faterion Brys eraill** Dim i'w nodi.	Nodwyd	Dim i'w nodi
3.2	**Dyddiadau ac Amseroedd y Cyfarfodydd Nesaf:** • 14 Mehefin 2022 cyfrifon archwiliedig 10:00am • 4 Gorffennaf 2022 09:00am	Nodwyd	Dim i'w nodi

Pwyllgor Arbennig Archwilio a Sicrwydd - CYHOEDDUS

COFNODION, PENDERFYNIADAU A CHAMAU I'W CYMRYD

10:00 – 10:45 14/06/2022

Galwad Teams

Cadeirydd	Marian Wyn Jones

Yn Bresennol (Aelodau)		Teitl	Sefydliad
Marian Wyn Jones	MW-J	Aelod Annibynnol, Cadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru
Ruth Glazzard	RG	Aelod Annibynnol, Is-gadeirydd y Bwrdd	Iechyd a Gofal Digidol Cymru
David Selway	DS	Aelod Annibynnol	Iechyd a Gofal Digidol Cymru
Presennol			
Stephen Chaney	StC	Dirprwy Bennaeth Archwilio Mewnol	Archwilio Mewnol PCGC
Simon Cookson	SC	Cyfarwyddwr Archwilio a Sicrwydd	Archwilio Mewnol PCGC
Mark Cox	MC	Cyfarwyddwr Cyswllt Cyllid	Iechyd a Gofal Digidol Cymru
Chris Darling	CD	Ysgrifennydd y Bwrdd	Iechyd a Gofal Digidol Cymru
Gareth Davies	GD	Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau	Iechyd a Gofal Digidol Cymru
Julie Francis	JF	Pennaeth Gwasanaethau Masnachol	Iechyd a Gofal Digidol Cymru
Claire Osmundsen-Little	CO-L	Cyfarwyddwr Gweithredol Cyllid	Iechyd a Gofal Digidol Cymru
Julie Robinson	JR	Cydlynydd Llywodraethu Corfforaethol	Iechyd a Gofal Digidol Cymru

Mike Whiteley	MW	Rheolwr Archwilio	Archwilio Cymru
Sian Williams	SW	Pennaeth Gwasanaethau Ariannol	Iechyd a Gofal Digidol Cymru
Ymddiheuriadau			
Julie Ash	JA	Pennaeth Gwasanaethau Corfforaethol	Iechyd a Gofal Digidol Cymru
Grace Quantock	GQ	Aelod Annibynnol, Is-gadeirydd y Pwyllgor Archwilio a Sicrwydd	Iechyd a Gofal Digidol Cymru
Nathan Couch	CC	Arweinydd Archwilio Perfformiad (Iechyd)	Archwilio Cymru
Darren Griffiths	DG	Rheolwr Archwilio (Perfformiad)	Archwilio Cymru
Gareth Lavington	GL	Arbenigwr Atal Twyll Lleol Arweiniol	Atal Twyll Lleol Caerdydd a'r Fro
Helen Thomas	HT	Prif Weithredwr	Iechyd a Gofal Digidol Cymru

Acronymau			
Iechyd a Gofal Digidol Cymru	Iechyd a Gofal Digidol Cymru	NWIS	Gwasanaeth Gwybodeg GIG Cymru
AIA	Awdurdod Iechyd Arbennig	AS	Archwilio a Sicrwydd
SoCNE	Datganiad o Wariant Net Cynhwysfawr	MfA	Llawlyfr Cyfrifon
SO's	Rheolau Sefydlog	CAS	Cyfarwyddiadau Ariannol Sefydlog

Rhif yr Eitem	Eitem	Canlyniad	Cam gweithredu
1	MATERION RHAGARWEINIOL		
1.1	Croeso a chyflwyniadau Croesawodd y Cadeirydd bawb i'r Pwyllgor Archwilio a Sicrwydd Arbennig a wnaeth ymgynnull i dderbyn a chymeradwyo'r adroddiad blynyddol terfynol a chyfrifon ar gyfer 2021/22, cyn iddynt gael eu cymeradwyo yng nghyfarfod Bwrdd yr Awdurdod Iechyd Arbennig yn ddiweddarach yn	Nodwyd	Dim i'w nodi

	ystod y dydd. Dywedodd y Cadeirydd fod y papurau wedi'u hailgyhoeddi i Aelodau'r Pwyllgor ddydd Gwener 10 Mehefin, a'r gwahaniaeth oedd bod y cafeatau wedi'u dileu gan fod y gwaith Archwilio wedi dod i ben heb unrhyw faterion nad ydynt wedi cael eu datrys.		
1.2	**Ymddiheuriadau am Absenoldeb** Nodwyd ymddiheuriadau am absenoldeb gan: • Grace Quantock, Is-gadeirydd y Pwyllgor Archwilio a Sicrwydd, Aelod Annibynnol, Iechyd a Gofal Digidol Cymru • Helen Thomas, Prif Weithredwr, Iechyd a Gofal Digidol Cymru • Ifan Evans, Cyfarwyddwr Gweithredol Strategaeth, Iechyd a Gofal Digidol Cymru • Julie Ash, Pennaeth Gwasanaethau Corfforaethol, Iechyd a Gofal Digidol Cymru • Gareth Lavington, Pennaeth Atal Twyll, Caerdydd a'r Fro • Nathan Couch, Arweinydd Archwilio Perfformiad, Archwilio Cymru	Nodwyd	Dim i'w nodi
1.3	**Datganiadau o Fuddiannau** Nid oedd unrhyw ddatganiadau o fuddiannau i'w nodi.	Nodwyd	Dim i'w nodi
2	**BUSNES Y CYFARFOD**		
2.1	**Cyfrifon Blynyddol 2021/2022** Cyflwynodd Claire Osmundsen-Little, Cyfarwyddwr Gweithredol Cyllid (CO-L) Gyfrifon Blynyddol 2021/22 a oedd yn cynnwys:- • Y cyfrifon blynyddol ar gyfer y flwyddyn ariannol a ddaeth i ben 31 Mawrth 2022; • A'r Llythyr Cynrychiolaeth a ddarparwyd mewn cysylltiad ag archwilio'r datganiadau ariannol. Derbyniodd y Pwyllgor Archwilio a Sicrwydd y cyfrifon drafft yn ei gyfarfod diweddar ar 24 Mai 2022 pan fu'n adolygu'r cyfrifon ac fe gafodd yr wybodaeth ddiweddaraf am y cynnydd a wnaed yn yr archwiliad a gynhaliwyd gan Archwilio Cymru. Roedd yr archwiliad bellach wedi'i gwblhau a chyflwynwyd y cyfrifon i'w cymeradwyo i'r Bwrdd yn ddiweddarach yn ystod y dydd, ac ar ôl hynny byddent yn cael eu cyflwyno i Lywodraeth Cymru ar 15 Mehefin 2022.	Cymeradwyo	Dim i'w nodi

	Roedd y cyfrifon yn cwmpasu cyfnod o 15 mis ers sefydlu Iechyd a Gofal Digidol Cymru ar 30 Rhagfyr 2022 tan 31 Mawrth 2022 ac fe'u crynhowyd o dan 5 datganiad allweddol a'u hategu gan gyfres o nodiadau manwl:- • Datganiad o Wariant Net Cynhwysfawr • Gwariant Net Cynhwysfawr Arall • Datganiad o'r Sefyllfa Ariannol ar 31 Mawrth 2022 • Datganiad o'r Newidiadau yn Ecwiti Trethdalwyr; a • Datganiad o Lifau Arian Parod am y cyfnod a ddaeth i ben 31 Mawrth 2022. Cafodd y Pwyllgor Archwilio a Sicrwydd sicrwydd bod Iechyd a Gofal Digidol Cymru wedi bodloni ei ofyniad i ymgymryd â'r ddwy ddyletswydd ariannol. Gwnaed nifer o newidiadau i'r cyfrifon drafft, a oedd yn ymwneud yn bennaf â'r dull o'u cyflwyno, a arweiniodd at gyflwyno'r cyfrifon terfynol. Ategodd Ruth Glazzard, Aelod Annibynnol (RG) sylwadau a wnaed ei bod yn flwyddyn eithriadol, a bod y Pwyllgor yn gwerthfawrogi'r gwaith a wnaed gan y tîm Cyllid i gyflawni'r canlyniad hwn. Ychwanegodd Mark Cox, Cyfarwyddwr Cyswllt Cyllid (MC) fod y tîm cyllid wedi ystyried bod y broses yn ffordd o ddysgu a gwella, yn ogystal â rhoi sicrwydd, a diolchodd i Archwilio Cymru a oedd wedi ategu'r dull a fabwysiadwyd gan Iechyd a Gofal Digidol Cymru ac a oedd wedi arwain at y canlyniad cadarnhaol. Penderfynodd y Pwyllgor: NODI A CHYMERADWYO Cyfrifon Blynyddol 2021/22 i'r Bwrdd gan gynnwys y Datganiadau Ariannol, Llythyr Cynrychiolaeth ac Adroddiad ISA260 Archwilio Cymru, i argymell ei fod yn cael ei gymeradwyo gan Fwrdd yr Awdurdod Iechyd Arbennig cyn ei gyflwyno i Lywodraeth Cymru ar 15 Mehefin 2022 fel rhan o'r adroddiadau blynyddol gofynnol ar gyfer 2021/2022.		
2.2	Adroddiad ISA260 Archwilio Cymru Cyflwynodd Mike Whiteley, Archwilio Cymru (MW) Adroddiad ISA260 Archwilio Cymru. Dywedwyd wrth y Pwyllgor Archwilio a Sicrwydd fod yr archwiliad yn gadarnhaol iawn. Tynnodd MW sylw at brif uchafbwyntiau'r adroddiad: • Roedd Archwilio Cymru wedi cyhoeddi adroddiad archwilio diamod ar y Cyfrifon a oedd yn arwyddocaol ar gyfer ei flwyddyn gyntaf.	Nodwyd	Dim i'w nodi

	• Nid oedd unrhyw gamddatganiadau heb eu cywiro. • Cywirwyd y camddatganiadau cychwynnol yn y cyfrifon, ac amlinellir gwybodaeth bellach yn Atodiad 3. • Nid oedd unrhyw faterion o bwys yn codi o'r meysydd yn y cyfrifon. • Mewn perthynas â'r un argymhelliad a amlinellir yn Atodiad 4, roedd hyn yn cael sylw rhagweithiol gan weithgor a sefydlwyd. • Y Llythyr Cynrychiolaeth. Cadarnhaodd Archwilio Cymru ei bod yn gyflawniad sylweddol cael barn ddiamod ar gyfres gyntaf o gyfrifon Iechyd a Gofal Digidol Cymru a diolchodd i bawb a oedd yn gysylltiedig â nhw. **Penderfynodd** y Pwyllgor: **NODI** Adroddiad Archwilio Cyfrifon (ISA260) ar gyfer Awdurdod Iechyd Arbennig Iechyd a Gofal Digidol Cymru.		
2.3	**Adroddiad Blynyddol 2021/22** Derbyniodd y Pwyllgor Adroddiad Blynyddol 2021/22. Cadarnhaodd Chris Darling, Ysgrifennydd y Bwrdd (CD) ei bod yn ofynnol i'r Awdurdod Iechyd Arbennig gyflwyno ei Adroddiad Blynyddol gan gynnwys ei Adroddiad Atebolrwydd i Lywodraeth Cymru erbyn 15 Mehefin 2022 a fydd yn adlewyrchu'r trefniadau perfformiad ac atebolrwydd a oedd ar waith yn ystod 2021/2022. Mae'r Llawlyfr Cyfrifon yn nodi ei bod yn ofynnol i holl sefydliadau'r GIG gyhoeddi Adroddiad Blynyddol a Chyfrifon tair rhan fel un ddogfen, sy'n cynnwys: • Yr Adroddiad Perfformiad • Yr Adroddiad Atebolrwydd • Y Datganiadau Ariannol Mynegodd CD ei ddiolch i gydweithwyr am yr amser a'r ymdrech sylweddol a roddwyd i ddatblygu'r wybodaeth a oedd wedi'i chynnwys yn yr Adroddiad Perfformiad. Byddai'r Adroddiad Perfformiad yn nodwedd allweddol o'r Cyfarfod Cyffredinol Blynyddol a drefnwyd ar gyfer 28 Gorffennaf 2022. Cynlluniwyd yr Adroddiad Atebolrwydd i fodloni'r gofynion allweddol ar gyfer adrodd i Lywodraeth Cymru ac roedd yn cynnwys yr elfennau canlynol: • Adroddiad Llywodraethu Corfforaethol • Adroddiad ar Dâl Cydnabyddiaeth a Staff • Adroddiad Atebolrwydd ac Archwilio Cynulliad	Cymeradwyo	Dim i'w nodi

	Cenedlaethol Cymru Cyflwynwyd drafft o'r adroddiad i Lywodraeth Cymru ar 6 Mai 2022 a chafodd ei gyflwyno hefyd i Archwilio Cymru ac Archwilio Mewnol i gael sylwadau ac adborth. Roedd yr holl adborth wedi'i dderbyn a'i ymgorffori'n ddiolchgar yn y fersiwn terfynol. Diolchodd David Selway, Aelod Annibynnol (DS) i Ysgrifennydd y Bwrdd a'i gydweithwyr am yr adroddiad a oedd wedi'i strwythuro'n dda a oedd yn rhoi eglurder o ran y gwaith a wnaed yn ystod y flwyddyn diwethaf ac am y rhyngweithio rhwng y Bwrdd a'r Pwyllgorau cyn y cyfarfod. **Penderfynodd** y Pwyllgor: **NODI** A **CHYMERADWYO** fersiwn terfynol Adroddiad Blynyddol 2021/22 i argymell ei fod yn cael ei gymeradwyo gan y Bwrdd cyn ei gyflwyno i Lywodraeth Cymru ar 15 Mehefin 2022 fel rhan o'r adroddiadau blynyddol gofynnol ar gyfer 2021/2022 a'i rannu yn y Cyfarfod Cyffredinol Blynyddol.		
2.4	**Adroddiad Blynyddol a Barn y Pennaeth Archwilio Mewnol 2021/2022** Cyflwynodd Simon Cookson, Pennaeth Archwilio Mewnol (SC) yr adroddiad a oedd yn nodi barn Pennaeth Archwilio Mewnol ynghyd â chanlyniadau cryno'r gwaith archwilio mewnol a wnaed yn ystod y flwyddyn. Roedd yr adroddiad hefyd yn cynnwys crynodeb o berfformiad archwilio ac asesiad o gydymffurfiad â Safonau Archwilio Mewnol y Sector Cyhoeddus. Roedd SC yn falch o adrodd bod Iechyd a Gofal Digidol Cymru wedi cael sicrwydd rhesymol bod trefniadau i sicrhau llywodraethu, rheoli risg a rheolaeth fewnol yn y meysydd a adolygwyd wedi'u cynllunio a'u cymhwyso'n effeithiol. Nodwyd bod nifer o'r gwasanaethau ariannol allweddol h.y. y gyflogres yn cael eu gweithredu gan Bartneriaeth Cydwasanaethau'r GIG a darparwyd crynodeb ar hyn yn yr adroddiad, ynghyd â dangosyddion perfformiad allweddol eraill. Rhoddodd SC ei ddiolch i'r holl swyddogion ac yn arbennig i'r Cyfarwyddwr Cyllid Gweithredol ac Ysgrifennydd y Bwrdd am eu cymorth a'u cydweithrediad yn ystod y broses hon. **Penderfynodd** y Pwyllgor : **NODI** A **CHYMERADWYO** statws Barn y Pennaeth Archwilio Mewnol ac Adroddiad Blynyddol 2021/2022	Cymeradwyo	Dim i'w nodi
3	MATERION I GLOI		

3.1	**Unrhyw Faterion Brys eraill** Dim i'w nodi.	Nodwyd	Dim i'w nodi
3.2	**Dyddiad ac amser y cyfarfod nesaf:** Dydd Mawrth 4 Gorffennaf 2022 09:00am	Nodwyd	Dim i'w nodi

DIGITAL HEALTH AND CARE WALES
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Agenda Item	2.2

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Chris Darling, Board Secretary
Presented By	Claire Osmundsen Little, Executive Director of Finance

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to: **NOTE** NHS Wales Shared Services Partnership Assurance Report	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	All

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below: Effective Care, Staff and Resources	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome:
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
GAF	Governance Assurance Framework	SOs	Standing Orders
SFI's	Standing Financial Instructions		

2 SITUATION/BACKGROUND

2.1 DHCW along with other NHS Wales bodies are a member of the NHS Wales Shared Services Partnership Committee

2.2 The Executive Director of Finance is the DHCW member on the Partnership Committee.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 DHCW receive a number of services from NHS Wales Shared Services. A summary of the most recent Partnership Committee meeting can be found as item 2.2i via the NHS Wales Shared Services Partnership Committee Assurance Report.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee

5 RECOMMENDATION

The Committee is being asked to:
NOTE the NHS Wales Shared Services Partnership Committee Assurance Report

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	19 May 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment Update

Gareth Hardacre, Director of People & OD gave an update on the progress being made on the Recruitment Modernisation Action Plan following the deep dive on this topic in the March Committee.

All organisations are now live on the latest version (3) of NHS Jobs. Progress has been made in letting the IT contract for the Pre-Employment Checks, but this has been slightly delayed as clarification is needed by the Home Office surrounding the cyber security requirements in the product specification. However, the deadline of September 2022, where either face-to-face checks are re-introduced or the IT solution is in place, should still be met.

The Action Plan for revising specific recruitment processes is due to go to Workforce Directors on May 20th and includes the proposal to establish a senior Programme Board to oversee delivery of the Plan. Performance against Recruitment Key Performance Indicators is improving, despite there being no drop in the level of activity across NHS Wales.

It has been agreed that a deep dive on Recruitment will be undertaken with the BCUHB Executive Board and the offer was made to do something similar with other NHS Wales organisations.

The Committee **NOTED** the update.

Medical Examiner Service

Andrew Evans, Director of Primary Care Services and Ruth Alcolado, Medical Director jointly presented to the Committee on progress with the development of the Medical Examiner Service. The service is currently examining around 1000 deaths a month, with a target of 2500 by the time the service is launched on a statutory footing, which is now likely to be April 2023 at the earliest. To date, the

service has been able to identify potential learning for Health Boards and Trusts in approximately 25% of cases reviewed, and it is considered that 10% of cases would benefit from a Stage 2 Mortality Review – these figures are consistent with what is being reported in England. There are however differences in the way that the service is operated in the two countries, and the nature of the set-up in Wales allows greater identification of local, regional, and national issues.

One of the key benefits of the service thus far is to give each family the opportunity to speak with a Medical Examiner Officer. This has been very well received and in many cases the families have expressed their gratitude for the care received by their family member from Health Boards and Trusts at the end of their life.

To further successfully develop the service Health Boards and Trusts need to ensure timely notification of death, availability of clinical notes, and access to the relevant doctor to discuss the cause of death. The commitment from the service to Health Boards includes that all deaths will be scrutinised by the autumn of this year; that there is effective communication on themes and trends; and that there should be effective monitoring of performance.

In summary it was noted that the service is already making a positive contribution to patient safety, and that consultation is underway and/or planned with clinical colleagues to address any issues and to maximise the benefits.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the March meeting. These have included:

- Meeting with the Minister as part of the all-Wales Chairs' Group. It was helpful that the Minister had recently visited IP5 and consequently gained a good understanding of what NWSSP does and had been left with a positive impression of the organisation;
- Attending her first NWSSP Audit Committee which again had been very positive;
- Continuing to meet with senior NWSSP management, and in particular recently from Specialist Estates and the Temporary Medicines Unit, to gain a better understanding of what they do;
- Attending the DHCW Board Development session in April where NWSSP received positive feedback;
- Chairing the Welsh Risk Pool Committee; and
- Arranging to attend the Velindre Trust Board at the end of June as part of their Board Development session.

Looking further forward the Chair is keen to hold a development session with the Committee, ideally in person for a half-day in the autumn and including other members of the NWSSP Senior Leadership Group. This could include a stock-take

session on what works well and what doesn't work so well for the Committee; allow the Committee to better understand what NWSSP does, ensuring that it is aligned to NHS Wales's organisation priorities and also those of the Welsh Government; looking to the future in terms of which services it should provide; and assessing the current structure of the Committee and whether it needs wider (e.g. clinical) representation. A plan for how the session might work will be brought back to the July Committee.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Senior NWSSP management participated in the meeting with Welsh Government in early May to review the IMTP. The meeting was very positive, and the IMTP has been well-received with the Outcome Letter expected in June;
- Work has been undertaken with colleagues from Welsh Government and Public Health Wales regarding the future plans for the recently vacated Lighthouse Laboratory at the IP5 facility. Within IP5, the Surgical Materials Testing Laboratory have had a new laboratory completed which will enable them to perform additional tests and to develop new testing regimes for medical devices, which they were unable to do at the existing Bridgend site;
- Progress continues to be made in terms of the overarching Transforming Access to Medicine Outline Business Case, with a number of workshops held to consider site selection. There is on-going discussion with workforce colleagues and Chief Pharmacists regarding the Organisational Change Programme; and
- The recent cyber security assessment, conducted as part of the NHS Wales Cyber Resilience Unit's work to implement the Network Information Security (NIS) Regulation in all health organisations in Wales, demonstrated that generally NWSSP is well protected from cyber-attacks. A formal project has been launched to address the key areas for improvement identified in the report's recommendations. One of the key tasks in the initial phase, a desktop exercise based around a cyber incident, was carried out at the May Informal Senior Leadership Group.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

Chris Lewis, Environmental Management Advisor presented the Plan which had been formally submitted to Welsh Government on 31st March. The Committee had previously had the opportunity to review the plan in detail at its November 2021 meeting. Clarity was provided in terms of explaining that this was the inward-facing NWSSP plan and that NWSSP were substantially involved in the production of the national plan which embraces the role that NWSSP plays in supporting NHS Wales organisations to achieve their own decarbonisation targets. Key actions in the internal facing plan include reducing the impact of our buildings, fleet, and

new laundry service, as well as working with staff to help raise the profile of decarbonisation across the organisation.

The Committee **ENDORSED** the Action Plan.

Laundry Detergent Contract

Anthony Hayward, Assistant Director of Laundry Services, attended the Committee to present a paper for endorsement and approval by the Committee. Following the transfer of laundry services to NWSSP from April 2021, there is now the opportunity to tender for laundry detergent on an all-Wales basis. This should provide opportunities for economies of scale compared to the current fragmented arrangements. However, the Laundry Service are also keen to include the provision of dosing pumps and a management information system into the contract which is anticipated to total £2m over a five-year period.

The Committee **ENDORSED** the paper.

Draft Annual Governance Statement 2021/22

The Committee reviewed the draft Annual Governance Statement which will be taken to the NWSSP Audit Committee in July for formal approval. The statement is substantially complete, but the formal Head of Internal Audit Opinion is still to be received and the final energy consumption figures for the year are still being calculated. The Statement is a positive reflection on the past year and there are no significant matters of control weaknesses that need to be included. The final version of the Statement will be brought back to the July Partnership Committee for information.

The Committee **ENDORSED** the Statement **IN PRINCIPLE** recognising that it was still draft, and that formal approval would be sought at the Audit Committee.

Service Level Agreements 2022/23

The Committee received the Service Level Agreements for the core service provided by NWSSP to NHS Wales for formal annual approval. The papers included the overarching Service Level Agreement and a cover paper detailing any amendments to the supporting schedules, none of which were significant. (The schedules were provided separately to Committee members for information). It was however noted that the Procurement SLA element would need to be brought back to the July Committee as it is to be further amended to reflect changes resulting from the implementation of the new Operating Model.

The Committee **APPROVED** the SLAs for 2022/23 noting that the Procurement SLA is due to be further amended and resubmitted for approval.

Salary Sacrifice – Staff Benefits

The Committee was presented with a paper setting out the arrangements for the Home Electronics and Cycle to Work Staff Benefit Schemes. There are currently different arrangements in place across NHS Wales, with some schemes being operated by NWSSP on behalf of NHS Wales organisations and other schemes

being operated and managed within health organisations. As well as potentially not providing optimal value-for-money, there is a risk that staff could fall below minimum wage rates due to being members of schemes administered by different organisations. The paper asked the Committee to approve a tender for a scheme to be administered by NWSSP that would cover home electronics and cycle to work schemes.

The Committee **ENDORSED** the approach being taken by NWSSP in awarding a contract(s) for Home Electronics and Cycle to Work with an aim of having an All-Wales arrangement in place, centrally administered by NWSSP, which will be made available to all Health Board, Trusts and Special Health Authorities.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported the outturn position, which is currently subject to external audit, and highlighted that a small surplus of £11k had been generated against total income of £870m. The DEL expenditure for the Welsh Risk Pool was £129.615m and the risk share agreement was invoked at the IMTP value of £16.495m. Additional Welsh Government risk pool funding of £4.861m was agreed above the core allocation and risk share funding to account for the additional cases settled in 2021/22. £17.018m capital funding was received in 2021/22 and fully utilised. £12.348m was spent in March 2022, including the purchase of Matrix House which completed on 30th March. The Committee were complimentary of the new style finance report.

Performance – Most KPIs are on track except for those relating to Recruitment Services, where the situation is improving due to the implementation of the Modernisation Plan, which was covered earlier on the agenda, but where there is still further progress to be made.

Project Management Office Update – Of the 24 schemes being managed by the PMO, there is only one that is currently rated as red. This is the project for the replacement of the Student Awards System which is approaching end-of-life and with no option to extend the support contract arrangements beyond March 2023. The deadline to issue a tender for the procurement of a replacement system is 31st May, but currently there is no guarantee of funding for this from Welsh Government.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.61% for March. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Part of the issue is in areas such as the Medical Examiner Service where staff may be on multiple contracts, but a solution is being sought for this. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme.

Corporate Risk Register – there remain two red risks relating to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, and the energy price increase. A new risk has been added relating to the Student Awards system, which was

highlighted earlier in the Project Management Office Progress Report.
Papers for Information
The following items were provided for information only: • Transforming Access to Medicine Progress Report • Information Governance Annual Report 2021/22 • Audit Committee Highlight Report • Quality and Safety Assurance Report • Complaints Annual Report 2021/22 • Finance Monitoring Returns (Months 12 and 1)
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.
Matters referred to other Committees
N/A

Date of next meeting	21 July 2022

Agenda item 2.3

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 June 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	All Wales NHS Audit Committee Chair's Meeting
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mr Paul Newman, Audit and Risk Assurance Committee Chair
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mr Paul Newman, Audit and Risk Assurance Committee Chair

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the paper is to present the Audit and Risk Assurance Committee with an update from the proceedings of the All Wales NHS Audit Committee Chairs' meeting held on 19th May 2022, chaired by Mr Paul Newman, Chair of Hywel Dda University Health Board (HDdUHB) Audit and Risk Assurance Committee.

Cefndir / Background

The All Wales NHS Audit Committee Chairs' meeting provides an opportunity to share information regarding common issues which arise within NHS bodies across NHS Wales and to share best practice. The forum is supported by attendance from a nominated Board Secretary from the All Wales Board Secretaries Network (AWBSN). In addition, meetings are attended by representatives from NHS Wales Shared Services Partnership Internal Audit (NWSSP IA), as providers of audit assurance through the independent and objective assessment of governance, risk management and internal control. Also in attendance are representatives from Audit Wales (AW), in their capacity as external auditors who also provide information and advice.

Asesiad / Assessment

The following is a summary of the main issues discussed at the meeting on 19th May 2022:

1. **Cyber Security**
   The Director of ICT, DHCW and the Interim Head of Cyber Security, DHCW provided a presentation highlighting the critical importance to business continuity of effective cyber security arrangements and outlining the scale of the potential impact of a successful cyber-attack upon service provision (with specific reference to health bodies, and using as an example the effects of a ransomware attack in May 2021 targeting the Health Service Executive – HSE - which provides all public health services in Ireland).

   It was noted that NHS Wales comprises 12 legal entities, it operates via a single IT network and this flexibility also represents a weakness, in that a security failure anywhere within NHS Wales can affect every entity.

Key elements of cyber security planning were highlighted in relation to a potential attack, grouped under the generic heading '*how to prevent* and *how to prepare for*.' These included the establishment of clear responsibility and governance arrangements at executive level for IT and cyber security, organisational investment in IT and cyber security resources, and the development of a Business Continuity Plan (which should focus upon provision of care and services to patients rather than the restoration of IT services). The establishment of *offline* IT backup systems was also critical to protect against the deletion or modification of data, and the supporting roles of the DHCW Cyber Security team and the NHS Wales Cyber Resilience Unit were outlined.

Recognising that associated risks should be comprehensively identified and captured, members discussed the level of detail which should be included on risk registers, together with appropriate fora in which to discuss cyber risks and agreed to review the submissions provided within their own organisations to ensure they have been scrutinised within the governance framework of the respective organisations.

2. NWSSP Internal Audit Update

Members received a presentation summarising the work of Internal Audit (IA) in respect of: 2021/21 audit progress, Limited Assurance reviews, themes emerging in relation to 2022/23 audit plans, changes to audit methodology, the IMTP 2022-25 and IA's workplan with AWACC 2022/23. The main points raised relating to IA work included:

- Key themes linked to Limited Assurance opinions included workforce (particularly control of contractors, consultancy and temporary staff) - reflecting common pressures impacting upon organisations, the wider clinical governance area (specifically around Mental Health) and specific aspects of governance - mainly relating to monitoring arrangements for specific projects.

- Key themes emerging from audit plans relate primarily to quality, with emphasis laid upon the need to maintain a quality focus in service recovery, particularly in the face of current workforce challenges. Members noted that cyber-risk was also listed as an emerging theme in 2022/23 audit plans.

- As regards changes to audit methodology, it was noted that a Business Manager had been appointed to the Internal Audit Team, whose remit would include identifying trends and emerging issues from different organisations, enabling more effective use and reporting of these themes.

  Noting that the development of meaningful quality Key Performance Indicators had been included on Internal Audit's workplan, consideration was given to how lessons could be learned from other Welsh health bodies, based on the findings of internal audits. Members were advised that this would be facilitated through the development of bespoke reporting from IA which would present an All Wales view in relation to individual findings. In regard to identification and adoption of 'best practice', the potential liability issues which may need to be considered by auditors and by organisations in adopting processes which subsequently prove to be detrimental or ineffective was recognised. Furthermore, the importance of using one auditor or audit team to work on the same area across different organisations to ensure the identification of good practice is based upon a consistent and comparative approach, and the merits of sharing what works well, as opposed to becoming overly preoccupied with relative gradings of 'good' and 'best'.

3. Audit Wales Update - External Audit Programme.

An update on work in progress was provided, together with an update on Public Accounts and Public Administration Committee (PAPAC) related developments and a summary of Audit Wales (AW) reports and outputs between January 2022 and April 2022.

Summary overviews were provided of findings from two specific reviews undertaken by AW: '*Care Home Commissioning for Older People*' (reported in December 2021) and '*Taking Care of the Carers?*' (published October 2021). The review of care homes, while being focused upon 6 Local Authorities and 1 Health Board in North Wales, identified significant generic challenges which are applicable regionally and nationally in relation to workforce (poor pay and lack of career structure), the need to better understand the experience of service users, the need for a better developed regional response in relation to commissioning, market stability and the need for a greater focus upon dementia. The inherent complexity of these issues, which inhibits the implementation of solutions and recognised the shift in the value which the general population attributes to care home workers as a key element in improving both career opportunities and rates of remuneration for staff within the sector was noted. Furthermore it was acknowledged that the need for Local Authorities to balance the allocation of funding to domiciliary care services in order to support people in their own homes with increases in funding to resource care homes.

The findings from the '*Taking Care of the Carers?'* review, which pointed to short and long-term risks to staff health resulting from the pandemic, also highlighted the focus which all NHS bodies in Wales had placed upon safeguarding staff at risk of COVID-19 and brought the need to focus upon staff wellbeing into sharper relief. In order to structure this focus, members were advised that the review had made 6 recommendations for health bodies and that AW had highlighted its expectations to Board Secretaries in regard to how its findings would be taken through the workforce and audit committees of their respective organisations.

4. Sharing Approaches across NHS Wales

Members noted that this agenda item was included as an action from the previous meeting (AWACC 22 08: C*omparison of how audit trackers and the Board Assurance Framework are managed and populated at the next meeting*). The need to ensure that service and department managers maintain ongoing discussion with audit committees in regard to progress and key issues impacting upon their respective areas was highlighted, as was the need to balance the aim of reducing the number of outstanding recommendations and actions listed on trackers as quickly as possible with the need to avoid placing undue demand upon staff who are already experiencing significant pressures

5. Update of Key and Relevant Matters from the All-Wales Board Secretaries Network (AWBSN)

Updates from the AWBSN meetings held on 28th January 2022 and 8th April 2022 were shared with the meeting papers. Members were informed that key issues discussed included accelerated cluster development and the approaches taken by health bodies in preparing for the forthcoming UK COVID-19 Public Inquiry.

6. AWACC Work Programme

Recognising the continuing relevance of certain topics included on the work plan which had been discussed at previous meetings, it was suggested that these be re-tabled for future meetings – cyber-security being highlighted as an example.

7. Chair and Support Arrangements

Members were informed that Martin Turner (WAST) would now take over the AWACC Chair and that the Board Secretary support role would at the same time pass to the WAST Board Secretary (Trish Mills). The next meeting will take place on 13th October 2022.
Argymhelliad / Recommendation The Audit and Risk Assurance Committee is requested to receive this report for information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Assurance reports to Committees and Board aligned to relevant standards.
Rhestr Termau: Glossary of Terms:	AWBSN – All Wales Board Secretaries' Network DHCW – Digital Health and Care Wales IMTP – Integrated Medium Term Plan WAST – Welsh Ambulance Service NHS Trust

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Board Secretary Chair, Audit & Risk Assurance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no direct financial implications within this report.
Ansawdd / Gofal Claf: Quality / Patient Care:	There are no direct quality or patient care implications within this report.
Gweithlu: Workforce:	There are no direct workforce implications within this report.
Risg: Risk:	There are no direct implications within this report.
Cyfreithiol: Legal:	There are no legal workforce implications within this report.
Enw Da: Reputational:	There are no direct implications within this report.
Gyfrinachedd: Privacy:	There are no direct implications within this report.
Cydraddoldeb: Equality:	• Has EqIA screening been undertaken? No • Has a full EqIA been undertaken? No

DIGITAL HEALTH AND CARE WALES
FORWARD WORKPLAN AND HORIZON SCANNING

Agenda Item	2.4

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Julie Robinson, Corporate Governance Co-ordinator
Presented By	Chris Darling, Board Secretary

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to: NOTE the contents of the report.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	The Corporate Risk log is presented at every meeting for oversight and scrutiny

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	AW	Audit Wales
SHA	Special Health Authority	IA	Internal Audit
SOP	Standard Operating Procedure	NCSC	National Cyber Security Centre
SO	Standing Orders	KPI	Key Performance Indicator

2 SITUATION/BACKGROUND

2.1 The Audit and Assurance Committee have a Cycle of Committee Business that is reviewed on an annual basis. Additionally, there is a forward workplan which is used to identify any additional timely items for inclusion to ensure the Committee are reviewing and receiving all relevant matters in a timely fashion.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The Forward Work-plan has been updated to include the:

- Cyber Resilience Unit. An update on the feedback of the recent completed Audits will be included.
- Welsh Community Care Information System (WCCIS) follow up report following receipt at the Senedd Public Administration and Public Accounts Committee.

3.2 The Board has requested additional horizon scanning is undertaken across all Committees to ensure appropriate governance process is followed and the Board is receiving the appropriate levels of assurance from the Committee activity. The Corporate Governance team will support the Executive Director of Finance as Executive lead for the Committee to identify items for the forward workplan on a continued basis.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The updated forward workplan can be found in full at item 2.4i Appendix A.

5 RECOMMENDATION

5.1 The Audit and Assurance Committee is being asked to NOTE the content of the report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Audit and Assurance Committee	May 2021	Initial workplan approved.

Agenda item 2.4i

Digital Health and Care Wales Audit and Assurance Committee Work Programme

Meeting Date	Standing Items	Governance	Finance	Internal Audit	External Audit	Additional Items
4th July	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme • Committee Highlight Report to Board • Audit Tracker	• Risk and Board Assurance Report • Declarations of Interest, Gifts and Hospitalities Report • Covid Inquiry preparedness update (including feedback from Solicitors (CD/MS) • Cyber Resilience Unit • Welsh Language Compliance update	• Losses and special payments report • Procurements and scheme of delegation report • High Value Purchase Order and Cumulative report	• Internal Audit Progress Report • Internal Audit reviews • Research & Development	• Audit and Assurance Committee updates • Audit Wales review reports • DHCW Audit Report Themes Review • WCCIS follow up report (a verbal update may be available if it has been received by Senedd by 4th July)	• Local Counter Fraud Update Report • Quality and Regulatory Compliance Report • Quality & Regulatory Annual Review • Estates Report • Standing financial instruction and compliance report (COL) • Counter Fraud Plan 2022/23
18th October	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme	• Risk and Board Assurance Report • Declarations of Interest, Gifts and Hospitalities Report • Covid Inquiry • Cyber Resilience Unit to include feedback from recent audits • Welsh Language Compliance Report	• Losses and special payments report • Procurements and scheme of delegation report • High Value Purchase Order and Cumulative report	• Internal Audit Progress Report • Internal Audit reviews	• Audit and Assurance Committee updates • Audit Wales review reports • DHCW Audit Report Themes Review • WCCIS follow up report following receipt by PAPAC •	• Local Counter Fraud Update Report • Quality and Regulatory Compliance Report • Estates Report

Agenda item 2.4i

	• Committee Highlight Report to Board • Audit Tracker •	•				
14th February	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme • Committee Highlight Report to Board • Audit Tracker	• Governance Assurance Framework review report • Standing Orders Annual compliance report • Cyber Resilience Unit • Welsh Language Compliance update	• Losses and special payments report • Procurements and scheme of delegation report • High Value Purchase Order and Cumulative report	• Internal Audit Progress Report • Internal Audit reviews	• Audit and Assurance Committee updates • Audit Wales review reports • DHCW Audit Report Themes Review	• Local Counter Fraud Update Report • Quality and Regulatory Compliance Report • Estates Report • Policy on the use of Welsh internally

Reference	Date of Meeting	Action/Decision Detail	Action Lead	Due Date	Status/Outcome Narrative	Status	Revised Action	Revised due date	Session Type
20211005-A03	05/10/2021	In relation to the Data Analytics report it was agreed a paper to be brought back on the development and research function to the Committee for assurance.	Rachael Powell (DHCW - Information Services)	30/12/2021	Action was noted as closed 03/05/22 Meeting. The report was emailed to members outside of the meeting, alongside papers for July committee on 20/06/20	Complete		01/04/2022	Public
20211005-A04	05/10/2021	An appropriate timeline for KPIs (data products) to be produced and brought back to the Committee	Rachael Powell (DHCW - Information Services)	30/12/2021	Will be brought to the April Committee. Update for April: work has been undertaken on setting a new milestone on R&I KPI's but not a timeline on the broader ISD KPI. July update RP will attend the Committee to provide an update.	Underway		20/06/2022	Public
20211005-A06	05/10/2021	Audit Wales to share the paper setting out WCCIS progress, following consideration by the Senedd Committee.	Wales Audit Office 3	04/11/2021	Audit Wales have produced an update paper on WCCIS for the Senedd Public Accounts and Public Administration Committee. The paper will be shared with DHCW after it has been presented to the PA&PAC for consideration.	Underway			Public
20220503-A01	03/05/2022	A link to Centre for Digital Public Services (CDPS) to be provided. RG will be linking with CDPS and DHCW Health Care Standards Teams.	Chris Darling (DHCW - Board Secretary)	20/06/2022	Contact details of CDPS and DHCW standards staff shared to make the links.	Complete			Public
20220503-A02	03/05/2022	The Audit Themes to be shared with the Incident Review and Learning Group (IR&L)	Chris Darling (DHCW - Board Secretary)	17/05/2022	Audit Themes report shared with Head of Corporate Services to take to IR&LG. Meeting held with NWSSP Internal Audit Business Analyst and Head of Corporate Services, an annual report on audit themes to be presented to the A&A Committee with themes captured after each meeting/audit report.	Complete			Public
20220503-A03	03/05/2022	Procurement will continue to look at patterns and trends and identify any different contract opportunities.	Michelle Sell (DHCW - Chief Operating Officer)	03/05/2022	Process agreed between finance and procurement to be managed through the Capital and Non-Pay Delivery Group	Complete			Public
20220503-A04	03/05/2022	A reporting mechanism for the Covid-19 Inquiry to be agreed for updating the Committee. MS to bring back an update on the Inquiry preparedness provided by NWSSP. Action for CD and MS	Chris Darling (DHCW - Board Secretary)	20/06/2022	A discussion between MS and CD has taken place re Covid-19 inquiry preparedness. Update to come to October meeting, following review of work to date with the solicitor, as there hasn't been significant change since the update at the May meeting for the July meeting.	Complete			Public
20220503-A05	03/05/2022	The review of the Standing Financial Instructions to be brought back to the next meeting in July.	Claire Osmundsen-Little (DHCW - Director of Finance)	20/06/2022	Added to the July Committee agenda.	Complete			Public

DIGITAL HEALTH AND CARE WALES
INTERNAL AUDIT PROGRESS REPORT 2022/23
NWSSP AUDIT & ASSURANCE SERVICES

Agenda Item	4.1

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Stephen Chaney, Deputy Head of Internal Audit
Presented By	Simon Cookson, Acting Head of Internal Audit

Purpose of the Report	For Assurance
Recommendation	
The Committee is being asked to: NOTE the Internal Audit Progress Report.	

1. IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	N/A

WELL-BEING OF FUTURE GENERATIONS ACT	A More Equal Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
Due to the nature of the internal audit work, multiple Standards are applicable.	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome:
N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DCHW	Digital Health and Care Wales	SHA	Special Health Authority

2. SITUATION/BACKGROUND

2.1 This document sets out the progress with the Internal Audit Plan for 2022/23 (the 'Plan') for Digital Health and Care Wales (DHCW), detailing the audits to be undertaken and the status of each of them. This is a standard format report that will be provided to every meeting of the Audit and Assurance Committee. It also confirms that the remaining two audits from the 2021/22 Internal Audit Plan have been finalised.

3. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The Committee provides assurance to the Board that an appropriate Internal Audit programme is in place for the year and is being delivered in accordance with required quality standards

3.2 The report contains the current status of the planned audits for 2022/23, including assurance and priority ratings, when completed. It also contains details of the two last remaining reports from the 2021/22 Internal Audit Plan.

4. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee.

5. RECOMMENDATION

5.1 The Committee is asked to NOTE the Internal Audit Progress Report

APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Internal Audit Progress Report

Audit and Assurance Committee

July 2022

Digital Health and Care Wales

NWSSP Audit and Assurance Services

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

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

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2. Completion of the 2021/22 Internal Audit Plan *3*

3. Progress of the 2022/23 Internal Audit Plan *3*

4. Other Activity *3*

5. Recommendation *4*

Appendix A: Progress against 2022/23 Internal Audit Plan *5*

1. Introduction

The purpose of this report is to:

- provide an overview of the completion of the 2021/22 Internal Audit Plan for Digital Health and Care Wales (DHCW) to the July 2022 Audit and Assurance Committee;
- highlight progress of the 2022/23 Internal Audit Plan for DHCW; and
- provide an overview of other activity undertaken since the previous meeting.

2. Completion of the 2021/22 Internal Audit Plan

There were 11 individual reviews to be reported within the 2021/22 Internal Audit Plan and a further two audits undertaken at NWSSP (Accounts Payable and Payroll).

The two remaining audits (Workforce and Directorate Review) from the 2021/22 Internal Audit Plan have been finalised and were both rated as reasonable assurance. This concludes our reporting in relation to the 2021/22 Internal Audit Plan and are presented to this Audit and Assurance Committee.

As previously reported, the Accounts Payable audit has been finalised (reasonable assurance). The Payroll audit has now also been finalised and is rated as reasonable assurance. We raised one high, two medium and one low priority recommendations.

3. Progress of the 2022/23 Internal Audit Plan

Detailed progress in respect of each of the 14 reviews in the 2022/23 Internal Audit Plan is summarised in Appendix A. However, the table below summarises the current status.

Total number of audits in plan	14
Work in Progress	4
Planning	4
Not yet started	6

4. Other Activity

The following meetings have been held/attended during the reporting period:

- attendance at Board Development sessions;
- monthly meetings between the Acting Head of Internal Audit and Board Secretary;
- Audit and Assurance Committee pre-meeting;
- audit scoping meetings; and
- liaison with senior management.

5. Recommendation

The Audit and Assurance Committee is invited to note the above.

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating	Summary of recommendations	Anticipated Audit Committee[1]
Financial Sustainability	Planning			January
Risk Management	Not yet started			May
Strategic Planning	Work in progress			October
Performance Management	Work in progress			October
Corporate Governance	Not yet started			May
Embedding the Stakeholder Engagement Plan	Work in progress			October
Centre of Excellence	Not yet started			January
Workforce Planning	Not yet started			January
Recommendation Tracker	Work in progress			October
Switching Services	Planning			October
Technical Resilience	Not yet started			May
Cyber Security	Not yet started			May
Decarbonisation	Planning			October
Estates Compliance	Planning			October

[1] May be subject to change

DIGITAL HEALTH AND CARE WALES
INTERNAL AUDIT REPORTS
NWSSP AUDIT & ASSURANCE SERVICES

Agenda Item	4.2

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Stephen Chaney, Deputy Head of Internal Audit
Presented By	Stephen Chaney, Deputy Head of Internal Audit

Purpose of the Report	For Assurance
Recommendation	
The Committee is being asked to: **RECEIVE** the Internal Audit reports which have been agreed with the Executive Lead and the Senior Leadership Team for **ASSURANCE**	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	DHCW0259 – Staff Vacancies

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Staff & Resources
If more than one standard applies, please list below: Governance Leadership and Accountability	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome:
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health & Care Wales	SHA	Special Health Authority

2 SITUATION/BACKGROUND

2.1 The audits have been completed and the reports have been produced in line with the Internal Audit Plan for 2021/22 for DHCW.

2.2 DHCW Workforce and Directorate Review Internal Audits have been completed and have been rated as reasonable assurance.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The Committee is asked to consider the findings and management responses of the reports.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 Any matters for escalation to the Board to be determined by the Committee following consideration of the reports.

5 RECOMMENDATION

5.1 The Committee is asked to RECEIVE the Internal Audit reports which have been agreed with the Executive Lead and the Senior Leadership Team for ASSURANCE.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Workforce
Final Internal Audit Report
May 2022

Digital Health and Care Wales

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

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

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Review reference:	DHCW-2122-13
Report status:	Final
Fieldwork commencement:	10th January 2022
Fieldwork completion:	7th April 2022
Draft report issued:	11th April 2022
Debrief meeting:	11th February 2022
Management response received:	6th May 2022
Final report issued:	10th May 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Laura Howells, Principal Auditor Rhian Gard, Principal Auditor
Executive sign-off:	Michelle Sell, Chief Operating Officer
Distribution:	Shikala Mansfield, Head of Workforce and Organisational Development
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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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

Audit reports are prepared by the staff of NHS Wales 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 Digital Health and Care Wales Special Health Authority and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

This review sought to provide Digital Health and Care Wales (DHCW) with assurance that it has adequately assessed and managed the recruitment of staff.

Overview

We have issued reasonable assurance on this area.

This audit focused on DHCW's status as a Special Health Authority (SHA), which was established in April 2021, and how the recruitment and resourcing of staff was managed.

The matters requiring management attention include:

- There is no standalone resource plan for DHCW.
- There is no detailed or complete terms of reference for the Recruitment Security Panel.
- A review of the pre-employment checks tracker for agency / apprenticeship staff is required.

Other recommendations /advisory points are within the detail of the report.

Overall, we have found that checks for substantive staff are undertaken, roles are adequately scrutinised before funding is approved and each role is appropriately banded.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A – New organisation

Assurance summary[1]

Assurance objectives		Assurance
1	Governance arrangements	Reasonable
2	Agenda for Change	Substantial
3	Recruitment reports	Reasonable
4	Resource requirements	N/A
5	Induction to DHCW	N/A

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Resource Plan	4	Design	Medium
2	Pre-employment Checks	3	Design	Medium

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

1. Introduction

1.1 The review of Workforce was completed in line with the 2021/22 Internal Audit Plan. Digital Health and Care Wales (DHCW) recognises that staff with the right skills are fundamental to the achievement of the organisation's vision. Therefore, the Workforce Team (the 'Team') play a key role in ensuring that the best recruitment process and use of human resources are achieved. The Team works in close partnership with all Directorates, including policy development, best practice and compliance with current legislation.

1.2 DHCW maintained the existing workforce arrangements until the TUPE process from the previous hosted organisation (NHS Wales Informatics Systems or 'NWIS') was fully completed. At that point, an organisational restructure was commenced, with additional staff recruited where required.

1.3 The key risks considered in this review were:

- poor service delivery due to workforce resource requirements not being managed effectively;
- increased financial costs due to an excess of staff recruited and / or inappropriate banding or incremental credit awarded;
- staff are paid at an inequitable rate to other equivalent positions under Agenda for Change;
- poor governance arrangements increasing the risk of inappropriate recruitment taking place;
- failure to achieve the strategic objectives of the organisation; and
- individuals starting employment before applicable recruitment checks have been completed correctly, resulting in increased reputational risk to DHCW.

1.4 Prior to the establishment of DHCW, the number of staff was 813. As at 1st March 2022 the number was 956.

2. Detailed Audit Findings

Audit objective 1: to ensure there are appropriate governance arrangements in place over the assessment and agreement of the ongoing workforce requirements, including reviewing:

- the Recruitment Scrutiny Panel;
- the creation of new positions, and whether they are in line with proposed establishment levels; and
- the oversight / approval of incremental credit arrangements.

2.1 The Recruitment Scrutiny Panel (the 'Panel') meets weekly and consists of key members of staff across multiple directorates. It is chaired by the Deputy Director of Finance and is responsible for reviewing all new job funding requests. There is

no specific terms of reference for the group, however, there is a document entitled 'Scrutiny Panel Process'. This document acts as the terms of reference and details the purpose and responsibilities of the panel. It does not however, detail the quoracy requirements for the Panel. This has been included as **matter arising three.**

2.2 For a sample of new positions, we followed through the process from the initial funding request sent to the Panel through to their approval. We noted that there were two instances (from 20) where no funding request forms could be located (but we confirmed that the vacancies had been presented to the Panel). Furthermore, there was one vacancy where we were not provided with the requested information and, consequently, we were unable to confirm if required steps had been adhered to.

2.3 However, these exceptions related to issues with the recruitment process prior to the new electronic funding forms being implemented. We reviewed the revised process and confirmed that it should not arise again, as the process is now automated. As the control weakness has already been addressed, we have not raised a recommendation over this.

2.4 Incremental credit applications (via the completion of a form) must be approved by the Team, with sufficient supporting evidence (e.g. previous payslips, job descriptions). We tested a sample of employees who were awarded incremental credit and confirmed that each had been appropriately approved, with the supporting evidence required.

Conclusion:

2.5 We confirmed appropriate governance arrangements were in place for the approval of new positions in DHCW with only minor amendments to the Scrutiny Panel Process document required. We have provided **reasonable assurance** over this objective.

Audit objective 2: to ensure that new positions have been appropriately developed in accordance with Agenda for Change

2.6 Job matching is an analytical way of comparing roles to nationally evaluated profiles, in the most efficient manner possible. Currently, this process is being undertaken by Velindre NHS Trust for DHCW staff, as this was the arrangement in place before DHCW was made a Special Health Authority.

2.7 Discussions are taking place to bring this in-house and for DHCW to complete their own job matching. This is to ensure the roles are understood and matched whilst considering the IT expertise required. Whilst we have not identified a weakness or a specific recommendation, DHCW should consider the objectives of the job matching process. For example, 'training must include an understanding of the avoidance of bias'[2] and the panel 'should be

[2] NHS Job Evaluation Handbook | NHS Employers

representative of the organisation as a whole', with an overall aim of ensuring the equality of pay across NHS Wales.

2.8 As part of the job matching process, there is a system called Caje which contains all the national NHS Profiles. The intention is to match the role via its job description and job specification with a national profile. The information within the documents is reviewed alongside 16 factors and scored appropriately, to provide the role with the correct banding.

2.9 We tested a sample of ten new starters (five external to NHS Wales and five new to DHCW, but from another NHS organisation) and found all the job roles had been through the job matching process and were in line with Agenda for Change.

Conclusion:

2.10 Roles are appropriately banded through the job matching process hosted by Velindre NHS Trust. Therefore, we have provided **substantial assurance** over this objective.

Audit objective 3: to determine if the recruitment process is robust, with appropriate pre-employment checks completed in a timely manner

2.11 DHCW utilises two processes for the recruitment of their staff. Most staff go through the national TRAC system, which supports the NHS to manage the end-to-end recruitment process including the processing of vacancies through to the induction stage.

2.12 There is a proportion of staff; mainly agency and apprenticeships, which go through an internal recruitment checks process. Within this process checks are monitored by an internal Pre-Employment Tracker (the 'Tracker'), as of February 2022 this detailed 45 new starters. Typically, the responsibility for employment references, pre-employment checks would reside with the applicable agency or apprenticeship body, however, DHCW confirmed its intent to continue its current processes for internal assurance purposes. DHCW plans to fine tune the controls in this area, to ensure it can provide consistent and timely evidence regarding recruiting agency and apprenticeships.

2.13 However, if the Tracker is required for the monitoring of pre-employment checks undertaken for agency / apprenticeship staff, then the significant number of gaps recorded should be investigated. This has been raised as **matter arising two.**

2.14 Key performance indicators are reported by NWSSP Recruitment to the Team and this information is submitted as part of monthly Board papers. The KPIs utilised are the same as are reported for all NHS Wales organisations. The figures for February 2022 are:

Target times	Responsibility	Recruitment check	Time taken	All Wales monthly Average
44	NWSSP Recruitment	Vacancy creation to conditional offer	38.6	45.7
3	DHCW Manager	Time to shortlist	10.1	7

2.15 We identified that the time for the manager to shortlist is longer than the all-Wales average and the target time. We confirmed, however, that this issue has been raised at the weekly Executive Team meeting for monitoring.

2.16 Within the monthly Board report, the Team also include DHCW's progress with recruitment, including how many staff are employed, how many vacancies exist and at what stage each are at.

Conclusion:

2.17 Monthly workforce reporting to the Board is embedded and issues arising are escalated to the Executive Team. There are areas for improvement around spot checking for staff who do not go through the TRAC recruitment process. We have provided **reasonable assurance** over this objective.

Audit objective 4: to ensure overall resource requirements have been adequately assessed, authorised and are consistent with the strategic objectives of DHCW

2.18 A standalone approved resource plan does not exist. The resource requirement for DHCW was determined as part of the transition plan with the Welsh Assembly Government (WAG). An allocation £2 million was allocated, as an additional resource from the NWIS funding. Over the past financial year, DHCW has continued to develop, with a new resource plan required to match to the strategic objectives and to ensure financial sustainability.

2.19 We were informed that DHCW is in the process of developing a new resource plan that sets out the vacancies for each directorate. This has been developed through meetings between Workforce Business Partners and each Directorate. The plan also includes vacancies for projects planned e.g. Project 365.

2.20 The plan has not yet been formalised. At the time of the audit, DHCW has not yet been provided with the funding allocation for the 2022/23 financial year. It is expected that this information will be used to formalise the resource plan and forecast future requirements over the course of the IMTP. This has been raised as **matter arising one.**

Conclusion:

2.21 We recognise that a resource plan is in the process of being developed, but until this has been completed, it is difficult to ascertain if financial sustainability will be achieved whilst still delivering the organisation's strategic objectives. As such, this audit objective has been recorded as 'not applicable'.

Audit objective 5: to determine if a sample of new employees have been appropriately inducted to DHCW

2.22 This audit objective is being completed as part of an audit of new starters joining DHCW – Directorate Review (DHCW 2122-03). As such, we have removed this objective from the audit and will report upon it separately.

Appendix A: Management Action Plan

Matter arising 1: Resource Plan (Design)	Impact
A resource plan detailing the number of vacancies across directorates and linked to the financial plan is not yet in place. We have been informed that this is in the process of being developed, with Workforce Business Partners engaging with each Directorate.	Potential risk of: • Roles being approved without funding. • Roles not being approved effectively giving an uneven resource requirement across the organisation. • Strategic objectives are not achieved, due to insufficient resource.

Recommendations	Priority
1.1 DHCW should develop a three-year resource plan, which details the number of vacancies within the organisation and across each directorate / project planned. The vacancies should be clearly linked to the funding available.	Medium

Management response	Target Date	Responsible Officer
1.1 Each directorate teams to work with Workforce & OD, Finance and Planning team to develop high level resource plan initially whilst DHCW is still fluid and embedding strategic structures.	October 2022	Director of People & OD

Matter arising 2: Pre-employment Checks Tracker (Design)	Impact
The majority of positions are recruited via NHS Jobs, which requires the completion of a TRAC application form. This end-to-end process is fully automated and pre-employment checks are undertaken by NHS Wales Shared Services Partnership (NWSSP). For staff recruited via an agency or an apprenticeship scheme, a pre-employment checks (PEC) spreadsheet is maintained. The number of individuals recorded on this spreadsheet is 45. However, we have been unable to determine if this spreadsheet is used for the tracking of pre-employment checks for individuals recruited via agencies / apprenticeships. If it is the responsibility of DHCW to complete the checks, then the spreadsheet requires a detailed review, as a large number of pre-employment checks have not been recorded and highlighted as exceptions. Equally, if it is not required, then the continuing maintenance / completion of the spreadsheet should be reviewed.	Potential risk of: • Individuals starting employment before applicable recruitment checks have been completed correctly. • Non-compliance with the NHS Employment Standards. • Staff not suitable for a role are employed.

	Recommendations	Priority
2.1	The DHCW Workforce Team should: - Determine if the spreadsheet utilised for the tracking of pre-employment checks of staff recruited via agencies or apprenticeships is still required. - If is required, each of the exceptions highlighted should be reviewed further, to determine if additional checks are required.	Medium

	Management response	Target Date	Responsible Officer
2.1	The spreadsheet utilised for the tracking of pre-employment checks for staff is still required. To ensure internal assurance, DHCW feel the requirement to have internal process for staff recruited via apprentices and agency schemes. DHCW will continue with existing tracker framework and fine tune it building in tighter controls.	September 2022	Senior Workforce Business Partner (Joanne Jamieson)

Matter arising 3: Recruitment Scrutiny Panel (Design)	Impact
The Recruitment Scrutiny Panel (the 'Panel') meets weekly and consists of key members of staff across multiple directorates. It is chaired by the Deputy Director of Finance. There are no specific terms of reference for the Panel. However, there is a document entitled, 'Scrutiny Panel Process'. This document acts in a similar manner as a terms of reference and details the purpose and responsibilities of the Panel. However, it does not set out quoracy requirements for the Panel.	Potential risk of: • Roles not being reviewed effectively and ineffective use of DHCW funds

Recommendations	Priority
3.1 DHCW should either develop the Scrutiny Panel Process document or create a terms of reference for the Recruitment Scrutiny Panel, detailing the quoracy requirements for each meeting.	Low

Management response	Target Date	Responsible Officer
3.1 DHCW will develop the Scrutiny Panel Process document add the quoracy requirement for each meeting	September 2022	Chair, Scrutiny Panel (Sian Williams)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Directorate Review
Final Internal Audit Report

May 2022

Digital Health and Care Wales

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

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Digital Health and Care Wales

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Review reference:	DHCW-2122-03
Report status:	Final
Fieldwork commencement:	28th February 2022
Fieldwork completion:	17th May 2022
Draft report issued:	17th May 2022
Debrief meeting:	28th April 2022
Management response received:	23rd June 2022
Final report issued:	23rd June 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Stephen Chaney, Deputy Head of Internal Audit Philip Lewis-Davies, Principal Auditor
Executive sign-off:	Michelle Sell, Director of Planning and Performance / Chief Commercial Officer Shikala Mansfield, Head of Workforce and Organisational Development Helen Thomas, Chief Executive
Committee:	Audit, Risk 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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Audit reports are prepared by the staff of NHS Wales 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 Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To provide Digital Health and Care Wales (DHCW) with assurance that key policies for staff recruited are adhered to.

Overview

We have provided **reasonable assurance** over this area.

Our review of the induction processes, and compliance with PADR and Statutory and Mandatory training requirements was supported by sample testing of starters who joined DHCW in the period April – December 2021.

We did not identify any significant matters for reporting. However, we have noted the following areas where improvements could be made:

- the induction process could be enhanced to improve control and monitoring of compliance; and
- the Appraisal Development and Review policy document is overdue for review (due March 2022).

All matters arising are detailed in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	All new starters receive an appropriate and timely induction	Reasonable
2	Performance appraisal and development reviews are undertaken, in accordance with the applicable policies	Reasonable
3	Statutory and mandatory training is completed, as required	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Induction Process	1	Operation	Medium
2	Record of PADR Completion	2	Design	Medium
3	Appraisal Development and Review Policy	2	Design	Medium

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

1. Introduction

1.1 The Directorate Review has been completed in line with the 2021/22 Internal Audit Plan. This review seeks to provide Digital Health and Care Wales (DHCW) with assurance that key policies for staff recruited are adhered to.

1.2 As DHCW continues to develop digital solutions, to assist with health and care delivery in Wales, workforce requirements have increased over the last 12 months. To support this process, key workforce policies are embedded to assist with the onboarding and continuing development of staff.

1.3 Our review considered the induction process, performance appraisals and development reviews (PADRs) and statutory and mandatory training for the Development & Support Directorate, being the directorate with the most starters recorded since April 2021. Our work was undertaken from a Workforce and Organisational Development perspective.

1.4 Compliance with policy and procedures in the identified areas was sample tested. A sample of individual starters was selected form those who joined DHCW in the period April to December 2021. Whilst the sample was selected from the Development & Support Directorate, being the Directorate with the largest number of starters, the results and associated issues are applicable across DHCW in their scope and impact.

1.5 The key risks considered in this review were:

- Non-compliance with key policies;
- Staff wellbeing / morale is adversely affected;
- Staff development opportunities are not identified; and
- Lack of awareness / understanding of DHCW deliverables.

2. Detailed Audit Findings

Audit objective 1: All new starters receive an appropriate and timely induction

2.1 The induction programme procedures are documented in SOP-WFOD-015 that was approved by the Workforce and Organisational Development (WOD) Business Partner on 14th January 2021 and is next due for review by 13th October 2022.

2.2 The document addresses the purpose, scope and roles and responsibilities of the induction programme. The appendices include a process flowchart, agenda templates, and linkages to the local induction checklist and the New Starter Development Review.

2.3 The main purpose of this document is to provide guidance to managers and staff on how to organise and conduct both Local and Corporate Staff Inductions across Digital Health and Care Wales (DHCW).

2.4 The induction process comprises the following mandatory elements:

- Local Induction (managers to ensure checklist has been completed with new member of staff, signed, and sent back to WOD - to be completed on day 1);
- Corporate Induction (to be completed by staff within 4 weeks);
- Completion of Statutory and Mandatory Training (to be completed by staff within 4 weeks); and
- New Starter Development Reviews (to be attended by staff within 3 months).

2.5 From testing of a sample of ten new starters who joined DHCW in the period April to December 2021 we noted that:

- Not all staff received their Corporate Induction within the required timescales - only six of the ten starters tested had been recorded as attending the Corporate Induction, however one of the starters subsequently left in September 2021 and no live file on the Electronic Staff Record (ESR) was held;
- Corporate Induction records were manually maintained until the end of 2021 and a mass update of data to ESR is required to record all current staff induction data on ESR;
- There is no record maintained centrally of the completion of Local Induction checklists – this is as managed and retained by new starters' Line Managers, prohibiting access by WOD staff; and,
- Of the six starters who attended Corporate Induction, all have been evidenced as being engaged in the New Starter Review managed by WOD. However, only one in the sample had recorded the actual date it was completed.

2.6 There is an opportunity to enhance the control over the Induction Programme.

2.7 We have raised the above issues in matter arising one in Appendix A.

Conclusion:

2.8 The induction programme procedures are well documented, but we identified instances where the procedures could be improved to provide greater control over the delivery and monitoring of the induction process. Therefore, we have provided **reasonable assurance** over this area.

Audit objective 2: Performance appraisal and development reviews (PADRs) are undertaken, in accordance with the applicable policies

2.9 The Appraisal Development and Review policy document WFOD-POL-016 V1 was obtained and reviewed. The policy document was approved in May 2017 by Velindre Trust, the host organisation of the NHS Wales Informatics Service (NWIS).

2.10 Whilst the policy document has been updated since the transition, in part to reflect removal of references to NWIS and insertion of DHCW, the revision history record is missing. In addition, the policy document was due a review in March 2022. We cannot find any evidence that this review has been performed and the policy updated, approved, and communicated. Any such review should reflect the impact on Appraisal Development and Review procedures necessary to effectively interlink with the requirements of the new All Wales Pay Progression policy. These issues have been raised as matter arising three in Appendix A.

2.11 From testing of a sample of new starters who joined DHCW in the period April to December 2021 we noted that:

- Of the ten samples tested, one member of staff left DHCW in September 2021. Of the remaining nine, six are up to date with their PADRs. This is a sample compliance rate of 67% as compared to the DHCW compliance rate reported in December 2021 of 91% (target is 85%);
- The PADR process is the responsibility of the Line Manager to ensure it is completed by the due date and that PADR dates are recorded on ESR. With few, if any, PADR forms uploaded to ESR (due to time and complexity), WOD only has visibility of the PADR dates and monitors compliance with process based on these dates alone. The sample selected shows some new starters with no PADR dates in ESR, but it is unclear whether this is because Line Managers have not put dates in ESR or have not completed the PADR process. We have raised this issue in matter arising two in Appendix A;
- WOD runs reports based on the ESR dates recorded which show the level of PADR compliance. The WOD Business Partner attends the Directorate Senior Team meetings every month highlighting anomalies in compliance and WOD also sends this data to Line Managers;
- Full PADR performance reports are provided to Senior Managers each month with non-compliance statistics for them to chase completion. WOD also provides guidance upon request if there are any issues. The information is also reported to Directorate level where a 'name and shame' approach is being implemented; and,
- PADR compliance statistics are also reported to the Board.

Conclusion:

2.12 We have raised two matters arising under this objective, the policy document being out of date, and that, in some cases, minimal information is held on ESR or the personal file to evidence the PADR process. Therefore, we therefore have provided **reasonable assurance** over this area.

Audit objective 3: Statutory and mandatory training is completed, as required

2.13 DHCW maintains a list of Statutory and Mandatory Training, that is available to all staff, on the intranet. Attendance at statutory and mandatory courses is essential for all staff and must be completed before any other selective development training is approved. The listing indicates the ESR title of each course, the topic covered and the frequency of course repetition.

2.14 All e-Learning training courses are undertaken using ESR. A catalogue of courses is available within ESR, however priority must be given to completing those that form part of the Core Skills Training Framework and, therefore are a legal requirement for all employees to complete. Staff must be 100% compliant, and this requirement forms part of the core objectives for Pay Progression.

2.15 The requirement for full compliance with statutory and mandatory training is linked to both the DHCW Induction Programme and the All Wales Pay Progression policy.

2.16 From testing of a sample of new starters who joined DHCW in the period April to December 2021 we noted that:

- The sample selected reflects a good compliance level but not all staff are 100% compliant. One starter had left in September 2021, with seven of the remaining nine starters being fully compliant. One starter has not yet undertaken four of the twenty listed courses, and another has yet to complete 15 of the 20, at the time of the audit. This reflects a sample compliance rate of 78% as compared to the DHCW compliance rate reported in December 2021 of 82% (target is 85%);
- WOD runs reports from ESR which show the level of compliance with statutory and mandatory training. The WOD Business Partner provides data to senior management and attends the Directorate Senior Team meetings every month highlighting anomalies. WOD also sends the compliance data to Line Managers; and
- As for PADR compliance, statistics on compliance with statutory and mandatory training are reported to the Board as part of the of information provided on the Organisational Performance Score Card.

Conclusion:

2.17 Whilst the sample compliance percentage is below the target and the DHCW rate achieved, the process is well defined, reported and monitored. In instances where staff are failing to achieve 100% compliance, we note that DHCW has recently adopted a 'name and shame' approach in their reporting to engage senior management in addressing resolution. We have raised no matters rising on this objective, therefore we have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Induction Process (Operation)	Impact
Corporate Induction The process is initiated by the new starter's Line Manager who invites the new starter to attend the Corporate Induction presentation within a fixed period of commencing service. A sample of new starters was selected from the period April - December 2021 was tested and identified that only 60% of the sample had attended the Corporate Induction, as recorded on manual listings maintained, prior to the Learning Admin Officer commencing at the end of 2021. A mass upload is to be requested of IBM to update the Electronic Staff Record (ESR) with all records. **New Starter Review** Where WOD has identified that Corporate Induction has been completed, within 2 to 3 months WOD invites the new starter to a New Starter Review meeting. All those in our sample who had received their Corporate Induction (six starters) had been provided a New Starter Review. However, it was noted that the date of each New Starter Review is not regularly recorded in ESR, preventing any review of the timeliness of the reviews performed. **Local Induction** Local Induction is the responsibility of the Line Manager to complete and record with the new starter. There is no record held on ESR so we could not evidence this process within the scope of our review (i.e., from a WOD perspective). There is an opportunity to save a copy of the completed Local Induction checklist on the individual's file which is accessible to WOD and Line Managers. This would evidence the process and permit WOD to perform a process audit review to gain confidence that the process is embedded.	Potential risk of: • New starter lack of awareness, and fail to comply with, key policies; and • New starter lack of awareness and understanding of DHCW objectives and their part in their delivery.

Recommendations	Priority
1.1 We recommend that WOD management ensures that: i. All Line Managers are reminded of their responsibilities to issue a Corporate Induction presentation invite to each new starter and update the ESR records detailing attendance records; ii. The mass upload of historic manual records of Corporate Inductions provided to new starters to ESR is actioned promptly;	Medium

iii. A periodic process audit is performed to provide confidence that all new starters attend the Corporate Induction presentation within the four-week target;

iv. The date of each New Starter Review is recorded by WOD in ESR, evidencing the timeliness of the reviews performed; and

v. Line Managers are instructed to save a copy of the completed Local Induction checklist on the new starter's individual file, evidencing the process and enabling WOD to perform a process audit review to gain confidence that the process is embedded across DHCW.

	Management responses	Target Date	Responsible Officer
1.1	i. This has commenced and People & OD team are currently tracking all new starters to ensure that they are booked on the DHCW Corporate Induction.	15.07.22	Organisational Development, Culture and Engagement Lead (Sarah Brooks)
	ii. The Corporate Induction under DHCW has greatly changed. People & OD team will ensure all new starters from 1st April 2021 i.e. since DHCW was formed are uploaded by end of November 2022.	01.11.22	Organisational Development, Culture and Engagement Lead (Sarah Brooks)
	iii. People & OD team to undertake quarterly audit to ensure all new starters attend the Corporate Induction with agreed target.	Starting 15.07.22	Organisational Development, Culture and Engagement Lead (Sarah Brooks)
	iv. The Starter Review System is currently under review. Once the Starter Review System is live, People & OD team will record on ESR the date of the review.	31.10.22	Senior Workforce Business Partner (Joanne Jamieson)
	v. People & OD team will remind Line Managers of their responsibilities and to save completed Induction checklist on the new starter's individual file.	15.07.22	Senior Workforce Business Partner (Joanne Jamieson)
	People & OD team will undertake quarterly audit and report findings at the directorate meetings.	Starting 01.08.22	Senior Workforce Business Partner (Joanne Jamieson)

Matter arising 2: Record of PADR Completion (Design)	Impact
The PADR process is the responsibility of the Line Manager to ensure it is completed by the due date. Of the sample of ten new starters who commenced between April and December 2021 that were tested, one member of staff left DHCW in September 2021. Of the remaining sample, 67% are up to date per the PADR records held on ESR. This contrasts with the DHCW-wide statistics reported to the Board in December 2021 of 82% compared with a target of 85%. Those in the sample showing as not up to date may be in error if Line Managers have completed the PADR process but not entered dates on ESR (testing this was out of scope for this review). Few, if any, PADR forms are uploaded into ESR, due to time and complexity. WOD can only see the PADR dates on ESR and monitor compliance with process, and provide reports, based on these dates. WOD run reports on masse which show the level of PADR compliance. The WOD Business Partners attend the Directorates' Senior Team meetings every month highlighting anomalies and WOD also sends the data to Line Managers. WOD also runs PADR courses for managers to attend to ensure they know how to conduct the PADR process. Full performance reports are provided to Senior Managers each month with non-compliance statistics for them to chase completion. WOD also provides guidance upon request if there are any issues. The information is also reported to Directorate level where a 'name and shame' approach is being implemented. The PADR forms can be saved on the personal file of each staff member, allowing WOD to determine whether ESR recorded dates are supported by actual PADR form completion, and vice versa.	Potential risk of: • new starters not fully engaging in staff development opportunities; and • staff wellbeing and morale adversely affected as new starters unaware of how their performance supports DHCW's objectives.

Recommendations	Priority
2.1 We recommend that WOD management: i. Instruct all Line Managers to place a copy of the PADR forms on each new starters personal file and ensure that they enter relevant dates in ESR promptly; and ii. Undertake a process audit review to gain confidence that Line Managers are completing the PADR forms by the due date and promptly updating ESR with accurate dates.	Medium

Management responses			Target Date	Responsible Officer
2.1	i.	People and OD team will ensure Line Managers are reminded to place a copy of the PADR forms on each new starters personal file and that they enter relevant dates in ESR.	15.07.22	Senior Workforce Business Partner (Joanne Jamieson)
		Regular audits to be carried out by People & OD team.	Starting 01.08.22	Senior Workforce Business Partner (Joanne Jamieson)
	ii.	People & OD team will remind Line Managers of their responsibility to undertake PADRs promptly and to record accurately on ESR. People & OD team will continue to report current position at the directorate review meetings.	15.07.22	Senior Workforce Business Partner (Joanne Jamieson)
		People & OD team will undertake quarterly audit which will include the quality of PADR forms and that they are completed promptly within due date and recorded accurately on ESR.	Starting 01.08.22	Senior Workforce Business Partner (Joanne Jamieson)

Matter arising 3: Appraisal Development and Review Policy Documentation (Design)	Impact
The current Appraisal Development and Review Policy is out of date. The Policy document was originally approved in May 2017 by Velindre Trust, host organisation of the DHCW predecessor NWIS until March 2021. On the establishment of DHCW the Policy was updated to reflect the new entity and was approved by the DHCW Board. However, the policy document does not reflect changes to the All Wales Pay Progression Policy and does not detail the revision history. The Policy was due a review by 31st March 2022 but no evidence of such a review and its approval has been evidenced. Any such review should reflect the impact on Appraisal Development and Review procedures to ensure they effectively interlink with the requirements of the new All Wales Pay Progression policy.	Potential risk of: • Compliance with the historic policy may be ineffective or inefficient; and • The historic policy may not be fully compliant with current legal requirements and NHS Wales processes.

Recommendations	Priority
3.1 We recommend that WOD ensures that the Appraisal Development and Review Policy is subject to review and that the updated Policy document be approved and communicated across DHCW as soon as possible, with any update considering the linkages with the requirements of the All Wales Pay Progression policy.	Medium

Management response	Target Date	Responsible Officer
3.1 A draft copy of the Review Policy, developed in partnership with Trade Unions, is being reviewed as per DHCW Policy Review Process. Once approved, People and OD team will ensure this is communicated across DHCW. Appraisal Development has been incorporated as part of the Pay Progression workshops which have been held for Line Managers since March 2022.	01.08.22	Senior Workforce Business Partner (Joanne Jamieson) / Organisational Development, Culture and Engagement Lead (Sarah Brooks)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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DIGITAL HEALTH AND CARE WALES
AUDIT WALES UPDATE

Agenda Item	4.3

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Nathan Couch, Audit Wales
Presented By	Nathan Couch, Audit Wales

Purpose of the Report	For Assurance
Recommendation	
The Committee is being asked to **RECEIVE** the report for **ASSURANCE**.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	The audit work will specifically cover corporate risks where appropriate

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below: Effective Care	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome:
Statement: Not required for this report.	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	AW	Audit Wales
EA	External Audit		

2 SITUATION/BACKGROUND

2.1 The paper provides an update on financial audit work, performance audit work, details of good practice events and resources, and a list of NHS-related audit reports published by Audit Wales since our last update to the Audit and Assurance Committee in May 2022.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The financial statements audit work is now complete, and the Auditor General certified the Performance Report, Accountability Report, and Financial Statements on 15 June 2022. These were laid before the Senedd on 17 June 2022.

3.2 Our Structured Assessment work commenced in June 2022. The review will build on the baseline governance review by assessing the corporate arrangements at Digital Health and Care Wales in relation to:

- Governance and leadership
- Financial management
- Strategic planning, and
- Managing the workforce, digital resources, estates, and other physical assets.

A copy of the Project Brief is available as item 4.3ii.

3.3 Our intention is to present the report for consideration at the Board meeting in November 2022 and the Audit and Assurance Committee meeting in February 2023.

3.4 One NHS-related report has been published since we last provided an update to the Audit and Assurance Committee in May 2022 – *Tackling the Planned Care Backlog in Wales*.

A summary of the key messages is provided at 4.3i Appendix 1. We have also published a blog and data tool on unscheduled care.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 No matters for escalation to the Committee.

5 RECOMMENDATION

5.1 The Committee is being asked to **RECEIVE** the report for **ASSURANCE**

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Archwilio Cymru
Audit Wales

Audit and Assurance Committee Update – **Digital Health and Care Wales**

Date issued: July 2022

Document reference: 2901A2022

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

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

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

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Appendix 1 8

Audit and Assurance Committee Update

About this document

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

Financial audit update

2 **Exhibit 1** summarises the status of our key accounts audit work currently underway.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of financial balances transferred from Velindre University NHS Trust to DHCW	Complete
Audit of the 2021-22 Performance Report, Accountability Report and Financial Statements	Complete. The Auditor General certified the Performance Report, Accountability Report, and Financial Statements on 15 June 2022. They were laid before the Senedd on 17 June 2022.

Performance audit update

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

- completed work since the last Audit and Assurance Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit and Assurance Committee
Baseline Governance Review 2021	January 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
Structured Assessment 2022	The structured assessment work will build on the baseline governance review by assessing the corporate arrangements in place at the SHA in relation to: • Governance and leadership. • Financial management. • Strategic planning, and • Managing the workforce, digital, resources, estates, and other physical assets. A copy of the Project Brief is available with this update.	Current status: Fieldwork in progress Planned date for consideration: Board consideration in November 2022 and Audit and Assurance Committee consideration in February 2023

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Locally focused work	The precise focus of this work is yet to be determined.	TBC
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	TBC

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 Details of future events are available on the GPX website.

NHS-related national studies and related products

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

7 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Tackling the Planned Care Backlog in Wales The key messages are summarised in **Appendix 1**	May 2022
Unscheduled Care (Blog and Data Tool)	April 2022

Appendix 1 – Key messages from recent national publications

Tackling the Planned Care Backlog in Wales (May 2022)

8 Our Planned Care review describes the significant challenges facing NHS Wales both in terms of shorter-term recovery and the need for longer term sustainable planned care services. There were clearly issues in some key areas about the balance of capacity and demand for services before the pandemic and is exacerbated significantly since.

9 In February 2022, there were nearly 700,000 patients waiting and numbers of waits continue to grow. Over half of the people currently waiting have yet to receive their first outpatient appointment, and across Wales over 100,000 patients are waiting over a year for their first outpatient appointment. This may mean their care cannot be effectively prioritised often because effective clinical prioritisation can only take place during outpatients and diagnosis.

10 The report highlights that referrals reduced during the pandemic and this suggests that there could be a pent-up demand for services which may result in higher than average or more complex and acute referrals in the short to medium term. If even half of those missing patient referrals emerge, this could mean that recovery of waiting lists to pre-pandemic levels could take seven years. Some specialties and services could recover more quickly, but others such as orthopaedics and eye care may take longer as these services have been under pressure for many years.

11 The Welsh Government made an extra £200 million available during 2021-22 to help recovery but NHS bodies could not use it all. They bid for and were allocated £146 million, but £12.77 million was returned to the Welsh Government at the end of March 2022. NHS bodies cited staff capacity, lack of physical space and limited private capacity to carry out planned care as barriers to spending the additional funding. While additional Welsh Government funding is going to be essential to tackle the backlog, this on its own, will not solve the problem. The NHS also needs to overcome some serious barriers, including the on-going impact of COVID on services, reducing the impact of emergency care on planned care service delivery and long-standing staff shortages and recruitment issues.

12 Our report makes five recommendations to the Welsh Government which focus on:

- Working with health bodies to set appropriately ambitious delivery targets;
- Producing a clear funding strategy including long term capital investment;
- Developing a workforce plan to build and maintain planned care capacity;
- Implementing system leadership arrangements to drive through the plan;
- Ensuring its arrangements focus on managing clinical risks associated with long waits, supporting patients while they wait, and delivering care efficiently and effectively.

13 While the recommendations are made to Welsh Government, health bodies across Wales also need to consider how they respond both to the issues identified in our report and locally required implementation of the recommendations. We are therefore seeking a written response from each health board and request that actions are tracked in routine recommendation monitoring arrangements and are reported to audit committees

14 Alongside our report, we've also published a waiting times data tool which sets out the different waiting times by health board.

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

Date issued: 25th May 2022

Structured Assessment 2022

Project Brief

Background

1 The Auditor General has a statutory requirement to satisfy himself that NHS bodies have proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources as set out in Section 61 of the Public Audit Wales Act 2004. To help in the discharge of this responsibility, the Auditor General undertakes annual Structured Assessment work at each NHS body that examines arrangements relating to corporate governance, financial management, strategic planning, and other factors affecting the way in which NHS bodies use their resources.

2 Our 2022 Structured Assessment work is taking place at a time when NHS bodies are continuing to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies are not only tackling the immediate challenges presented by the public health emergency but are also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. Therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

Audit approach

3 As in previous years, our work is focused on the corporate arrangements of NHS bodies for ensuring that resources are used efficiently, effectively, and economically.

4 Our structured assessment work will allow the Auditor General to answer the overall question: **Are the organisation's corporate arrangements supporting good governance and the efficient, effective, and economical use of resources?** The key lines of enquiry are set out in **Exhibit 1**.

Exhibit 1: key lines of enquiry

Are the organisation's corporate arrangements supporting good governance and the efficient, effective, and economical use of resources?

1. Is the organisation well led and well governed?
   - Does the Board promote and demonstrate a commitment to public transparency of Board business?
   - Are there proper and effective arrangements in place to support the effective conduct of business?
   - Is the Board (and its committees) operating effectively?
   - Does the Board and its committees receive timely, high quality information that supports effective scrutiny, assurance and decision making?
   - Does the Board promote and demonstrate a commitment to continuous improvement?
   - Does the Board promote and demonstrate a commitment to hear from patients / service-users and staff?
   - Do the leadership arrangements and organisational structure / design support effective governance?
   - Is there an appropriate and effective Board Assurance Framework (BAF) in place for managing the risks to delivery of organisational objectives?
   - Is the BAF underpinned by an appropriate and effective risk management system?
   - Is the BAF underpinned by an appropriate and effective performance management framework?
   - Is the BAF underpinned by an appropriate and effective clinical / quality governance framework?
   - Is the BAF underpinned by appropriate and effective information governance and information and cyber security frameworks?
   - Does the Board receive assurance that there are appropriate and effective systems in place for tracking progress to address audit and review recommendations and findings?

2. Is there an effective approach to strategic planning?
   - Does the NHS body have a clear vision and long-term strategy that is rooted in population health?
   - Is the long-term strategy underpinned by a long-term clinical strategy?
   - Does the IMTP satisfy Welsh Government requirements?

- Has the NHS body been able to produce an approvable IMTP in line with Welsh Government guidance and requirements?
- Are prudent healthcare and value based healthcare principles clearly evident within corporate strategies and plans?
- Do corporate strategies and plans identify and contain clear milestones, targets, and outcomes?
- Have corporate strategies and plans been developed in liaison with relevant partner agencies and stakeholders?
- Is there an effective approach to overseeing the development of corporate strategies and plans, and monitoring their implementation?

3. Is there an effective approach to financial sustainability?
    - Did the NHS body meet its financial objectives for 2021-22?
    - Is the NHS body likely to meet its financial duties in 2022-23?
    - Are financial planning arrangements robust?
    - Are savings and cost improvement plans designed to support financial sustainability and service transformation?
    - Are the arrangements for financial management and control appropriate and effective?
    - Are there appropriate and effective arrangements for accurate and timely oversight and scrutiny of financial performance?

4. Is there an effective approach to managing the workforce, digital resources, the estate, and other physical assets?
    - Is there an effective approach to managing the workforce?[1]
    - Is there an effective approach to managing digital resources?
    - Is there an effective approach to managing the estate and other physical assets?

5 Auditors will also pay attention to the progress made by NHS bodies to address all outstanding structured assessment recommendations from previous years, as well as outstanding recommendations from other relevant reviews.

6 Our work will be based on a review of relevant documentation, observations at Board and committee meetings, and structured discussions with the appropriate

[1] Please note that, as set out in our Audit Plans for 2022, auditors will be undertaking a separate review into workforce planning arrangements later in 2022.As a result, our structured assessment work in 2022 will focus primarily on arrangements in place at NHS bodies to support staff wellbeing.

people at the NHS body. We will work with the Board Secretary to agree the precise timing of the work, who we need to speak to at the NHS body, and any information required to support our work that is not in the public domain. In the main, we will be undertaking our audit work remotely. If attendance in person is deemed necessary, we will agree this in advance with the Board Secretary and ensure all appropriate risk assessments are undertaken in line with current COVID-19 guidelines.

Reporting our findings

7 We will prepare a report for individual NHS bodies setting out local findings and any recommendations arising from our work.

8 If any immediate concerns emerge during our work, we will liaise with the Board Secretary to agree the most appropriate way of sharing these.

9 In line with Audit Wales arrangements for public reporting, we will publish the final report on our website once it has been formally considered by the relevant Board committee.

Timing of the work

10 The indicative timescales for the key stages of the work are shown in **Exhibit 2**.

Exhibit 2: timing of the work

Key stage	Timing
Set up	May 2022
Evidence gathering	May to August 2022
Draft report	End of October 2022
Final report	End of November 2022

Audit Wales contacts

11 Further information can be obtained from Darren Griffiths, Performance Audit Manager (darren.griffiths@audit.wales) or Nathan Couch, Performance Audit Lead (nathan.couch@audit.wales).

Data Protection

Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at Appendix 1. We ask that you share this project brief with Board members, and anyone we intend to interview, to ensure they understand the purpose and scope of our review and how information may be used and shared.

Appendix 1 – Fair Processing Notice

This privacy notice tells you about how the Wales Audit Office processes personal data provided by you in connection with our Structured Assessment of NHS Trusts and Health Boards in Wales.

Who we are: The Auditor General for Wales examines how public bodies manage and spend public money, and the Wales Audit Office (WAO) provides staff and resources to enable him to carry out his work.

Data Protection Officer (DPO): Our DPO is Martin Peters, who can be contacted by telephone on 029 20320500 or by email at: infoofficer@audit.wales.

The relevant laws (legal basis): We process personal data in accordance with the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR). Our lawful basis for processing is the statutory powers and duties under the Public Audit (Wales) Act 2004, the Government of Wales Act 1998 and Well-being of Future Generations (Wales) Act 2015.

Purpose of processing: We are collecting opinions and information to help us carry out our Structured Assessment of health bodies. Some of this information may be about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals. The information collected will be used for this work and may also be used in our wider statutory audit work.

Who will see the data? The Auditor General and the WAO audit team will have access to the information you provide. We may share some information with senior management at the audited bodies involved, and our published report may include some information. We may share some data with the NHS Wales Audit and Assurance Service for the purpose of its internal audit and such information will be processed in accordance with the NHS Wales Audit and Assurance Service privacy policies.

How long we keep the data? We will keep the information collected, including your personal data, for a period of 6 years following publication of our report, or 25 years if published within a report, and we will hold your data securely in accordance with our Information Security Policy.

Your rights: You have rights to ask for a copy of the current personal information held about you or to object to data processing that causes unwarranted and substantial damage and distress. Contact the Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales.

Our rights: The Auditor General has rights to information, explanation and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006 and/or section 52 Public Audit (Wales) Act 2004 and/or section 26 of the Local Government (Wales) Measure 2009. It may be a criminal offence, punishable by a fine, for a person to fail to provide information.

The Information Commissioners Office: If you require further information in relation to your rights under data protection law or are dissatisfied with how we are handling your personal data you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, or email casework@ico.gsi.gov.uk or telephone 01625 545745.

DIGITAL HEALTH AND CARE WALES
AUDIT ACTION LOG

Agenda Item	4.4

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Julie Ash, Head of Corporate Services
Presented By	Julie Ash, Head of Corporate Services

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to **NOTE** the Audit Action Log	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	ISO 9001
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Not applicable	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below Audit findings contribute towards the improvements of processes and procedures leading to better quality services
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	NHAIS	National Health Application and Infrastructure Service
DR	Disaster Recovery	IT	Information Technology
SMT	Senior Management Team	IMTP	Integrated Medium Term Plan
NWSSP	NHS Wales Shared Services Partnership	SFI	Standing Financial Instructions
BAF	Board Assurance Framework	FBP	Finance Business Partner
FCP	Financial Control Procedure	SMB	Service Management Board
WPAS	Welsh Patient Administration System	BI	Business Intelligence

2 SITUATION/BACKGROUND

2.1 This paper details the current position with respect to audit recommendations that have been made, including those that have been completed during the period, those that are on schedule, those that are overdue and those anticipated to not meet target dates. The audit recommendation analysis (2.1) shows how progress is being made against the recommendations and illustrates the on-going movement and change of status.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The audit log shows the current reported status against recommendations received. The analysis below shows all recommendations giving the current status of each recommendation which remained open at the last Digital Health & Care Wales (DHCW) Audit and Assurance Committee and also those presented in report form to the Committee since submission of the last log.

3.2 Following advice from Internal Audit, one action dependent on a third party is being managed via a separate log for tracking.

3.3 There were 16 actions reviewed at the last meeting where 13 were closed leaving a total of 3 open actions. The Committee received four reports at the last meeting (listed below) which contained a total of 36 new actions.

These have been added to the log which now contains a total of 39 actions.

1. Data Centre Project Move
2. General Governance Part Two
3. System Development
4. Core Financial Systems

The status of the 39 open actions is shown in the table below:

Number	RAG	Status
29	GREEN	Complete
8	YELLOW	Indicates that the action is on target for completion by the agreed date
0	AMBER	Indicates that the action is not on target for completion by the agreed date
2	RED	Indicates that the implementation date has passed and management action is not complete

3.4 In particular, the Committee are requested to note:

- The completion of the following actions:
  - Review and agreement of Strategic Objectives
  - Assessment of strategies, frameworks and programmes as part of IMTP 2022-2025
  - Formal approval of Strategic Objectives
  - Alignment of Performance Reporting to Strategic Objectives
  - Identification of key performance messages
  - Receipt of Health & Care Standards report by Board
  - Inclusion of information on compliance with Health & Care Standards in IMTP
  - Development of the DHCW Board Assurance Framework
  - Use of SkillSoft to fulfil training needs within the Applications Directorate
  - Identification of professional development pathways for technical roles
  - Utilisation of a Training Matrix within the Applications area
  - Monitoring and reporting of SkillSoft usage now in place
  - Agreement of SkillSoft administration arrangements
  - Representation of Applications Directorate on the Cyber Security Service Improvement Plan Project Board
  - Application Team Leads identified for Secure Coding
  - Update of WPAS Code Review Document to include a check with secure coding standards
  - Run rates and key cost drivers now referenced in Finance Reports
  - Development of standard reporting templates within Finance
  - Scheduling of budget holder meetings

- Creation of an action log to monitor and track outcomes from budget holder meetings
- Power BI Training Session held
- Monitoring of Power BI usage in place
- Process established to ensure formal approval of budget virements
- Use of electronic signatures to evidence monthly reconciliation and review of budget journals
- Virements sections of FCPs have been updated to ensure clarity in the authorisation process
- Electronic signatures introduced into bank reconciliation process as evidence
- All FCPs include a review date and are published in the Integrated Management System
- Pre-employment checks are now embedded in procurement processes for temporary/agency workers
- Operational Guidance for the procurement and contract management of agency contract staff updated to reflect changes

3.5 The following actions which have not been completed by their target date but are due to be completed within the next month:

- Applications Directorate to access funding for additional Skillsoft Licences
- All training undertaken within the Applications Directorate to be added to the Training Matrix

3.6 The remaining 8 actions are on target for completion by their target date.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 Excellent progress has been made over the period with a total of 29 actions closed. Progress against actions will continue to be monitored by the Head of Corporate Services in conjunction with Lead Directors on a regular basis.

4.2 There are two actions identified as overdue however they are expected to be completed within the next month.

5 RECOMMENDATION

5.1 The Committee is being asked to **NOTE** the Audit Action Log.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Agenda item 4.4i

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation passed management action not complete

Digital Health & Care Wales
Outstanding Actions

	Recommendation	Priority	Management Action	Responsible Manager/ Department	Accountable Officer	Current/ Revised Implementation Date	Status	Comments Audit Committee
External Audit - WAO - Nationally Hosted NHS IT Systems Annual Audits								
2019.1	DHCW still use a number of servers and machines that operate using the Windows Server 2008 operating system and SQL server 2008 platforms. A replacement programme is underway as legacy IT systems are replaced.	High	Replace the legacy Windows Server and SQL Server 2008 operating system, used on national NHS ICT infrastructure environments, with a supported operating system.	Carwyn Lloyd-Jones/Jamie Graham	Helen Thomas	Jun-22	Yellow - Action on target to be completed by agreed date	Re-introduced to log in Oct 21. Work is continuing to remove legacy operating and database systems from the environment. There are complex dependencies but progress is being made. Approximately a third of those remaining have been decommissioned since April 2021.
2021.9	DHCW are moving to a new national data centre. Once the move is complete, the updated IT DR Plans including resilience arrangements should be fully tested.	Medium	Test the IT DR plans including arrangements for testing at the new national data centre	Carwyn Lloyd-Jones/Jamie Graham	Helen Thomas	Oct-22	Yellow - Action on target to be completed by agreed date	Our resilience programme ensure tat all systems complete a full test of their geographic resilience annually. 100% of services completed a fail-over before the migration, in preparation for the move. A full DR test of each service will be complete within the first 12 months of occupation.
NWSSP Findings								
WRIS04	Consideration should be given to bringing the control over password settings into the central management function.	Medium	Development required. However, appetite for this from the Service will likely be low due to the procurement of a new RIS system. Will highlight at the next SMB for possible inclusion in Release 2.5	Gareth Evans/Meirion George	Helen Thomas	Release 2.5 date	Yellow - Action on target to be completed by agreed date	Release date unknown

GenGovPt2 1.1a	Once the Board has approved revised mission, vision and strategic objectives in March 2022, they should be provided with assurance that the current strategic objectives in the latest draft of the 2022-2025 IMTP remain valid or are amended as required.	Medium	The Board Development session on the 3 March will review and agree/approved the mission and vision. The strategic objectives will also be reviewed at this session as part of the IMTP 2022-2025. The Board Development discussions will confirm if the strategic objectives remain valid, and will go to Public Board on 31 March for formal approval.	Michelle Sell/Ifan Evans	Helen Thomas	Mar-22	Action Complete	Complete
GenGovPt2 1.1b	The status of the key supporting strategies, frameworks and programmes should be assessed, identifying what is in place and whether it remains fit for purpose, for the agreed strategic objectives.	Medium	The supporting strategies, frameworks and programmes included in the reservation of decisions for the Board will be reviewed as part of the IMTP 2022-2025, development of DHCW's long term strategy and Board forward workplan.	Michelle Sell/Chris Darling	Helen Thomas	Mar-22	Action Complete	Complete
GenGovPt2 1.1c	Once the Board has approved its revised mission, vision and strategic objectives, they should receive assurance that the current strategic objectives remain valid or are amended, as required.	Medium	The Board Development discussions will confirm if the strategic objectives remain valid, and will go to Public Board on 31 March for formal approval.	Michelle Sell/Ifan Evans	Helen Thomas	Mar-22	Action Complete	Complete
GenGovPt2 2.1a	Ensure performance reporting and planned actions are more clearly linked to specific DHCW strategic objectives;	Low	The Performance Report presented to the Board will be updated in line with the IMTP for 2022-25 to align more explicitly to the Strategic Objectives.	Michelle Sell/Ifan Evans	Helen Thomas	May-22	Action Complete	A new format of reporting will go to Board at the July meeting and quarterly thereafter.
GenGPt22. 1b	Highlight key performance messages and issues of assurance, exceptions, and actions required of the Board	Low	The presentation of the Performance Report will continue to be refined through the next financial year, including a focus on key performance messages and issues of assurance, exceptions, and actions required of the Board.	Michelle Sell/Ifan Evans	Helen Thomas	Mar-22	Action Complete	Complete and ongoing.
GenGovPt2 2.1c	To ensure performance reporting is linked to compliance with relevant Health and Care Standards.	Low	The Performance team will work with the Health Care Standards lead(s) in DHCW to highlight compliance with the standards applicable to DHCW.	Michelle Sell/Ifan Evans	Helen Thomas	Jul-22	Yellow - Action on target to be completed by agreed date	Discussions ongoing between Head of Organisational Performance and Head of Corporate Services (Health & Care Standards Lead)
GenGovPt2 3.1a	The Audit and Assurance Committee provides the Board with assurance on compliance with the Health and Care Standards for the 2021-2022 period	Low	The Audit and Assurance Committee reviewed the Health and Care Standards for 2021-22 on the 18 January, and reported to the Board on the 27 January that the Health and Care Standards report had been received for assurance. In addition the standards relevant to the DG&S Committee will go to the DG&S Committee on the 18 February for further scrutiny and a Health and Care Standards report to the Board on the 31 March.	Chris Darling	Helen Thomas	Mar-22	Action Complete	Complete

GenGovPt2 3.1b	Future IMTP and annual plans comment on planned compliance with the Health and Care Standards, linking to key evidence.	Low	The IMTP 2022-2025 will include information on compliance with the Health and Care Standards.	Michelle Sell/Ifan Evans	Helen Thomas	Mar-22	Action Complete	Complete
GenGovPt2 4.1a	We recommend that DHCW updates the Board as to the individual process steps still to be performed in support of the delivery of a fully effective BAF reporting process, together with key milestone dates. This should acknowledge agreed resource requirements from management to initially establish, and then continue to refresh thereafter, the BAF reporting process.	Medium	Work is progressing to develop the BAF and BAF reporting process during February and March 2022, an update on this work will be provided to the Board on the 31 March. It is acknowledged that the initial BAF is likely to require future iterations to take into account Board member feedback before a final version is agreed. This is likely to take place at the Board meetings on the 26.05.22 and 28.07.22.	Chris Darling	Helen Thomas	Jul-22	Action Complete	Complete. BAF taken to Board on 26 May 2022 and approved for future use.
SD1	An overall training plan should be developed that ensures that all identified training needs can be met.	Medium	Application Managers have agreed we will use the Skillsoft computer-based-learning package to fulfil most of our training needs.	Tim Mullis/Meirion George	Helen Thomas	May-22	Action Complete	Complete
			Identify the professional development pathways for a range of technical roles that are not covered by Skillsoft.	Geoff Norton/Meirion George	Helen Thomas	Apr-22	Action Complete	Complete. Skillsoft will now cover the needs of Application Architects.
			Application teams to review & agree to use the training matrix (written by the Medicines Application Manager) to plan training for each job role. This will enable a clear and consistent view of the skill set required for all technical posts in ADS.	Application Managers/ Meirion George	Helen Thomas	May-22	Action Complete	Complete.
			Monitor the use of Skillsoft within each Application Team. And provide Application Managers appropriate usage reports.	Helen Robertson/ Meirion George	Helen Thomas	May-22	Action Complete	Complete.
			Access funding for additional Skillsoft licenses to cover all staff including new recruits.	Stuart Davies/ Merion George	Helen Thomas	May-22	Red - Implementation passed management action not complete	In progress but slightly delayed, will be completed by the end of June 2022
			Directorate Management Team to take over the Skillsoft administration for ADS.	Helen Robertson/ Meirion George	Helen Thomas	May-22	Action Complete	Complete.

			Advanced ISTQB Training (which is not provided in Skillsoft) will be co-ordinated across all Application teams.	Geoff Norton/Meirion George	Helen Thomas	Jun-22	Yellow - Action on target to be completed by agreed date	Requirements identified and training scheduled pending confirmation from supplier
			All training undertaken to captured and cross referenced to the Training Matrix.	Helen Robertson/ Meirion George	Helen Thomas	May-22	Red - Implementation passed management action not complete	In progress but slightly delayed, will be completed by the end of June 2022
SD2	All code management should be in TFS	Medium	WRIS Senior Product Specialist Support & Business Analysts to review and plan the implementation of the following Software Development guidelines – CS-ADS-004 Managing Source Control, section 7.1 and CS-ADS-003 T-SQL Coding Standards	Gareth Evans/Meirion George	Helen Thomas	Sep-22	Yellow - Action on target to be completed by agreed date	Scheduled for completion at end of September 2022
SD3.1	Work should continue to integrate security into the development process, with the production of the security toolkit and review of this by security. Higher risk projects should then include security representation into the project / scrums.	Medium	Ensure Application Development & Support is represented on the Cyber Security Service Improvement Plan Project Board. (We expect the SIP to include the introduction of a common Static Application Security Testing (SAST) tool within its scope)	Tim Mullis/Meirion George	Helen Thomas	Apr-22	Action Complete	Complete
		Medium	Nominate a Lead Software Developer from each Application team to lead on Secure Coding	Geoff Norton/Meirion George	Helen Thomas	Apr-22	Action Complete	Complete. Individuals identified for each application to undertake this role
SD3.2	The requirement for checking compliance with secure coding standards should be added to the WPAS code review document.	Medium	We continue to integrate security into the development process by – Publishing CS-ADS-005 Managing packages and dependencies into the quality management system and we will agree a standard set of code analysis tools for integrated development environments and build pipelines. And add these to our current coding standards.	Geoff Norton/Meirion George	Helen Thomas	Dec-22	Yellow - Action on target to be completed by agreed date	Scheduled for completion at end of December 2022
		Medium	The WPAS code review document has been updated to indicate a check with secure coding standards has taken place	Carl Davies/Meirion George	Helen Thomas	Mar-22	Action Complete	Complete

SD4	DHCW should consider rolling out the use of Trello Boards or other Kanban style management products to other teams.	Low	All teams to work together to determine a standard Kanban product to use in all application areas.	Carl Davies/Meirion George	Helen Thomas	Aug-22	Yellow - Action on target to be completed by agreed date	On target for completion by August 2022
CFS 1.1	The SHA should clearly set out how and when the SFI Board reporting requirements are met, ensuring this is also the case in practice.	Medium	As part of the monitoring returns DHCW will present run rates and key cost drivers and ensure when relevant they are referenced or included in the Finance Board Reports.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	May-22	Action Complete	Complete
CFS 1.2a	The Finance Team should develop standard reporting templates/a checklist for directorate SMT reports which align to the requirements of the SFI/FCPs	Medium	Whilst standard templates and approach are available it is noted that there is variability in terms of content a revised template and monitoring log has been produced.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	May-22	Action Complete	Complete
CFS 1.2b	The Finance Team should: ensure monthly meetings between budget holders and FBPs take place for all budget holders / cost centres on a timely basis through: i. scheduling all meetings in advance for the financial year; and ii. holding the meetings as close to the month-end close process as possible to allow timely response to variances	Medium	Whilst there have been availability issues during the pandemic its is accepted that the meetings can be more timely. The finance department will schedule sessions for the full year with a requirement that an appropriate budget holder deputy be nominated to avoid cancellation. These will all be scheduled for the first half of the month.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	May-22	Action Complete	Complete
CFS 1.2c	The Finance Team should ensure there is a robust mechanism to capture and monitor minutes, budget variances and actions, including i. developing and implementing standard agendas and minutes to capture the discussions and actions arising from the monthly budget holder meetings; ii. ensure explanations for variances documented within Power BI provide adequate explanation of the reason and that actions (including owners and timescales) are identified. A guidance on minimum requirements could be developed to support this; and iii. develop, implement and monitor a standard action log (including action owners and timescales) to ensure actions are implemented and are effective. This could be achieved through further development Power BI to incorporate an actions page, allowing Finance Business Partners and budget holders to log, drill down on and monitor implementation of actions.	Medium	A manual action log is now currently in place, this allows for analysis by directorate, budget holder, cost code and issues which will meet the requirements of this recommendation. A first step in terms of improvement is to construct a SharePoint site with defined fields and completion criteria to drive behaviour and provide a transparent monitoring point for Finance, budget holders and assurance by senior finance leads. A review will also be initiated to include linkages to the Power BI Dashboard and addition to the 22/23 development requirement.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	May-22	Action Complete	Complete

CFS 2.1	The Finance Team should identify existing budget holders who require further support in the use of Power BI. Support should be provided through formal training or one-to-one support from Finance Business Partners, as appropriate	Medium	A survey has been issued and closed requesting feedback of any issues, improvements or assistance, this (alongside 1.2c) will form part of the improvement plan. The finance training and awareness sessions are typically arranged around the start of the financial year with ad hoc sessions. We will undertake to support this by recording e-learning tools and scheduling specific 1-1 sessions. Training sessions have been arranged for May to capture new starters and any staff requiring refresher training. Also, Business partners will discuss Power BI in their regular budget holder meetings.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Jun-22	Action Complete	Complete. Training session held on 24th May 2022.
CFS 2.2	The Finance Team should utilise the inbuilt functionality to monitor budget holder access and usage of Power BI. This should be undertaken formally, e.g., through quarterly reporting to the directorate SMT meetings. Action should be taken to address any budget holders who do not regularly use Power BI	Medium	Quarterly monitoring of budget holder usage will also be enhanced in order to inform unused reports and flag any areas of concern.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Mar-22	Action Complete	Complete
CFS 3.1a	The Finance Team should ensure: i. approval of budget virements is formally evidenced for all virements – email approval would be acceptable, provided the audit trail is retained in an appropriate central location (i.e., not individual inboxes); and ii. ii.there is robust supporting evidence for all budget virements, including clear explanations as to how documentation supports the virement. This could be achieved through use of a template budget virement approval form, which sets out the requirements for approval and supporting evidence.	Medium	Budget virement templates are now in place with further staff training regarding completion and supporting documentation to be retained. The use of Budget categories to further help analysis of movements is to be implemented within the revised processes and the Oracle financial ledger in 22-23.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Apr-22	Action Complete	Complete. Power BI monitoring reports are distributed to Finance Business Partners for action and statistics are forwarded to Internal Controls Group for monitoring/escalation.
CFS 3.1b	The Head of Financial Services and Reporting should evidence their monthly reconciliation and review of budget journals.	Medium	Although reviewed, during the pandemic wet signatures were not possible. The department has however instigated electronic signature functionality to meet evidence requirements.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Apr-22	Action Complete	Complete.
CFS 3.1c	The Finance Team should consider reviewing and updating the virements section of the FCPs to ensure clarity in the authorisation and supporting evidence requirements.	Medium	The FCP's are reviewed as a minimum once a year, we will look to review and update as appropriate in March.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Apr-22	Action Complete	Action Complete.

CFS 4.1a	The review of bank reconciliations should be formally evidenced in line with best practice.	Medium	Although reviewed, during the pandemic wet signatures were not possible. The department has agreed going forward to instigate the electronic signature functionality to meet evidence requirements. This item has been added to the Monthly Financial Accounting Timetable.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Mar-22	Action Complete	Complete
CFS 4.1b	The FCP should be updated to specify who should perform the review and how this should be evidenced.	Medium	The FCP's are reviewed as a minimum once a year, we will look to review and update as appropriate in March.	Sian Williams/Claire Osmundsen-Little	Helen Thomas	Apr-22	Action Complete	Complete.
CFS 5.1a	We concur with the approach to obtain pre-employment check confirmation forms from Framework agencies prior to agency staff commencing work. The Commercial Services team should ensure the forms are completed and approved by the Frameworks and implemented in practice as a matter of urgency	Medium	These are approved and are now embedded in our procurement processes for temporary/agency workers	Julie Francis/Michelle Sell	Helen Thomas	Mar-22	Action Complete	Complete
CFS 5.1b	Update the operational guidance for the procurement and contract management of agency contract staff to reflect the new pre-employment check forms.	Medium	Operational Guidance draft updated and currently being reviewed. Anticipated sign-off of this by 08th March 2022.	Julie Francis/Michelle Sell	Helen Thomas	Mar-22	Action Complete	Complete. Guidance updated.

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation passed management action not complete

Third Party Actions
Outstanding Actions

	Recommendation	Priority	Management Action	Responsible Manager/ Department	Accountable Officer	Current/ Revised Implementation Date	Status	Comments Audit Committee
External Audit - WAO - Nationally Hosted NHS IT Systems Annual Audits								
2016.1	NHS Digital (formerly known as HSCIC) are decommissioning the NHAIS system and replacing the functionality with a third party supplier system from Capita for the payments engine for calculating general medical services payments. NHS Digital are also developing the demographic registration and reporting systems required to replace NHAIS functionality. For NHS Wales, DHCW (formerly NWIS) and NWSSP are considering the system replacement options for Welsh requirements as NWIS also support and develop the Welsh Demographic System (WDS).	Medium	DHCW (at the time NWIS) should, as they manage, support and develop the Welsh Demographic System (WDS) plan to provide the required functionality for NHS Wales in developing the WDS for patient demographic purposes.	Meirion George/Ken Leake	Helen Thomas	Jul-22	Yellow - Action on target to be completed by agreed date	DHCW (then NWIS) met with NHS Digital in November 2020 where they confirmed they are still not in a position to give us revised dates for the start of decommissioning. NHS Digital are currently not in a position to provide dates for key Capita deliverables. The WDS Phase 3 development will be aligned with these timescales but more clarity is needed from England before substantive work can take place. We are advised that the implementation date is unlikely to be before January 2022, and may take up to 6 months to complete.

DIGITAL HEALTH AND CARE WALES
COUNTER FRAUD ANNUAL REPORT
2021-2022

Agenda Item	4.5

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Gareth Lavington, Counter Fraud Manager
Presented By	Gareth Lavington, Counter Fraud Manager

Purpose of the Report	For Approval
Recommendation	
The Committee is being asked to REVIEW and APPROVE the contents of the Annual Report that details the Counter Fraud provision supplied to the organisation carried out in the financial year 2021-2022.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: 20/06/2022
No, (detail included below as to reasoning)	Outcome: NA
Statement: NA	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
CAVUHB	Cardiff and Vale University Health Board		

2 SITUATION/BACKGROUND

2.1 As part of the functional requirements of the NHS Counter Fraud Authority, the Counter Fraud Manager, or deputy, is required to provide a detailed annual report of work carried out at the end of the financial year.

2.2 This report details the cost, the allocation of days, any investigatory work, any pro-active work and a summary of compliance with the Gov Standard 13 Requirements. In essence it is a summary of the Counter Fraud Work carried out on behalf of the organisation by the CAVUHB Counter Fraud team from 01-04-21 through 31-03-2022.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The Annual Report can be found in full at item 4.5i.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee

5 RECOMMENDATION

5.1 The Committee is being asked to REVIEW and APPROVE the contents of the report that relate to the Counter Fraud work carried out in the financial year 2021-2022.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Executive Director of Finance	16/06/2022	Approved

NHS WALES
Digital Health and Care Wales

Annual Counter Fraud Report
01/04/2021- 31/03/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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1. INTRODUCTION

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS') to provide a written report at least annually to Digital Health and Care Wales (DHCW) on Counter Fraud work undertaken. All NHS organisations, in compliance to their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance to the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of information reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made

This report has been complimented throughout the year with detailed progress reports presented to the Audit Committee and additional briefings being presented to the Executive Director of Finance. Following acceptance and approval by the Audit Committee, this Counter Fraud Annual Report is distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance Team for review if requested.

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care (DHSC). For more information, the NHSCFA website is www.cfa.nhs.uk. For the purposes of this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss to the organisation.

2. SUMMARY OF COMPLIANCE

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The LCFS' has demonstrated compliance towards the recognised Government standard requirements as detailed below.

Compliance is Measured as follows:

Green – fully compliant

Amber – partially compliant

Red – non-compliant

- Accountable Individual and Audit Assurance

  The LCFS' overall governance is held by the Executive Director of Finance. The LCFS' has ensured to notify her of any referrals received and regular updates are provided throughout the investigation process. Additional to this, the LCFS' have extended this exchange of information to ensure that where appropriate, the senior workforce members have been briefed where aspects of a Counter Fraud investigation may overlap with that of a disciplinary concern. During the course of the year regular updates and meetings have taken place between the LCFS and DoF and the Counter Fraud Champion and other managers.

  The LCFS is an invited member of the Audit Committee and as such has presented regular progress reports of Counter Fraud work undertaken throughout the year. All quarterly progress reports have been provided to committee. The Annual Report has now been completed and submitted. The

Annual Plan has now been completed in draft form and awaits approval from DoF and Audit Committee. There has been a delay in reporting during this end of year period due to the change of management within the counter fraud department.

GREEN

- Counter Fraud Bribery and Corruption Strategy / Policy and Response Plan

The organisation has adopted the All Wales Counter Fraud, Bribery and Corruption Policy. This will require review in the oncoming year to ensure that it is in date and fully aligned to the NHS CFA strategy.

The policy is available to staff via the Intranet and has been promoted during fraud awareness work carried out by the team throughout the year. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible. The LCFS team this year has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

GREEN

- Risk Assessment

The LCFS' team have, where appropriate continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy which aims to strengthen the wider practices to reducing the risk of fraud through poor policy or governance controls. All risk work follows the rationale proscribed by NHSCFA. Throughout the upcoming year this will be strengthened further with a full review into the relevant policies related to Counter Fraud Work. Where local risks are identified, assessment work is carried out accordingly. A 'pre-employment check' risk-assessment was carried out during the year for all organisations that Cardiff and Vale Counter Fraud Team maintain provision for, which found that DHCW carried out their own robust fir for purpose pre-employment checks. Due to the implementation of a new risk management reporting style adopted by the NHS CFA, a delay in training, and the service being stretched for a significant part of the year not all of this work has been recorded in the new format. All new risk work will now align to this methodology and be reported upon the CLUE case management system and locally through the AAC process, and recorded on the local risk register. Relationships and information sharing will be built throughout the year between LCFS and key contacts in key areas of risk including Workforce and OD, Procurement, and Internal Audit. A review of the joint working protocols in place between LCFS

and these departments will take place throughout the year ahead with a view to identifying areas of weakness in order that risk-assessment work is informed. CFA rationale will be followed in regard of risk work undertaken.

AMBER

- Annual Action Plan

An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document currently awaits agreement and sign off from the DoF and subsequent ratification by the Audit Committee. Progress of the LCFS teams work will be reported periodically at the Audit Committee. Due to the nature of Counter Fraud work the plan remains broad, flexible and subject to change throughout the year as new risks and requirements are identified.

GREEN

- Outcome Based Metrics

Throughout the year the work of the LCFS team has constantly been measured and statistics produced. This is carried out in the areas of raising awareness, investigation, risk, awareness, joint working, strategic planning, sanctioning, and financial loss and recovery. The service has been successful in documenting direct results. Further work is being implemented in Q1 of the year ahead to routinely collect data in relation to further areas that will assist in being able to directly measure the effectiveness of strategies implemented and work carried out. For example, the effectiveness of a new interactive internal Fraud Enquiry / Reporting tool being implemented, promoted and publicised, will be directly measured against a rise or fall in the amount of contact that is made by staff members. Further monitoring of risk work carried out will be implemented to introduce periodic review in order to assess any savings made as a result of implemented recommendations.

GREEN

- Reporting Routes

Staff have been made aware throughout the year via staff presentations of the reporting routes available to them. These include direct contact with the team via email, phone and in person, the use of the online CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers, and an internal reporting form. All instances of fraud reporting are initially assessed

and those that are furthered to formal investigation are recorded on the case management system (CLUE) and reviewed accordingly. New reporting methods are being introduced this year as laid out in the annual plan. Improvement required in awareness of existing and new reporting routes and as a result a new communications strategy is being developed.

AMBER

- Reporting Identified Loss

The CF team reports all incidents of suspected fraud, bribery using the CLUE management system that was introduced on 9th April 2021. This reporting tool is used to record all investigations, sanctions, recoveries and losses and also has a mechanism to record system weakness and Local Proactive Exercise work. This system is supervised by CFS Wales and all information is used to inform progress reporting to Audit Committee and CFS Wales. The information is also shared as and when necessary across the wider NHS and externally in order to inform of relevant risk. Onward reporting to Welsh Government is made by CFS Wales.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators that were supported by a full-time administrative support assistant. One of these investigators was off work on sickness leave and remained so throughout the year. The administrative support assistant left in September 2021. The team were joined by a further investigator in January 2022. This team member is at the time of reporting three quarters of the way into an accreditation qualification. This is due to be completed in June 2022. The team have been under staffed for the majority of the year and have provided extra time and been bolstered throughout the year with assistance from the CFS Wales team and members of other NHS Wales teams on an ad hoc basis in order to ensure successful provision of the Counter Fraud Plan for 2021-2022.

GREEN

- Undertake Detection Activity

Where anomalies are identified through counter fraud work e.g. investigations, data mining exercises the CF team strives to carry out detection activity to assess whether there is any outlying information

present. Where this is the case action is taken to investigate identified offences and corrective activity is proactively undertaken to mitigate the identified risk. Data mining has not been undertaken within the context of the NFI database as DHCW have not yet been added to this system. Improvement is required in relation to understanding the bespoke nature of DHCW in order to identify key areas of risk and areas pertinent to detection activity.

AMBER

- Access to and Completion of Training

Due to the COVID situation fraud awareness sessions to staff members have been significantly disrupted. However remotely delivered sessions have been created and delivered where possible. The plan for the year ahead is to get back to in room presenting and making sure that Fraud Awareness is mandatory at corporate induction. This is not the case at this time. All wales fraud awareness training has remained available throughout via ESR however this is not a mandatory training package within DHCW. A counter fraud newsletter has been published in order to keep staff appraised and signpost to fraud awareness and training materials. CF team staff have attended all sessions of training provided by CFS Wales and NHS CFA and a number of webinars from NHS CFA have also been undertaken in relation to update training into areas such as risk assessment and CLUE implementation.

AMBER

- Policies and Registers for Gifts and Hospitality and Conflicts of Interest

The organisation has an in-date Standards of Behaviour policy in compliance with this requirement. Declarations of interest are always covered at AAC meetings. A conflicts of interest register is maintained.

GREEN

3. Allocation of Resources

At 31st March 2022, **29** days of Counter Fraud work have been completed against the agreed **40** days in the Counter Fraud Annual Work-Plan for the 2021/22 financial year as shown below. The days have been used preparing, delivering and analysing the feedback from the fraud awareness presentations; staff training and CPD; preparing quarterly and annual

reports for, and attending, the organisation's audit committee meetings and carrying out a risk assessment exercise on pre-employment checks conducted by agencies which supply staff to the organisation.

Strategic Requirements 18 Days

(inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all wales meetings.)

Proactive Work 11 Days

(inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins)

Reactive Work 0 Days

4. Summary of Costs

Proactive Costs	**£8,268**
Reactive Costs	**£5,082**
Total Costs	**£13,350**

5. Breakdown of Investigative work areas

At 1st April 2021 a total of 0 investigations were open. During the reporting period the CF team received no referrals in relation to DHCW.

Offence	No. of Referrals	Type
NA	NA	NA

6. Sanctions and Recoveries

During the financial year the team has achieved the following sanctions and recoveries. In the oncoming year savings as a result of risk and proactive detection work will also be included in these totals.

Disciplinary Sanctions	**0**
Criminal Sanctions	**0**
Civil Sanctions	**0**
Recoveries	**0**

7. Fraud Awareness

During the period 1st April 2021 – 31st March 2022 a total of 2 awareness sessions were delivered to 32 staff members across the organisation. The feedback from these presentations was positive. Further to this an awareness session was delivered to new members of the Audit Committee.

8. Lines of Reporting

CEO – Helen Thomas

Executive Director of Finance – Claire Osmundsen-Little

Counter Fraud Manager – Gareth Lavington

LCFS – Nigel Price

LCFS – Emily Thompson

LCFS (training) – Henry Bales

9. Executive Sign Off / Declaration

I declare that the Counter Fraud work carried out on behalf of Digital Health and Care Wales for the year 2021/2022 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Counter Fraud Manager: Gareth Lavington

Executive Director Finance: Claire Osmundsen-Little

Date: 30/05/22

DIGITAL HEALTH AND CARE WALES
COUNTER FRAUD ANNUAL PLAN
2022-2023

Agenda Item	4.6

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Gareth Lavington, Counter Fraud Manager
Presented By	Gareth Lavington, Counter Fraud Manager

Purpose of the Report	For Approval
Recommendation	
The Committee is being asked to REVIEW and APPROVE the contents of the Annual Plan that details the Counter Fraud work proposed for 2022-2023.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: 20/06/2022
No, (detail included below as to reasoning)	Outcome: NA
Statement: NA	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below Failure to have a fit for purpose counter fraud plan and strategy implemented runs the risk of financial loss to the organization as result of fraudulent activity.
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
CVUHB	Cardiff and Vale University Health Board		

2 SITUATION/BACKGROUND

2.1 As part of the functional requirements of the NHS Counter Fraud Authority, the Counter Fraud Manager, or deputy, is required to provide a detailed annual plan of proposed work for the upcoming financial year.

2.2 This plan is fully aligned to the NHS requirements as prescribed by the new Gov.13 Standard in relation to Counter Fraud work which aims to bring a consistent approach to all Counter Fraud work across all government and public bodies.

2.3 The plan provides a flexible approach for work to be completed over the upcoming year in order that the provision can remain dynamic to meet the needs of the organisation.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The Annual Plan 2022/23 can be found in full at item 4.6i.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee

5 RECOMMENDATION

5.1 The Committee is being asked to REVIEW and APPROVE the contents of the plan that relate to the proposed counter fraud work for the financial year 2022-2023.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Executive Director of Finance	16/06/2022	Approved

NHS WALES
Digital Health Care Wales
(DHCW)

COUNTER FRAUD PLAN
2022/2023

Gareth Lavington
Manager Counter Fraud
Cardiff and Vale UHB

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Manager on behalf of DHCW in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Claire Osmundsen-Little

Date: 30/05/2022

WORKPLAN 2022-2023

Background

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is 31/05/2023. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. They will provide a grading of compliance in relation to all areas of the functional standards. (Green, Amber or Red)

In order to achieve the standards set by the NHSCFA, Digital Health Care Wales Special Health Authority (DHCW) follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and buys in provision of a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS) from Cardiff and Vale university Health Board. To ensure that the organisation's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the Counter Fraud Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided below formulates Local Counter Fraud arrangements for DHCW for 2022-2023. The tasks outlined will be considered and reviewed dynamically throughout the year as the need arises. The

effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan for the first time will directly mirror GovS:13 Standard (Counter Fraud) in order to bring the organisations provision into line with the NHSCFA Counter Fraud Bribery and Corruption Strategy. This in turn supports the objectives set by the Welsh Government.

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

Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the Local Counter fraud Specialist (LCFS).
The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified in the course of investigations, or analysis of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

Meeting key personnel in the health board and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work. Any risks which are identified by the LCFS will be recorded in line with local procedures adopted for such by the organisation, shared with the Internal Audit department and reported to DoF and Audit Committee. This aims to provide another level of assurance that the risk will be **owned** and managed. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices. Information received from external sources will be assessed and any risks locally identified will be targeted as a result.

To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued up to date risk assessment advice and training. This helps the LCFS when assessing the counter fraud arrangements at their own organisation. This provides direction in risk assessment work and provides a basis of measuring local risks using a dedicating risk matrix scoring system and template. Results of all local risk work carried out by the Counter Fraud Team will be reported through the quality

assurance process to NHS CFA, managed on the CLUE case management system and will be locally reported to the Audit Committee

Outcomes/Results

Accurate records of counter fraud work are crucial. They inform upon the effectiveness of work undertaken, assist in the planning of future work and help to identify strengths and weaknesses within the organisation. Accurate records of all work undertaken by the Counter Fraud team for this upcoming year will be kept and updated. These results will be reflected in the quarterly progress reports and end of year annual report.

The Counter Fraud team are aware 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 and the Cardiff and Vale UHB Counter Fraud team, on behalf of DHCW will maintain a close working relationship with Wales Audit as required.

Resource Provision

Resource Provision for DHCW	Days Planned 22 / 23
Counter Fraud Manager and LCFS provision from CAVUHB	40

Resource by Activity

Activity	Days Planned 22 / 23
Proactive	30
Reactive	10
Total	40

With the move to the GovS:13 taking place and old 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account now obsolete, the methodology to be adopted in breaking down resource time spent by activity area is simplified into Proactive and Reactive areas. Generally *Proactive* work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises involving risk assessment. Reactive work will involve activities such as, investigation into referrals received, carrying out system weakness analysis as a result of investigation findings

NHSCFA states that Proactive work should not be absorbed by Reactive activity or *vice versa* and to this end NHSCFA strongly encourages Proactive work to be 'ring-fenced'. However due to the dynamic nature of the Counter Fraud environment the plan is intended to be flexible to the needs of the service, so may be subject to review and change where service priorities and risk require. If this occurs then careful consideration will be given to any changes made and this will be reported in progress reports to the DoF and the Audit and Assurance Committee. Any changes to the overall days provided or in regard to the areas planned for will be reported in the end of year report.

Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.

Gov s013 / NHS Requirement	Objective	Proposed Delivery
1: Accountable individual NHS Requirement 1A: A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the	Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed. The DoF to act as the link between the Audit and Assurance Committee (AAC) and Risk Management Group to allow key risks to be identified, managed and mitigated. CFM to produce the DHCW Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee. CFM to provide quarterly progress reports to Dof and AAC and to present these quarterly at AAC.	Ongoing throughout the year Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation NHS Requirement 1B: The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.	Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order. Where necessary and appropriate Counter Fraud Manager (CFM) will seek to hold regular one to one meetings with the Audit Committee Chairperson, Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with non-executive Audit Committee and Board Members. Counter Fraud to remain a standing agenda item at AAC. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year. CFM to report to DoF and AAC any matters arising from NHSCFA in relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises.	As required Ongoing throughout the year Throughout the year addressing matters arising as necessary Throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	CFM to liaise regularly with internal partners, such as Internal Audit, HR, Information Governance and Communication Department to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM to carry out annual reporting to NHSCFA in the form of the NHS CFA Functional Standard return and to subsequently address any issues rising from the results of this assessment.	Q1 Q4

Gov s013 / NHS Requirement	Objective	Proposed Delivery
2: Counter fraud bribery and corruption strategy NHS Requirement 2: The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. **(The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)**	CFM to verify that the organisational Counter Fraud Bribery and Corruption Policy is in place and review to check that in date and fit for purpose. CFM to ascertain whether the local policy is properly aligned to the current NHS CFA Strategy. CFM to ensure that work planned for in the Annual Counter Fraud Plan and that work carried out is aligned to the NHS CFA strategy and that the objectives are being met. CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.	Q1 & Q2 Q1 Continual Monitoring
3: Fraud bribery and corruption risk assessment	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk	

Gov s013 / NHS Requirement	Objective	Proposed Delivery
NHS Requirement 3: The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud	to be recorded in line with the organisations Risk Management Policy and entered on to the appropriate risk registers. All risks identified to be assessed and remedial action identified and reported to key stakeholders. All matters arising to be reported to DoF and AAC by way of counter fraud progress reporting. Counter Fraud department to develop a fraud risk profile upon the CLUE case management system in order to effectively evaluate, evidence and measure the effectiveness of counter fraud risk assessment work with a view to reducing fraud to an absolute minimum. Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year as a result of local identification or if informed by CFA Fraud Prevention Notices and national exercises. All risk analysis work to be subject to timed ongoing review to assess if recommendations acted upon.	Dynamic – throughout the year as the need arises Ongoing throughout the Year Ongoing throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
risks within any associated sub company of the NHS organisation.	CF manager to explore with Corporate Governance the preferred method of reporting and recording risk, including the maintenance of a register review. (To compliment the recording upon CLUE) Where resource implications are present priority to be given to those areas identified as higher risk.	Q1& Q2
4: Policy and response plan NHS Requirement 4: The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF Manager to establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. Counter Fraud team to promote awareness of the policy at presentations and through newsletters. CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.	Q1 Throughout the Year Q3 & Q4

Gov s013 / NHS Requirement	Objective	Proposed Delivery
5: Annual action plan NHS Requirement 5: The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	CF Manager to complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period. CF Manager to ensure the plan is agreed by DoF, ratified by AAC and is informed by national and local risk and is aligned to organisational objectives and CFA Strategy. CF Manager to ensure that the provision of the CF function is written in to the overall organisation plan. CF manager to provide quarterly reports to AAC. CF manager to provide quarterly statistics to Counter Fraud Service Wales. CF manager to provide annual report measuring the effectiveness of the plan.	Q4 (Due to change of manager 22/23 plan provided Q1 as agreed by AAC) Q1 Q1 Throughout the Year Q4

Gov s013 / NHS Requirement	Objective	Proposed Delivery
6: Outcome-based metrics NHS Requirement 6: The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	The new contact, enquiry and reporting methods being developed by the CF Team will benefit from the automatic facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team. Where necessary regular review will be used to inform change. Data will be collected in relation to the amount of fraud awareness work is carried out. In turn the effectiveness of these actions will be measured by how many enquiries/actions are generated on a newly developed internal interactive Counter Fraud Enquiry/Referral Form. A new local incident reporting form is to be created in order that all enquiries made to the team are recorded an have an audit trail not just those that are logged on the CLUE system.	Development and Implementation Q1 Data collection throughout the year Development and Implementation Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	The development of a generic email account (hosted by CAVUHB) will take place in order to assist in the process of this.	Q1 development and implementation
	Interactive feedback forms will be developed and utilised to measure the effectiveness of the service supplied by the CF team throughout the year.	Throughout the Year
	Locally and nationally informed risk assessments will be recorded according to local policy and using the CLUE case management system and will and a suitable review date added to check upon progress of recommended remedial action. These items will also be shared automatically with the Internal audit department and reported to the AAC.	Throughout the Year
	All investigations will be recorded and Managed on the CLUE case management system and reported to AAC via the Audit Committee quarterly reporting	Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA. All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	
7: Reporting routes for staff, contractors and members of the public NHS Requirement 7: The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and	CF team to undertake a project of assessing the current infrastructure in place for the reporting of concerns and making of general enquiries from all groups. This will involve infrastructure development to include the creation a dedicated Counter Fraud Enquiry email address, the development of interactive referral/awareness request forms available internally to provide a dedicated route of reporting and enquiry	Q1 & Q2 Implementation Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	to staff (incorporating an anonymised version to provide assurance to the reporter), liaison with the Communications Department in order to ensure that this process and route is promoted in the most effective way in order to give the CF Fraud team have a brand identity and presence. CF manager to arrange and meet with Communications team in order to discuss the creation of a dedicated CF page on the organisation's intranet. Ongoing review of the effectiveness of the work undertaken via data analytics and where necessary remedial action to take place dynamically throughout the year. Continuance of promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA.	Q1 Throughout the Year Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	Ongoing events throughout the year such as half-day events at key premises promoting the reporting methods available to all groups. E.g. DHCW HQ.	
8: Report identified loss NHS Requirement 8: The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises	CF team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting. CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. H Bales to be added upon accreditation as ACFS. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated . CF manager to oversee live investigations on CLUE.	Ongoing throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting. CF manager to provide direction to IO concerning case management where necessary. CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and AAC at progress updates and at year end in Annual report.	Ongoing throughout the Year
9: Access to trained investigators NHS Requirement 9: The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work	The organisation currently employs/has access to provision from, three fully accredited, nominated and qualified LCFS. The team has a further member who is currently undertaking ACFS training course. Target date for accreditation July 2022. Nomination to CFA to follow accreditation and to be actioned by CF manager. All members work on a full-time basis.	Throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.	All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. All staff will keep abreast of changes and updates to legislation and undertake training as necessary. All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. CF team will undertake continuing professional development opportunities associated with role throughout the year as they become available. All staff to maintain full compliance with mandatory training/e learning as measured on the ESR system.	Throughout the Year Throughout the Year Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to relevant IT systems, data systems and access to NHS Wales) All training and development to be recorded on ESR and referenced during annual staff appraisals.	Throughout the Year
10: Undertake detection activity NHS Requirement 10: The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are	CF team to undertake national exercise work as it is published by NHS CFA throughout the year. CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Health Boards and Special Health Authorities. CF team will undertake Local Proactive exercises in response to locally identified risk with a view to	Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	identifying if fraud has occurred. Remedial action will be reported as appropriate and any necessary investigative action undertaken. CF Manager to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Communications Department and HR to foster relationships improve awareness of CF department and function. CF Manager to agree to a joint working protocol with Internal Audit and to meet with Head of IA on a quarterly basis to discuss ongoing areas of mutual concern. CF team will engage with investigators from other organisations and agencies where necessary	Throughout the Year Throughout the year (with the aim of scheduling regular quarterly catch ups.) Quarterly and as required Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	(including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption. CF team to make use of NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.	As required
11: Access to and completion of training NHS Requirement 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard	CF team to assess whether Fraud Awareness training is mandatory and a standing item of agenda at all corporate inductions. CF manager to liaise with workforce / education and development directorates accordingly if this is not the case in order to drive forward. CF team to develop/maintain an up to date e-learning module for staff to undertake.	Q1 Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to • Digital banners on organisation intranet site • Regular publishing of Counter Fraud news items via Counter Fraud Newsletter • Regular messaging across available social media systems • All staff email bulletins to advise of fraud alerts • Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation • The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate in order to provide face to face contact with staff promoting the work of the team and its function	Development and implementation to take place Q1 Delivery throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF team to fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide. CF team to fully participate in National Counter Fraud Week initiative.	 Q3
12: Policies and registers for gifts and hospitality and COI. NHS Requirement 12: The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested	CF manager to assess whether a conflicts of interest/business conduct policy is in place and is in date. CF team to assess whether a register for conflicts of interest, gifts and hospitality is in place and in date and being utilised effectively. CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters.	Q1 & Q2 Q1 & Q2 Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review.	Throughout the Year

DIGITAL HEALTH AND CARE WALES
COUNTER FRAUD PROGRESS REPORT

Agenda Item	4.7

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Gareth Lavington, Counter Fraud Manager
Presented By	Gareth Lavington, Counter Fraud Manager

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to NOTE the contents of the report that relate to the Counter Fraud work carried out in period one of the financial year 2022-2023.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: 20/06/2022
No, (detail included below as to reasoning)	Outcome: NA
Statement: NA	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
CVUHB	Cardiff and Vale University Health Board		

2 SITUATION/BACKGROUND

2.1 The Audit and Assurance Committee are required to receive quarterly Counter Fraud reports to provide assurance that the organisation has a robust Counter Fraud Bribery and Corruption provision.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The progress made in the Counter Fraud Provision for DHCW during the first quarter of 2022-2023 (1st April 2022-20th June 2022) can be found in full at item 4.7i.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee.

5 RECOMMENDATION

5.1 The Committee is being asked to NOTE the contents of the report that relate to the Counter Fraud work carried out in period one of the financial year 2022-2023.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Executive Director of Finance	16/06/2022	Approved

NHS WALES
Digital Health Care Wales
(DHCW)

Counter Fraud Progress Report
01/04/2022 – 20/06/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of DHCW from the 1st April 2022 to the 20th June 2022.

The report's format has been adopted in order to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 20th June 2022, 15 days of Counter Fraud work have been completed against the agreed 40 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response and staff awareness.

The breakdown of these days is as follows:

TYPE	Days
Proactive	15
Reactive	0

2. Progress

The Counter Fraud Annual Plan 2022/2023 and the Annual Counter Fraud report 2021/2022 have now both been completed and approved by Executive Director of Finance. They are to be submitted to the AAC for review and approval on 4th July 2022

Staffing

On the 1st April 2022 the new Counter Fraud Manager commenced employment with CAVUHB. This means that the Counter Fraud department now has a team of four personnel. Three are fully accredited (ACFS) the fourth member of the team is a fully qualified investigator joining from a police background and is currently undertaking his ACFS accreditation - the projected time for completion and subsequent nomination to the counter fraud authority is June/July 2022. The new Counter Fraud Manager is a fully accredited LCFS and qualified fraud investigator. This team has the responsibility to provide the Counter Fraud service for five other NHS organisations and this staffing level allows for a maximum provision of 40 days Counter Fraud work per annum to DHCW.

Activity

Infrastructure/Annual Plan

During this reporting period, the main focus has been placed upon developing and getting underway the implementation the Counter Fraud Plan for 2022-2023. This plan has been written and approved at executive level and is now aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The plan states proposed actions throughout the year. In tandem with any investigation work that is referred and requires action, the main focus of the team in the first quarter of the reporting period (April-July) has been to review and improve the Counter Fraud infrastructure in relation to awareness of fraud in the NHS, awareness of the Counter Fraud Team, addressing any shortcomings in relation to reporting routes and contact for staff members, and identifying the presence and status of relevant policy documents. So far this has led to the following actions been undertaken -

a. The creation and implementation of a dedicated generic email address – the aim is for this to lead an additional reporting route open to staff that will compliment existing routes; will assist in recording activity generated as a result of awareness work; and will double as a dedicated incident reporting

and logging tool which automatically collects data and allows for accurate recording of outcome metrics. ***Complete***

b. The creation of a comprehensive activity database that will assist in maintaining a detailed record of work undertaken with a view to saving resource time in relation to corporate governance. ***Complete***

c. The creation of a new, up to date, interactive and dedicated Counter Fraud enquiry form and a separate Awareness session request form. Accessible by links and QR coding. These are easily available to all staff and aim to provide an additional, more effective, and speedy route to the team that compliments the national reporting line. The enquiry form is provided below (click on following link Counter Fraud Enquiry Form) ***Complete***

d. Review of the Counter Fraud Bribery and Corruption Policy – DHCW use the All Wales Counter Fraud Bribery and Corruption Policy. This requires review and updating. Liaison has been made with NWSSP and this is underway. ***Ongoing***

e. Review of CF digital presence – Counter Fraud have, historically, had very little presence within DHCW digitally. Enquiries and meetings with Comms Department undertaken. Agreed that a bi-monthly newsletter will be completed by the team and forwarded to comms for inclusion in the 'Insider'. Whilst the newsletter is a useful method of updating staff with all things fraud it acts also as an awareness tool highlighting the presence of the team, the work it does and the easy methods that staff can use to make contact. Further to this all fraud alerts, bulletins to be shared with comms team in a timely manner and distributed accordingly by them throughout DHCW staffing cohorts. Work is underway to develop a fit for purpose Intranet Site that can be accessed by all NHS organisations that a service is provided to. This will be hosted by CAVUHB and when complete will be appropriately signposted within DHCW. This strategy aims to build and re-enforce an anti-fraud culture throughout the organisation. ***On-going***

f. Joint working protocol with Internal Audit agreed with Head of Internal Audit and regular meetings scheduled throughout the year to assist in this protocol ***Complete***

g. Review of Counter Fraud e-Learning arrangements – whilst eLearning available on ESR – it is not a mandatory module at this time. Statistics show

that those Health Bodies that include this as mandatory training have a markedly better uptake against those that don't. Liaison to be made with Workforce departments with a view to making this training mandatory. In addition to this work is underway with the LED team at CAVUHB to develop a modern fit for purpose learning site on the All Wales Learning at Wales Platform. When complete this will be available to all DHCW staff as an education and awareness tool that will be signposted internally within the organisation ***On-going***

h. The team have been liaising with Workforce and OD department in relation to instating counter fraud as a standing awareness session at Corporate Induction. ***On-going***
i. Three Mandate/Invoice fraud awareness sessions arranged in July to be presented virtually by the CF team to relevant staffing groups within the organisation. ***On-going***
j. Meetings requested to gain a better understanding of the bespoke nature of the organisation in order to better understand fraud risk. ***On-going***

Alerts/Bulletins

During this reporting period, **two fraud alerts** have been issued:

1. To all fraud champion for cascading to relevant staffing groups in relation to mandate fraud (Appendix 1)
2. To all staff in relation to a prevalent scam in relation to Dell Computers. (Appendix 2)

Awareness Sessions

During this reporting period no fraud awareness sessions has been delivered to DHCW staff.

Arrangements are underway to deliver sessions to staff in relation to general fraud awareness. Firm arrangements are diarised for July and onwards in relation to mandate fraud. Outcome of discussions with Workforce and OD in relation to Counter Fraud being included in corporate induction are, that at this

time there is no space in the session as conducted virtually. When it returns to in person then this can hopefully be achieved.

Newsletters

During the reporting period one newsletter has been produced. (Appendix 3)

Fraud Prevention Notices and IBURN notices

During this reporting period one FPN has been issued by the NHS CFA. This was in relation to the risks associate with Credit Card terminal fraud taking place elsewhere in the NHS. A brief investigation carried out and awaits results from the organisation whether Credit Card Terminals are in use and whether best practice (issued) is being followed. Reported upon CLUE database accordingly.

Referrals/Enquiries

During this reporting period the CAVUHB CF team have received 0 referrals via the online enquiry form from DHCW staff.

3. Investigations

At 1st April 2022 there were zero (0) investigations open. In this reporting period no referrals have been received in relation to DHCW.

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20 May 2022

Fraud Alert – Mandate Fraud

For attention of all staff working in NHS finance and payroll teams, particularly those responsible for setting up bank account details and processing bank payments:

Please be reminded that mandate fraud is a real risk to the organisation that has the potential, if successful, to cause substantial financial loss.

Recent attempts to change bank details have involved fraudsters impersonating the following legitimate supply companies:

Vanguard Healthcare Solutions, 4C Strategies Ltd, Inovus Ltd, Accomplish Group Ltd, Centre Great Ltd

Staff are reminded to be extremely vigilant in relation to changes to banking details relating to the companies named above and also to any other company/ supplier to your organisation.

Staff are to ensure that they follow the robust financial procedures in place and to refresh their knowledge using the guidance issued by the NHS Counter Fraud Authority Quick Guide.

Should any staffing group require an awareness input in relation to this area from the Counter Fraud Team then please click on the awareness session request form below.

Likewise, If you or your staffing group require a copy of the NHS CFA quick guide to mandate fraud please follow this LINK or email us at the below address.

Counter Fraud Enquiry Form (LINK)

Report any concerns or queries to the Counter Fraud Team using the link above or QR code.

Awareness Session Request (LINK)

Request an Awareness Session/ Input from Counter Fraud using the link above or QR code.

CounterFraudEnquiries.CAV@wales.nhs.uk

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Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

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12th April 2022

Fraud Alert

Social Engineering – Phone Calls Regarding Dell Computers

Information has been received at Digital Health and Care Wales Counter Fraud Department from a local Health Board regarding a recent suspicious phone call that had been made to a member of staff.

A member of staff reported they had received a telephone call from a person reporting to be from Dell computers. The caller was asking for details about their work's computer.

Staff should not provide any information about details of their computers or their login information to someone over the telephone.

You will only be contacted over the telephone by the ICT Department if you have logged an incident with the ICT Service Desk. If you have logged an incident there will be a call reference number (you would have received a confirmation email after logging the call) and you **must** ask the caller on the telephone to provide you with this (**do not read it out to them**). If you are suspicious about the person on the end of the telephone, immediately end the call, and report it to the ICT Department.

If you are worried about family members, friends or yourself being scammed there is plenty of advice available online at: Action Fraud – National Fraud & Cyber Crime Reporting Centre | National Cyber Security Centre

Local Counter Fraud Team

If you would like more information about fraud or to raise a concern please contact one of your Local Counter Fraud Specialists by Email, Phone or drop into the office.

Gareth Lavington
Tel: 029218 36265
Gareth.Lavington2@wales.nhs.uk
Counter Fraud Manager

Nigel Price
Tel: 029218 36481
Nigel.Price@wales.nhs.uk
Local Counter Fraud Specialist

Emily Thompson
Tel: 029218 36262
Emily.Thompson@wales.nhs.uk
Local Counter Fraud Specialist

Henry Bales
Tel: 029218 36264
Henry.Bales@wales.nhs.uk
Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

Report any suspicions or concerns about fraud in the NHS to the NHS Counter Fraud Authority at https://cfa.nhs.uk/reportfraud or by calling 0800 028 4060 (available 24 hours)
All reports are treated in **confidence**, and you have the option to report **anonymously**. Alternatively, you can also speak to your LCFS.

Counter Fraud Newsletter

May 2022

CAVUHB | Velindre | HEIW | PHW | NWSSP | DHCW

Local Counter Fraud Specialists (LCFS)

Welcome to the May 2022 edition of the Counter Fraud Newsletter

The Counter Fraud Department has gone through some changes recently, the contact details for all of the team members is on the second page of the newsletter. We have also recently introduced a generic email account for that can also be used to contact the team:

CounterFraudEnquiries.CAV@wales.nhs.uk

It is probably important at this point to remind everyone that although we are based in Cardiff and Vale UHB we do provide the counter fraud services to all six organisations listed above, so please do not be put off by the CAV email if contacting us from one of our other organisations!

Counter Fraud Enquiry Form (link)

- Click on the above link or scan the QR code to access our new form that can be used for any general enquiry to the counter fraud department and/or to report any concerns you may have in relation to a fraud or possible fraud being committed against the organisation.
- It is completely anonymous, we will only know your details if you choose to supply them.
- All enquiries are treated confidentially whether you provide your details or not.
- Providing your details often makes it easier to investigate a report.

Fraud Awareness Sessions (link)

- Click on the above link or scan the QR code to access a new form that allows you to request an input for your department/team/ organisation for Counter Fraud Awareness.
- These sessions can be in person or via Teams and can be a general awareness session or more specific to your needs (such as providing specific sessions on Mandate Fraud etc).

Fraudulent practice manager brought to justice by NHS counter fraud investigation

Julie Ann Stevenson, a 63-year-old former NHS Practice Manager at Castle Surgery, Neath, has been sentenced for the crime of defrauding the Practice and the NHS Pension Authority over an 18-month period, thus gaining in excess of £35,000 in remuneration and pension that she was not entitled to.

She was sentenced to 6 months' imprisonment, suspended for 12 months at Swansea Crown Court.

More details can be found here: Fraudulent practice manager brought to justice by NHS counter fraud investigation. nhs.uk)

Fraud E-Learning Package - ESR

There is an online Fraud Awareness learning package that can be accessed through ESR. Although this is not a mandatory package at this time it is a valuable course that will take under half an hour to complete.

It has been estimated that the NHS' vulnerability to fraud, bribery and corruption leads to a loss of £1.14 billion (2019-2020) we all have our part to play in protecting the organisation from this activity. You are encouraged to learn more by carrying out the learning provided.

The course can be accessed here: Fraud Awareness E-Learning

NHS fraud. Spot it. Report it. Together we stop it.

Local Counter Fraud Team

The counter fraud department has a **new online reporting tool** which can be accessed from the link or by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the Fraud Department. Any information provided is treated **confidentially**.

Counter Fraud Enquiry Form (link)

CounterFraudEnquiries.CAV@wales.nhs.uk

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DIGITAL HEALTH AND CARE WALES
RISK MANAGEMENT REPORT

Agenda Item	5.1

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Sophie Fuller, Head of Corporate Governance
Presented By	Chris Darling, Board Secretary

Purpose of the Report	For Discussion/Review

Recommendation

The Audit and Assurance Committee is being asked to:
NOTE the status of the Corporate Risk Register and Board Assurance Report.
DISCUSS the Corporate Risks, particularly those assigned to the Audit and Assurance Committee.
NOTE the Risk and Board Assurance Milestone Plan and progress to date

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	All are relevant to the report

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	ISO 9001
If more than one standard applies, please list below: ISO 14001, ISO 20000, ISO 27001, BS10008	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below: Safe Care, Effective Care	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Risk Management and Assurance activities, equally affect all. An EQIA is not applicable.	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	Additional scrutiny and clear guidance as to how the organisation manages risk has a positive impact on quality and safety.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	Should effective risk management not take place, there could be legal implications
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below
	Should effective risk management not take place, there could be financial implications
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
BAF	Board Assurance Framework		

2 SITUATION/BACKGROUND

2.1 The DHCW Risk Management and Board Assurance Framework (BAF) Strategy was endorsed by the Audit and Assurance Committee and Digital Governance Committee and Safety and approved formally at the SHA Board on the 26 May 2021. This outlined the approach the organisation takes to managing risk and Board assurance.

2.2 Work across the year on the Board Assurance Report has resulted in the final BAF dashboard report being approved at the SHA Board Meeting on 26 May 2022, this can be seen as item 5.1i Appendix A. Further updates and validation were identified and will be received at the 28 July 2022 SHA Board Meeting. These included the risk appetite for the strategic missions to be owned by the relevant Executive Owner and final validation of the timescales for delivery of the gap actions plans.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Committee members are asked to consider risk, in the context of assurance 'what could impact on the Organisation being successful in the short term (1 – 12 months) and in the longer term (12 – 36 months)'.

3.2 DHCW's Corporate Risk Register currently has 22 risks on Register, 13 are detailed at item 5.1ii Appendix B. The other 9 are security related and are considered at every Digital Governance and Safety Committee in private session as per the Committee assignment approach.

3.3 Committee members are asked to note the following changes to the Corporate Risk Register (new risks, risks removed and changes in risk scores) since the last report:

NEW (6) 1 Private, 5 Public
A number of risks have been escalated to the Corporate risk register since the last meeting, these are as below:

Risk Ref	Risk Title	Risk Description	Primary Impact Domain
DHCW0284	Increased Utility Costs Financial Pressure	IF utility costs increase significantly (circa £620k per annum) as expected THEN cost will exceed those normally	Financial

		budgeted for RESULTING IN increased facilities costs and financial pressures	
DHCW0285	Unfunded NI increase	IF the additional 1.25% employer NI contributions are unfunded centrally THEN DHCW will have a cost pressure of £319k in 22/23 RESULTING IN DHCW's ability to breakeven.	Financial
**DHCW0286	***PRIVATE***		
DHCW0287	Digital Priorities Investment Funding (DPIF)	IF DPIF budgets are requested to be significantly re-profiled (greater than £2.5 million) THEN the completion of planned developments will not be possible with associated supplier payment issues RESULTING IN reputational damage, non-delivery of investments, cost pressures and potential legal challenge.	Development of Services
DHCW0288	Data Centre Migration Revenue Funding	IF Data Centre migration activity takes place in 2022/23 THEN additional cost pressures will emerge RESULTING IN a requirement to source additional funding.	Service Delivery
DHCW0289	Digital Inflation	IF supply chain issues (such as the chip shortage) and underlying digital price pressures have a negative impact upon prices THEN there will be additional price increases RESULTING IN higher cost equipment and maintenance contracts.	Service Delivery

REMOVED (5) 3 Private, 2 Public

Risk Ref	Risk Title	Risk Description	Primary Impact Domain
DHCW0201	Infrastructure Investment	IF recurrent funding is not available to support the replacement of obsolete infrastructure, THEN the risk of failure and under performance will increase RESULTING in service disruption.	Service Delivery
**DHCW0276	**PRIVATE**		
**DHCW0283	**PRIVATE**		
DHCW0273	Welsh language Two Way Text	IF the Two-Way Text Solution launches in English only THEN this is in breach of Welsh Language legislation RESULTING in reputational harm to NHS	Development of Services

		Wales/DHCW and Welsh Language citizens being disadvantaged by the offering.	
**DHCW0261	**PRIVATE**		

SCORE CHANGES

There have been no other risk score changes since the last meeting.

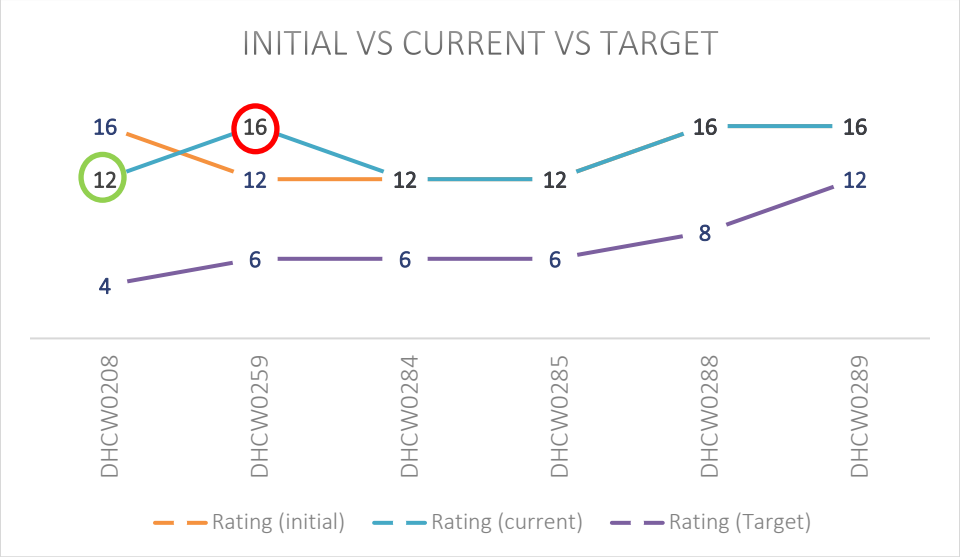
3.4 The Committee are asked to consider the DHCW Corporate Risk Register Heatmap showing a summary of the DHCW risk profile. The key indicates movement since the last risk report.

CONSEQUENCES	LIKELIHOOD: RARE (1)	UNLIKELY (2)	POSSIBLE (3)	LIKELY (4)	ALMOST CERTAIN (5)
CATASTROPHIC (5)			**DHCW0257 ⟷ **DHCW0277 ⟷ **DHCW0278 ⟷ **DHCW0279 ⟷ **DHCW0280 ⟷ **DHCW0281 ⟷ **DHCW0282 ⟷	DHCW0204: **Canisc System** ⟷	
MAJOR (4)			DHCW0208: **Welsh Language Compliance** ⟷ DHCW0228: **Fault Domains** ⟷ **DHCW0229 ⟷ DHCW0263: **DHCW Functions** ⟷ DHCW0264: **Data Promise** ⟷ **DHCW0286 ★	DHCW0237: **Covid-19 Resource Impact** ⟷ DHCW0259: **Staff Vacancies** ⟷ DHCW0269: **Switching Service** ⟷ DHCW0287: **Digital Priorities Investment Funding** ★ DHCW0288 – **Data Centre Migration Revenue Funding** ★ DHCW0289 – **Digital Inflation** ★	
MODERATE (3)				DHCW0284 – **Increased Utility Costs Financial Pressure** ★ DHCW0285 – **Unfunded NI Increase** ★	
MINOR (2)					
NEGLIGIBLE (1)					

**Private risks

★ New Risk ⟷ Non-Mover ↓ Reduced ↑ Increased

3.5 The Committee are also asked to consider the risks assigned to the Committee, the overview of initial risk score versus current versus target and risks that may be identified for further investigation and action. Those highlighted with a red circle represent those risks with a score increased from their initial scoring, those in green have reduced their current score below initial scoring, the remainder are the same as their initial score.



3.6 All the risks on the Corporate Risk log are assigned to a Committee as outlined in the Risk Management and Board Assurance Framework Strategy to provide the SHA Board with the necessary oversight and scrutiny. As previously stated, the private risks are reviewed in detail by the Digital Governance and Safety Committee in a private session. There are six risks assigned to the Audit and Assurance Committee:

- DHCW0259 Staff Vacancies
- DHCW 0288 Data Centre Migration Revenue Funding
- DHCW0289 Digital Inflation
- DHCW 0208 Welsh Language Compliance
- DHCW 0284 Increased Utility Costs Financial Pressure
- DHCW 0285 Unfunded NI increase

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The Committee is asked to note the changes in the risk profile during the reporting period as a result of six new risks being added and five risks being removed from the Corporate Risk Register.

4.2 The Risk Management and Board Assurance Framework plan is included at item 5.1iii Appendix C which details the progress to date for the Risk Management and Board Assurance Framework Strategy implementation. The final milestone was completed, and the SHA Board approved the principal risks at the 26th of May 2022 meeting.

5 RECOMMENDATION

5.1 The Audit and Assurance Committee is being asked to:
NOTE the status of the Corporate Risk Register and BAF Report.

DISCUSS the Corporate Risks, particularly those assigned to the Audit and Assurance Committee.
NOTE the Risk and Board Assurance Milestone Plan and progress to date.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Risk Management Group	7 June 2022	Discussed and verified

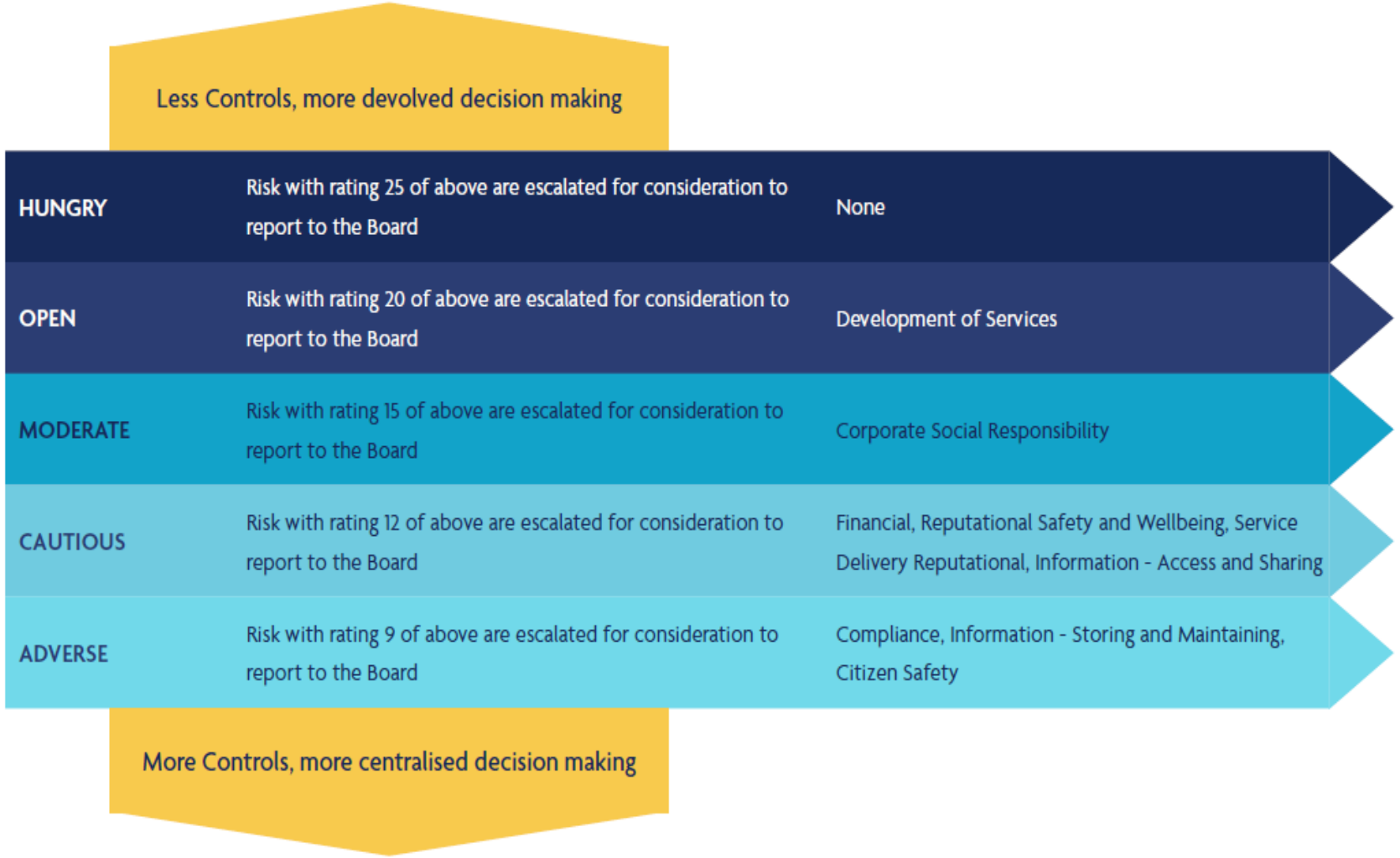
The Board Assurance Report Dashboard

Digital Health and Care Wales

DHCW Risk appetite statement and tolerances

DHCW RISK APPETITE

- DHCW must take risks to achieve its strategic ai and deliver beneficial outcomes to stakeholders
- Risks will be taken in a considered and controlle manner
- Exposure to risks will be kept to a level of impact deemed acceptable by the Board
- The acceptable level may vary from time to time and will therefore be subject to at least annual review and revision
- Any risk outside our agreed appetite may be accepted and will be subject to a governance process to ensure visibility and management
- Some particular risks above the agreed risk appetite may be accepted because:
  - the likelihood of them occurring is deemed to be sufficiently low
  - they have the potential to enable realisation of considerable reward/benefit
  - they are considered too costly to control given other priorities
  - the cost of controlling them would be greater than the cost of the impact should they materialise
  - there is only a short period of exposure to them
  - mitigating action is required by an external party



Principal risk summary

The Principal risk summary gives an overview of the Principal risk in relation to each of the DHCW strategic objectives and the rationale for the scoring.

Type	Detail	Current risk score and rationale	Target risk score and rationale
OBJ	**1. Enabling Digital Transformation supporting joined up, consistent care**		
PR	IF we do not co-design safe and secure services with users supported by common standards and collaborative ways of working THEN our development may not meet user needs RESULTING IN not being able to digitally transform services at pace	**16 - 4 (Likely) x 4 (Major)** This risk score is derived from our analysis of systems as part of developing new strategies over the last twelve months.	**4 – 1 (Rare) x 4 (Major)** Each of our strategies addresses complexity and silos through a commitment to standards based open architecture, which is intended to streamline and simplify our systems and delivery interoperability.
OBJ	**2. Delivering high quality technology, data products and services to support efficiencies and improvements in care processes**		
PR	IF we do not deliver safe, secure, accessible, resilient products and services of high quality THEN the ability of health and care partners to deliver and modernise services is compromised RESULTING IN less effective, less sustainable care that could cause harm and would not meet the expectations of patients or professionals.	**9 - 3 (Possible) x 3 (Moderate)** Established operational support is in place and work has been undertaken in recent years to improve the availability and security of the services, but further action is needed to ensure resilience and security is at the required level.	**4 – 2 (Unlikely) x 2 (Minor)** There are clearly articulated plans for the activity required to increase the resilience and security of the system which should reduce the risk to an acceptable level with careful scrutiny and monitoring.
OBJ	**3. Expanding the content, availability and functionality of the digital health and care record so that care and treatment quality is improved**		
PR	IF we fail to expand the content, availability and functionality of the Digital Health and Care Record at the required pace THEN information could be incomplete, inconsistent, or held in different places RESULTING IN a reduced ability to use information to inform care and empower citizens, leading to better outcomes.	**12 – 3 (Possible) x 4 (Major)** The digital health and care record has developed over recent years, but we know this expansion must continue at pace to ensure that patients and clinicians have the best possible information to support the achievement of high quality care outcomes.	**6 – 2 (Unlikely) x 3 (Moderate)** The new NDR strategy has set out a clear and prioritised road map for the single health record along side development in digital services such as WCP and WNCR. We will continue to explore enhanced functionality supporting use cases in the strategy and using AI.
OBJ	**4. Driving Value and innovation for better outcomes and value based care**		
PR	IF we do not focus on making use of data and innovation to improve outcomes THEN we may not be optimising value for citizens RESULTING IN less sustainable health and care services and reduced or delayed benefit for the public and patients.	**16 – 4 (Likely) x 4 (Major)** Fragmented approaches to driving value from data may result in lost opportunities to innovate, enhance operational delivery and improve health and care outcomes.	**12 – 3 (Possible) x 4 (Major)** A best practice approach and operating model to sharing data for operational delivery, research and innovation.
OBJ	**5. Becoming the trusted strategic partner and a high performing, inclusive, ambitious organisation supporting our workforce and stakeholders**		
PR	IF we do not become a trusted partner and a high performing inclusive organisation THEN people will not want to work with and for us RESULTING IN a failure to achieve our strategic ambition of delivering world leading digital services.	**15 – 3 (Possible) x 5 (Catastrophic)** As a new organisation the initial risk score reflects the work still to do in terms of continuing to be a learning organisation which will support recruitment and retention of staff as well as working collaboratively with partner organisations . This includes the implementation of the DHCW organisational structure and approach across the organisation.	**5 - 1 (Rare) x 5 (Catastrophic)** There are multiple activities that contribute to the delivery of the strategic objective and these include a focus on the digital workforce, recruiting and retaining the best talent, being organised in the most efficient and effective way, as well as working in a high trust environment with partners to enable digital transformation.

Principal risk heat map

Progress Report

The planned activity for the principal risks is for action April 22 – March 23 with aim to move towards or achieve the target risk score by then. The report will be presented to the SHA Board in May and November each year, it will provide a self assessment RAG status from the objective/mission owner to indicate the current areas of concern. Additionally it will give an overview of progress on the action plans to address any gaps and will provide narrative as to the trajectory of the principal risks.

Starting points for each risk are shown by numbers corresponding to the objective/mission in the heat map to the right, in future reports changes in score will be indicated through movement along the black line. Should a risk increase in score this will be highlighted by a dotted line and the number will be moved to that space.

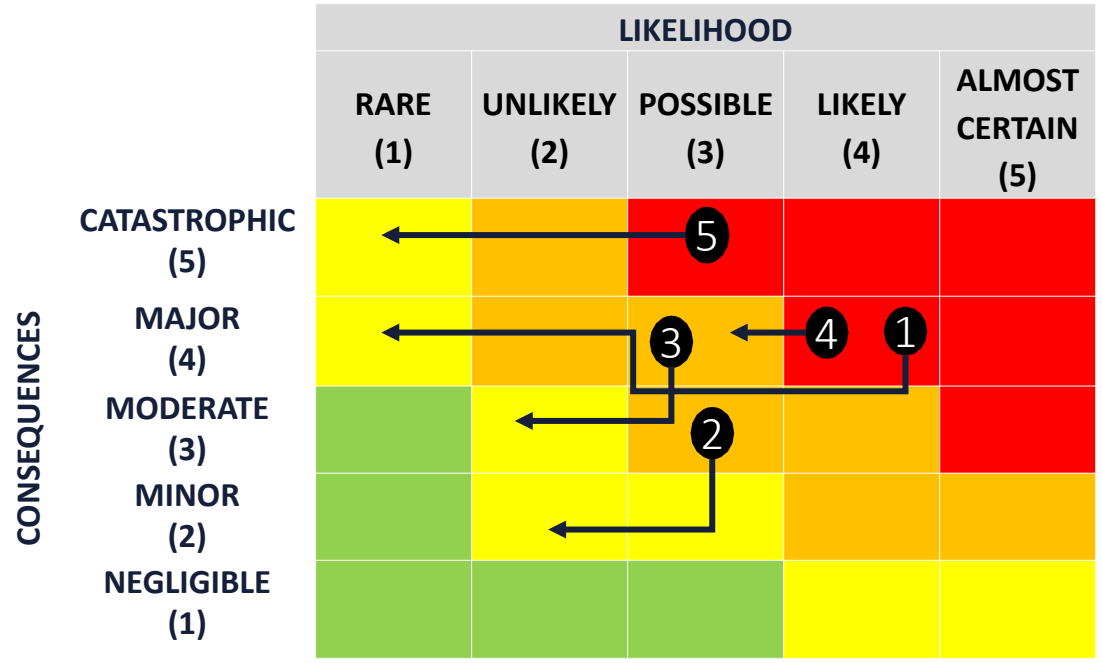
Strategic Principal Risk Impact Statement

Should any of the strategic risks being realised the consequence would include potential of harm to patients, impacts on the working conditions of staff, poor quality service, failure to achieve the required digital transformation at pace, potential litigation at both a corporate and personal level with financial and/or penal sanctions and/or significant reputational damage which could threaten the future of the organisation and it's success.

Questions to ask yourself:

- Is the progress of the action plans later in the report sufficient to achieve the target score?
- Are you satisfied the principal risks are still accurate and reflective with reference to the delivery of the strategic objectives?

Residual Principal Risk Severity Map (showing direction of travel to target)



Assurance Summary

Key – Control and assurance RAG Rating		
	LOW NUMBER OF CONTROLS IN PLACE	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
	MEDIUM NUMBER OF CONTROLS IN PLACE	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
	HIGH NUMBER OF CONTROLS IN PLACE	Controls in place assessed as adequate/effective and in proportion to the risk
	INSUFFICIENT DATA TO PROVIDE A RAG	Insufficient information at present to judge the adequacy/effectiveness of the controls

Type	Detail	Associated risk impact domain		Risk Appetite	Risk Appetite rationale/likely scenario	Assurance Self-Assessment
M	**1. Enabling digital transformation supporting joined up, consistent care**	• Reputational • Development of services • Information – Access and Sharing • Information – Storing and maintaining	• Financial • Service Delivery • Patient/Citizen Safety • Corporate Social Responsibility	**CAUTIOUS**	DHCW will accept a small amount of risk in ensuring compliance with information governance, information security and cyber security. We will manage the associated corporate risks at their appetite levels to protect against the potential consequences.	
PR	IF we do not co-design safe and secure services with users supported by common standards and collaborative ways of working THEN our development may not meet user needs RESULTING IN not being able to digitally transform services at pace					
M	**2. Delivering high quality technology, data products and services to support efficiencies and improvements in care processes**	• Patient/Citizen Safety • Development of services • Service Delivery	• Financial • Information – Access and Sharing • Compliance	**CAUTIOUS**	DHCW will accept a small amount of risk in the provision of secure and resilient high quality digital services. Where we are developing services we will take more risks.	
PR	IF we do not deliver safe, secure, accessible, resilient products and services of high quality THEN the ability of health and care partners to deliver and modernise services is compromised RESULTING IN less effective, less sustainable care that could cause harm and would not meet the expectations of patients or professionals.					
M	**3. Expanding the content, availability and functionality of the digital health and care record so that care and treatment quality is improved**	• Reputational • Patient/Citizen Safety • Development of services • Service Delivery	• Financial • Corporate Social Responsibility • Compliance	**MODERATE**	DHCW will accept a moderate amount of risk to deliver successful expansion of the digital health and care record with input from users. We will carefully manage the associated corporate risks with a focus on prioritising any patient/citizen safety risk concerns.	
PR	IF we fail to expand the content, availability and functionality of the Digital Health and Care Record at the required pace THEN information could be incomplete, inconsistent, or held in different places RESULTING IN a reduced ability to use information to inform care and empower citizens, leading to better outcomes.					
M	**4. Driving Value and innovation for better outcomes and value based care**	• Reputational • Information – Access and Sharing	• Development of services	**OPEN**	DHCW will accept risks in the pursuit of driving innovation to achieve better value evidenced by improved outcomes.	
PR	IF we do not focus on making use of data and innovation to improve outcomes THEN we may not be optimising value for citizens RESULTING IN less sustainable health and care services and reduced or delayed benefit for the public and patients.					
M	**5. Becoming the trusted strategic partner and a high performing, inclusive, ambitious organisation supporting our workforce and stakeholders**	• Reputational • Safety and Wellbeing	• Corporate Social Responsibility • Compliance	**MODERATE**	DHCW will accept a moderate amount of risk in the pursuit of becoming recognised as a trusted partner and a high performing inclusive organisation.	
PR	IF we do not become a trusted partner and a high performing inclusive organisation THEN people will not want to work with and for us RESULTING IN a failure to achieve our strategic ambition of delivering world leading digital services.					

MISSION 1: Enabling Digital Transformation supporting joined up, consistent care

EXECUTIVE OWNER: Director of Strategy

REPORTING PERIOD: 1ST April – 30th April 2022

DATE OF REVIEW: 26th May 2022

RAG STATUS: AMBER
Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks

SELF ASSESSMENT ASSURANCE RATING	KEY CONTROLS	ASSURANCE
	TBC	TBC

RISKS

PRINCIPAL RISK 1	CURRENT SCORE	TARGET SCORE
IF we do not co-design safe and secure services with users supported by common standards and collaborative ways of working THEN our development may not meet user needs RESULTING IN not being able to digitally transform services at pace	**16/25** **4 (Likely) x 4 (Major)**	**4/25** **1 (Rare) x 4 (Major)**

Risk Key: ★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

ASSOCIATED CORPORATE RISK/S	CURRENT SCORE	TARGET SCORE
0264 – Data Promise	**4x3 = 12/25**	**1x4 = 4/25**

CONTROLS AND ASSURANCE

KEY CONTROLS GAPS	ACTION PLAN	ASSURANCE GAPS	ACTION PLAN	PROGRESS ON ACTION PLAN – NARRATIVE PROVIDED BY EXECUTIVE OWNER
• Open Architecture Strategy - need to develop implementation plan • NDR Data Strategy - develop an implementation plan • Cloud strategy - develop an implementation plan • National rulebook for accessing open architecture	• Approval of the Open Architecture Implementation plan by SHA Board • Create an implementation plan for the NDR data strategy • Create an implementation plan for the cloud strategy • Create a national rulebook for accessing open architecture and seek approval from the SHA Board	• Lack of organisational reporting on the compliance with the national data standards • Lack of reporting on the delivery of the implementation plans as a result of approval of the NDR data strategy • Lack of reporting on the organisational compliance with the Cloud strategy • Lack of reporting on the effective implementation of the national rulebook for accessing open architecture	• Create a method for monitoring compliance with the agreed standards with reporting to operational and assurance arenas • Create DHCW compliance reporting against the NDR data strategy delivery plan • Create DHCW compliance reporting against the Cloud strategy • Create progress reporting on the effectiveness of the national rulebook	Q1 progress report to be provided to the July Board meeting

MISSION 2: Delivering high quality technology, data products and services to support efficiencies and improvements in care processes

EXECUTIVE OWNER: Director of Operations

REPORTING PERIOD: 1ST April – 30th April 2022 | **DATE OF REVIEW: 26th May 2022**

RAG STATUS: AMBER
Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks

SELF ASSESSMENT ASSURANCE RATING	KEY CONTROLS	ASSURANCE
	TBC	TBC

RISKS

PRINCIPAL RISK 2	CURRENT SCORE	TARGET SCORE
IF we do not deliver safe, secure, accessible, resilient products and services of high quality THEN the ability of health and care partners to deliver and modernise services is compromised RESULTING IN less effective, less sustainable care that could cause harm and would not meet the expectations of patients or professionals.	**9/25** **3 (Possible) x 3 (Moderate)**	**4/25** **2 (Unlikely) x 2 (Minor)**

ASSOCIATED CORPORATE RISK/S

Risk Key: ★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

RISK REFERENCE	CURRENT SCORE	TARGET SCORE	RISK REFERENCE	CURRENT SCORE	TARGET SCORE
0228 – Fault Domains	**4x3 = 12/25**	**3x2 = 6/25**	**0278 - PRIVATE	**5X3 = 15/25**	**2X5 = 10/25**
**0229 - PRIVATE	**3x4 = 12/25**	**3x2 = 6/25**	**0279 – PRIVATE	**5X3 = 15/25**	**2X5 = 10/25**
**0257 – PRIVATE	**5X3 = 15/25**	**5X2 = 10/25**	**0280 – PRIVATE	**5X3 = 15/25**	**2X5 = 10/25**
**0277 - PRIVATE	**5x3 = 15/25**	**2x5 = 10/25**	**0281 – PRIVATE	**3X5 = 15/25**	**2X3 = 6/25**
0287 - Digital Priorities Investment Funding (DPIF)	**4x4 = 16/25**	**3x4 = 12/25**	**0282 - PRIVATE	**3X5 = 15/25**	**2X5 = 10/25**
0289 – Digital Inflation	**4x4 = 16/25**	**3x4 = 12/25**	**0286 – PRIVATE	**3x4 = 12/25**	**2x4 = 8/25**

CONTROLS AND ASSURANCE

KEY CONTROLS GAPS	ACTION PLAN	ASSURANCE GAPS	ACTION PLAN	**PROGRESS ON ACTION PLAN** – NARRATIVE PROVIDED BY EXECUTIVE OWNER
• (User experience): (1) need to more consistently embed feedback on user centred design; (2) No systemic and routine implementation of the feedback across all services. • Product Approach: (1) define implementation plan	• Introduce User Experience Involvement Group; group to oversee implementation of the strategy ensuring consideration of feedback at every level	• Lack of assurance for widespread user experience on the range of systems	• Provide effectiveness reporting to the Product Owner, Senior Management Team and assurance reporting on how user feedback is being considered	Q1 progress report to be provided to the July Board meeting

MISSION 3: Expanding the content, availability and functionality of the digital health and care record so that care and treatment quality is improved

EXECUTIVE OWNER: Director of Strategy

REPORTING PERIOD: 1ST April – 30th April 2022 | **DATE OF REVIEW: 26th May 2022**

RAG STATUS: AMBER
Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks

SELF ASSESSMENT ASSURANCE RATING	KEY CONTROLS	ASSURANCE
	TBC	TBC

RISKS

PRINCIPAL RISK 3	CURRENT SCORE	TARGET SCORE
IF we fail to expand the content, availability and functionality of the Digital Health and Care Record at the required pace THEN local solutions could be sought RESULTING IN disparate data stored outside the single record and potential impact on system wide digital transformation and patient care.	**12 /25** **3 (Possible) x 4 (Major)**	**6 /25** **2 (Unlikely) x 3 (Moderate)**

Risk Key: ★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

ASSOCIATED CORPORATE RISK/S	CURRENT SCORE	TARGET SCORE
0204 – Canisc System	**5X4 =20/25**	**3X2 = 6/25**

CONTROLS AND ASSURANCE

KEY CONTROLS GAPS	ACTION PLAN	ASSURANCE GAPS	ACTION PLAN	PROGRESS ON ACTION PLAN – NARRATIVE PROVIDED BY EXECUTIVE OWNER
• User experience: (1) need to more consistently embed feedback on user centred design; (2) Create systemic and routine implementation of the feedback across all services. • Clinical Feedback: (1) Need to formalise the mechanism for gaining more sophisticated understanding of clinical user need;(2) Continuous feedback from clinical users on the extent to which how digital is supporting joined up consistent care	• Introduce User Experience Involvement Group; group to oversee implementation of new systems on the clinical patient experience ensuring consideration of feedback at every level • Create and seek approval for the clinical user feedback approach	• Reporting of structured feedback on services and systems at a Directorate and organisational level	• Create consistent approach to gathering feedback including establishing user groups to provide feedback • Include learning and action from feedback into the assurance reporting to the relevant Committee	Q1 progress report to be provided to the July Board meeting

MISSION 4: Driving Value and innovation for better outcomes and value based care

EXECUTIVE OWNER: Medical Director

REPORTING PERIOD: 1ST April – 30th April 2022 | **DATE OF REVIEW: 26th May 2022**

RAG STATUS: AMBER
Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks

SELF ASSESSMENT ASSURANCE RATING	KEY CONTROLS	ASSURANCE
	TBC	TBC

RISKS

PRINCIPAL RISK 4	CURRENT SCORE	TARGET SCORE
IF we do not focus on making use of data and innovation to improve outcomes THEN we may not be optimising value for citizens RESULTING IN less sustainable health and care services and reduced or delayed benefit for the public and patients.	**16/25** **4 (Likely) x 4 (Major)**	**12/25** **3 (Possible) x 4 (Major)**

Risk Key: ★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

ASSOCIATED CORPORATE RISK/S	CURRENT SCORE	TARGET SCORE
0269 – Switching Service	**4x4 = 16/25**	**3x2=6/25**
0263 – DHCW Functions	**4x3 = 12/25**	**4x1 = 4/25**

CONTROLS AND ASSURANCE

KEY CONTROLS GAPS	ACTION PLAN	ASSURANCE GAPS	ACTION PLAN	PROGRESS ON ACTION PLAN – NARRATIVE PROVIDED BY EXECUTIVE OWNER
• Information Asset Register (1) Finalise and close project and move to business as usual • Research and Innovation Strategy (1) need to develop the strategy; (2) need to develop implementation plan • Data Promise (1) need to develop the strategy; (2) need to develop implementation plan	• Identify ownership of the 'Asset Register' • Research and Innovation Strategy to be completed for sign off by the DHCW SHA Board • Work with Welsh Government to define requirements and approach for data promise	• Routine reporting to monitor the health of the Information Asset Register • Reporting on progress of implementation of the Research and Innovation Strategy • Reporting on compliance with the elements of the data promise	• Create routine reporting for the Information Asset Register both operationally and to the relevant Committee • Create reporting mechanisms for the R&I strategy both operationally and to the relevant Committee • Create a reporting mechanism for compliance with the data promise both operationally and to the relevant Committee	Q1 progress report to be provided to the July Board meeting

MISSION 5: Becoming the trusted strategic partner and a high performing, inclusive, ambitious organisation supporting our workforce and stakeholders

EXECUTIVE OWNER: Chief Executive Officer

REPORTING PERIOD: 1ST April – 30th April 2022 | **DATE OF REVIEW: 26th May 2022**

RAG STATUS: AMBER
Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks

	TBC	TBC
SELF ASSESSMENT ASSURANCE RATING	KEY CONTROLS	ASSURANCE

RISKS

PRINCIPAL RISK 5	CURRENT SCORE	TARGET SCORE
IF we do not become a trusted partner and a high performing inclusive organisation THEN people will not want to work with and for us RESULTING IN a failure to achieve our strategic ambition of delivering world leading digital services.	15/25 3 (Possible) x 5 (Catastrophic)	5/25 1 (Rare) x 5 (Catastrophic)

ASSOCIATED CORPORATE RISK/S

Risk Key: ★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

RISK REF	CURRENT SCORE	TARGET SCORE	RISK REF	CURRENT SCORE	TARGET SCORE
0259 – Staff Vacancies	4X4 = 16/25	2X3 = 6/25	0237 - New requirements impact on resource and plan	4x4 = 16/25	3x3 = 9/25
0288 – Data Centre migration revenue funding	4x4 = 16/25	2x4 = 8/25	0208 – Welsh Language Compliance	3x4 = 12/25	1x4 =4/25
0285 – Unfunded NI increase	4x3 = 12/25	2x3 = 6/25	0284 – Increased Utility Costs Financial Pressures	4x3 = 12/25	3x2 = 6/25

CONTROLS AND ASSURANCE

KEY CONTROLS GAPS	ACTION PLAN	ASSURANCE GAPS	ACTION PLAN	PROGRESS ON ACTION PLAN
• DHCW ISO Internal audit plan • Corporate succession plan to outline (initially) succession into the top three tiers • Welsh Language Scheme - (1) finalise Scheme and seek Board sign off (2) Set up assurance activity to review compliance • Communications strategy (1) finalise strategy and seek sign off (2) Create new KPI's to measure the impact • People and OD Strategy (1) need to develop the strategy; (2) need to develop implementation plan • Lack of assurance mechanism in relation to the effectiveness of the Long term financial strategy • Commercial Strategy for using third parties to increase workforce capacity • Organisational Values Review	• Finalise ISO Internal audit plan for 22/23 • Complete Corporate Succession Plan • Consult on and Sign off Welsh Language Scheme • Communications Task and finish group to review finalise strategy • People and OD Strategy and implementation plan to be completed for sign off by the SHA Board • Create Long-Term Financial strategy and associated plan • Agree commercial strategy for using third parties to increase workforce capacity and implementation plan • Undertake and review of the organisations values	• Lack of assurance mechanism in relation to effectiveness of DHCW ISO Internal Audit plan • Reporting on the progress of the succession plan • Progress reporting on effectiveness of implementation of Communications strategy • Lack of assurance mechanism in relation to the effectiveness of the Long term financial strategy • Commercial Strategy for using third parties to increase workforce capacity • Organisational Values Review • Progress reporting on effectiveness of implementation of People and OD strategy • Lack of assurance mechanism in relation to the effectiveness of the Health and Wellbeing group • Lack of assurance mechanism in relation to effectiveness of Governance Assurance Framework • Progress of implementation of stakeholder engagement plan	• Create reporting parameters for DHCW ISO Internal Audit Plan • Create regular review mechanisms for the Corporate Succession plan • Create reporting on the Communications strategy both operational and assurance • Create reporting on the Long-Term Financial strategy and associated plan • Create a resourcing group to assess the effective use of the commercial strategy and establish next steps • Undertake review and validation of the organisational values with the staff • Create reporting on the People and OD strategy both operational and assurance • Create reporting mechanism on activities of the H&WB group and feedback on activities • Create reporting for GAF • Create 6-monthly report on stakeholder engagement as part of the SHA IOPR	Q1 progress report to be provided to the July Board meeting

5.1i Appendix A – Corporate Risk Register

Risk Matrix

		LIKELIHOOD				
		RARE (1)	UNLIKELY (2)	POSSIBLE (3)	LIKELY (4)	ALMOST CERTAIN (5)
CONSEQUENCES	CATASTROPHIC (5)	5	10	15	20	25
	MAJOR (4)	4	8	12	16	20
	MODERATE (3)	3	6	9	12	15
	MINOR (2)	2	4	6	8	10
	NEGLIGIBLE (1)	1	2	3	4	5

Key – Risk Type:

Critical	Significant	Moderate	Low

Ref	Description	Opened date	Review date	Rating (initial)	Action Status	Rating (current)	Impact (current)	Likelihood (current)	Rating (Target)	Impact (Target)	Likelihood (Target)	Risk Owner	Trend	Committee Assignment	Primary Risk Domain
DHCW0204	Canisc System IF there is a problem with the unsupported software used within the Canisc system THEN the application will fail RESULTING IN disruption to operational service requiring workarounds.	08/02/2018	23/05/2022	15	AIM: REDUCE Impact and REDUCE Likelihood FORWARD ACTION: Replace Canisc across Wales, Continue development of replacement functionality and interfaces (Phase 1), Health Boards to continue UAT of functionality VCC Go Live 14th November 2022 (WPAS & WCP), Health Board plans to launch dataset forms for two cancer tumours across Wales in Sept 2022 and potentially MDT forms. Plans will be confirmed by the end of May 22. Commence development of Phase 2 work streams (Palliative Care & Screening & Colposcopy) ACTIONS TO DATE: 23/05/22 Continued iterative roll out of software made available for UAT in WCP and WPAS. 03/05/22: VCC & DHCW revised timeline for VCC go live from May 22 to November 2022. Design for Phase 2 Screening & Colposcopy and Palliative Care almost complete. Significant progress made on the replacement of Canisc interfaces, build completed on majority and	20	5	4	6	3	2	Executive Medical Director	Non Mover	Digital Governance & Safety Committee	Service Delivery

					they have been handed over to VCC for testing. 2 remaining (out of 33) interfaces are still in the requirement and design phase. Additional functionality been developed and made available for UAT in WCP and WPAS. Clinical functionality in WCP continues to be released in a staggered /agile approach. All software to be available for testing by 30th May 2022. All Health Boards engaged with testing Cancer specific functionality in WCP and WPAS. Since October 2020 the Cancer Informatics Programme has been running an accelerated plan in order to mitigate the risks posed by the legacy Cancer system CaNISC and deliver an integrated national solution for cancer services ahead of the original November 2022 deadline. The Canisc replacement MVP (14 workstreams) in development/completed in readiness for testing in 22/23 Q1 for All Wales Cancer services. Specific developments delivered and already available for testing. Collaborative working with Programme Partners to finalise developments required for Palliative care and Screening & Colposcopy									
DHCW0237	New requirements impact on resource and plan IF new requirements for digital solutions to deal with Covid 19, recovery of services and other new areas of work continue to come in, THEN staff may need to be moved away from other deliverables in the plan RESULTING in non delivery of our objectives and	30/03/2020	30/05/2022	16	AIM: REDUCE Impact and REDUCE Likelihood FORWARD ACTIONS: Continue to monitor new requirements for TTP and recovery from Covid and other new initiatives. Use formal change control methods to ensure impact is mapped and impacted work is re-baselined. ACTIONS TO DATE: IMTP approved by SHA Board end March 2022. Annual Business Plan approved April 2022 - this plan is flexible and new requirements will be assessed against available capacity and go through a formal	16	4	4	9	3	3	Executive Director of Strategy	Non Mover	Digital Governance & Safety Committee	Development of services

	ultimately a delay in benefits being realised by the service.				change control process before being added to the plan. Still significant Covid backlog and new requirements coming through some of which are on a candidate list until resource is confirmed. Pressures and impact due to late DPIF resourcing reduction being assessed. IMTP 22/25 drafted for approval end March 2022 which sets baseline plan. Lessons Learnt for Q3 21/22 presented to Management Board for review and comment. Action plan being led by the PPMG. Impact of decreasing restrictions on required functionality being considered. Improved formality with external boards around change control of dates, eg due to extra requirements. Significant increase in numbers of Requests for Change (RFCs) coming to PPMG since Sept 2021.										
DHCW0259	Staff Vacancies IF DHCW are unable to recruit to vacancies due to skills shortages and unavailability of suitable staff THEN this will impact on service deliverables and timescales RESULTING in delays to system support and new functionality for NHS Wales users.	11/12/2020	06/06/2022	12	AIM: REDUCE Impact and REDUCE Likelihood FORWARD ACTIONS: DHCW are attending a variety of job fairs and academic fairs across Wales to improve our profile. We will be starting to work with a PR company to raise our profile. Working with directorates for them to identify which vacancies/projects can be outsourced. Updating JDs in line with DDaT Plus framework. The recruitment team are now targeting candidates via CV library and Linked in which to date has offered some success. Current the team are creating a recruitment strategy which will include any new innovative methods to attract new candidates. ACTIONS TO DATE: 03/03/2022 Recruitment task force continues to meet weekly. Careers days have taken place, there is also a dedicated WFOD	16	4	4	6	2	3	Director of People	Non Mover	Audit and Assurance Committee and Local Partnership Forum	Service Delivery

					team focusing on this issue A recruitment task force was established including all areas of the organisation to focus on recruitment with support from a co-ordinated communications approach. Additionally, agency support was procured to aid with the volume of recruitment required and support managers with vacancies to ensure speed of appointment.										
DHCW0269	Switching Service IF the current switching service fails THEN no data new will be acquired into the ISD Data Warehouse RESULTING IN the inability to provide updates to multiple reporting systems.	07/12/2020	24/05/2022	9	AIM:REDUCE Likelihood and REDUCE Impact FORWARD ACTION: Now that the Director of Operations is in post, ISD are looking to share ownership of the risk with Operational Services and there will be an internal audit review of the Switching Service which should provide specific feedback during June 2022 in order to advance this work. ACTION TO DATE: 21/02/2022 - NDR confirmed that a plan to replace switching service functionality will be considered as part of the data strategy work. In the meantime a paper is being drafted within ISD to propose some immediate solutions for geographical resilience in order to consider reducing the risk score.	16	4	4	6	3	2	Executive Medical Director	Non Mover	Digital Governance & Safety Committee	Information - Access and sharing
DHCW0287	Digital Priorities Investment Funding (DPIF) IF DPIF budgets are requested to be significantly re-profiled (greater than £2.5 million) THEN the completion of planned developments will not be possible with associated supplier payment issues RESULTING IN reputational damage, non-delivery of	16/05/2022	16/05/2022	16	AIM: Reduce Likelihood FORWARD ACTIONS: Review final proposals with NHS Wales Directors of Digital. ACTIONS UNDERTAKEN: Response to the proposed re-profiling submitted to Welsh Government.	16	4	4	12	4	3	Executive Director of Finance	Non Mover	Digital Governance & Safety Committee	Development of services

	investments, cost pressures and potential legal challenge.														
DHCW0288	Data Centre Migration Revenue Funding IF Data Centre migration activity takes place in 2022/23 THEN additional cost pressures will emerge RESULTING IN a requirement to source additional funding.	16/05/2022	16/05/2022	16	AIM: Reduce Likelihood FORWARD ACTIONS: Business Case identifying all resource requirements and timing to be constructed. Explore possible funding options. ACTIONS UNDERTAKEN: Project Group established. Full plan being developed.	16	4	4	8	4	2	Executive Director of Finance	Non Mover	Audit & Assurance Committee	Service Delivery
DHCW0289	Digital Inflation IF supply chain issues (such as the chip shortage) and underlying digital price pressures have a negative impact upon prices THEN there will be additional price increases RESULTING IN higher cost equipment and maintenance contracts.	16/05/2022	16/05/2022	16	AIM: Reduce Likelihood FORWARD ACTIONS: To research and construct cost avoidance actions. ACTIONS UNDERTAKEN: Engaged with sector specialists to ascertain potential impact and future trends.	16	4	4	12	4	3	Executive Director of Finance	Non Mover	Audit & Assurance Committee	Service Delivery
DHCW0208	Welsh Language Compliance IF DHCW are unable to comply with Welsh Language Standards outlined in the Welsh Language Scheme under development THEN they would not be compliant with national legislation applicable to other public bodies RESULTING in the potential for reputational damage	21/05/2018	27/05/2022	16	AIM: REDUCE Likelihood FORWARD ACTIONS: Focus on supporting the Digital Services for patients and the public programme in bilingualism. Compliance report to be presented to the Welsh Language group for monitoring. Undergo Public consultation and prepare an outcome report for approval by the Welsh Language Commissioners Office. Planned for November 22 with Launch in December 22. All Wales Welsh Language Preference System first release is undergoing a second pilot with a wider test base June 22. Work on the More than just words action plan in collaboration with	12	4	3	4	4	2	Board Secretary	Non Mover	Audit & Assurance Committee	Compliance

					the Welsh Government. ACTIONS TO DATE: Assurance compliance reporting established with the Audit and Assurance Committee. Investment proposals to support the language preference data sharing across systems submitted and in further discussion. Initial work on setting the vision for DHCW's bilingual objective.											
DHCW0228	Fault Domains IF fault domains are not adopted across the infrastructure estate THEN a single infrastructure failure could occur RESULTING IN multiple service failures.	05/06/2019	06/06/2022	16	AIM: REDUCE Likelihood and REDUCE Impact FORWARD ACTIONS: A newly installed virtual server farm has been implemented with two fault domains at each data centre. Work is now underway to plan the migration of existing virtual servers onto this infrastructure which is expected to take around 9 months. This will provide some additional resilience for many of our services. Introduction of further fault domains will be considered in the planning and migration of services from on-premises to cloud providers. ACTIONS TO DATE: 06/06/2022 - Work continues to utilise further fault domains for all new deployments. 21/04/2022 - Fault domains installed in some new equipment installation when funding has allowed this. Additional new equipment has been installed to increase availability of hosted services. Fault domains were incorporated into new areas of infrastructure as part of the Data Centre Exit Project where cloud provisions is being utilised to provide some of the fault domains required.	12	4	3	6	3	2	Interim Executive Director of Operations	Non Mover	Digital Governance & Safety Committee	Service Delivery

5.1i Appendix A – Corporate Risk Register

DHCW0263	DHCW Functions IF directions from Welsh Government do not provide a sound legal basis for the collection, processing and dissemination of Welsh resident data, THEN (i) partners, such as NHS Digital, may stop sharing data, (ii) DHCW may be acting unlawfully if it continues to process data RESULTING IN (i) DHCW being unable to fulfil its intended functions regarding the processing of data, or, in the case of continued processing, (ii) legal challenge, or (iii) the need to submit a further application to the Confidentiality Advisory Group (which may not be successful) to assess the public interest in processing confidential data without a legal basis or consent.	26/01/2021	02/05/2022	12	AIM: REDUCE Likelihood FORWARD ACTIONS: Continue discussions with Welsh Government colleagues to define the parameters of the functions. Review in July 2022 ACTIONS TO DATE: Actions set against Welsh Government to define a set of Directions that will enable DHCW to move forwards on BAU and to provide cover for important functions such as NDR: (i) DHCW's establishment functions and initial set of directions in the form of a letter has been published on the Welsh Government's website, to ensure that DHCW's remit is clear and transparent. (ii) Welsh Government have informed the Confidentiality Advisory Group (CAG) of DHCW's new statutory status and legal basis for processing data. CAG have confirmed that they are content that we would no longer be requesting section 251 support for the handling of data not related to research. (iii) Welsh Government are planning to issue a new direction for DHCW regarding the collection of prescription data, which will test the process for issuing new directions. (iv) a letter was sent from Ifan Evans to confirm DHCW's functions in response to a request for clarity from the Chair of the Digital Governance and Safety Committee and a deep dive provided at November 2021's meeting.	12	4	3	4	4	1	Executive Medical Director	Non Mover	Digital Governance & Safety Committee	Information - Access and sharing

DHCW0264	Data Promise IF the national conversation regarding the use of patient data (Data Promise) is delayed, THEN stakeholders and patients will not be assured that the proposed uses of Welsh resident data include sufficient controls to ensure data is treated responsibly, handled securely and used ethically. RESULTING IN (i) potential challenges to proposed uses of data, and/or a loss of public/professional confidence, and (ii) a failure to realise the desired outcomes regarding 'data and collaboration' (effective and innovative uses of data, joined up services, better outcomes for individuals) set out in Welsh Government's Digital Strategy.	26/01/2021	02/05/2022	12	AIM: REDUCE Likelihood FORWARD ACTIONS: Continue discussions with Welsh Government colleagues to define the Data Promise. To be reviewed in July 2022 ACTIONS TO DATE: The specific responsibilities for implementation of the Data Promise have been given to the Head of Data Policy in Welsh Government, who will be supported by a Data Policy Manager who will focus on delivering the Data Promise. (i) Stakeholder engagement is underway. (ii) The Minister for Health and Social Services has endorsed the proposals to deliver a Data Promise for health and care. (iii) A steering group has been set up to review and comment on Data Promise materials and help to make decisions on the direction of the programme. (iv) Aim of launching the Data Promise 'publicity' campaign in 2022.	12	4	3	4	4	1	Executive Medical Director	Non Mover	Digital Governance & Safety Committee	Information - storing and maintaining
DHCW0284	Increased Utility Costs Financial Pressure IF utility costs increase significantly (circa £120k per annum) as expected THEN costs will exceed those normally budgeted for RESULTING IN increased facilities costs and financial pressures	21/10/2021	13/05/2022	12	AIM: REDUCE Impact FORWARD ACTION: Build potential cost pressures into IMTP assumptions. Continue to report to Welsh Government to ensure DHCW pressure is incorporated within the central risk management and any future consequential funding is secured. ACTIONS TO DATE: Engagement with NWSSP Procurement to confirm All Wales NHS Utilities contract terms Communication with Landlords to understand timing and impact of any change Discussed with Associate Finance	12	3	4	6	2	3	Executive Director of Finance	Non Mover	Audit & Assurance Committee	Financial

					Directors and Finance Business Partner										
DHCW0285	Unfunded NI increase IF the additional 1.25% employer NI contributions are unfunded centrally THEN DHCW will have a cost pressure of £319k in 22/23 RESULTING IN DHCW's ability to breakeven.	11/05/2022	11/05/2022	12	AIM: Reduce Likelihood FORWARD ACTIONS: Monitor financial impact and report to Welsh Government on a monthly basis to ensure that DHCW pressures are represented in the central Risk Register. In that way, any consequential funding will have been identified and made available to the organisation. ACTIONS TO DATE: Forecast submitted to Welsh Government.	12	3	4	6	3	2	Executive Director of Finance	Non Mover	Audit & Assurance Committee	Financial

5.1II APPENDIX B - RISK MANAGEMENT & BAF MILESTONE PLAN

	TASK	TIMELINE/REVISED DUE DATE	STATUS UPDATE
DHCW Approach to Risk Management and Board Assurance Framework	1. Develop Risk Management and Board Assurance Framework Strategy, to be considered via the Risk Management Group, Audit and Assurance Committee, Management Board, DHCW Board.	May 2021	Approved at Special Health Authority Board on 27th May 2021.
	2. Write and ask that new risks are articulated with; IF (this happens - cause) THEN (event) RESULTING IN (impact will be – effect). Ask that high risks and those on the corporate risk register are re-worded to use: IF, THEN, RESULTING IN.	May – July 2021	This approach has been discussed at the risk management group on the 1 June 2021. The Corporate Risk Register will now be re-written using this approach.
	3. Arrange time on the Risk Group agenda to: • Review the draft Risk Management and BAF Strategy • Discuss/confirm proposed process to include triggers and hierarchy, how risks get into the corporate risk register and Principal risks onto the BAF (informed by the Annual Plan/IMTP) • The role of Management Board in owning the corporate risk register and initial identification of principle risks. • The role of the DHCW Board in overseeing the Principal risks and BAR • Review risk scores on risk registers • Consider how DHCW risks with potential impact on the wider health and care system are best communicated to partners	May – July 2021	The detail of the Risk and Board Assurance Framework Strategy was discussed at the risk management group on the 1 June 2021. The risk narrative and scores were reviewed, and suggestions made at the risk management group on the 1 June 2021 for the owners of the risk to review and update where necessary.
	4. Board Risk Management and Board Assurance Training Provided. Amberwing to provide the training. *NB: DHCW Annual Plan to include Strategic Objectives to be reviewed/discussed at the Board Development Session on 01.07.2021*	1 July 2021	Session took place on 1st July 9am – 11am to include all Board member.
	5. The identification of principle risks to the organisation are considered at the Management Board (and the DHCW Risk Group) in June 2021. Facilitated by Amberwing.	22 July 2021 & 9 August	Facilitated sessions took place on 22nd July and 9th August, to include Management Board staff and Independent Board members. The output from the session was a draft principal risk analysis for each DHCW Strategic aim.
	6. Assurance and controls mapping exercise undertaken by Directorates based on the principle risks identified and agreed.	22 July 2021 – end of February 2022	The assurance mapping plan was concluded in February as planned but further review and validation work was requested by Directors in readiness for approval by the DHCW SHA Board.
	7. Risk Management training to be provided to relevant DHCW staff / Directorates to cover (building on training provided to Board members): • The basics of risk management • The process for escalating risk • The triggers for escalating risk • How risk will be discussed and reviewed at the Management Board 8. The DHCW risk appetite and what this means for the organisation.	September 2021 – March 2022	Training was delivered on the Risk and BAF strategy and associated approach to 75% of all 8b's and above. Work will now be undertaken to record the session and shared across the whole organisation.
	9. Board Development session to consider and agree the DHCW Board risk appetite. Facilitated by Amberwing.	2 September 2021 – end of Jan 2022	Risk appetite has been approved at the January 2022 SHA Board meeting, this will now be included in the final Risk and Board Assurance Framework Strategy and training provided for all Directorates.
	10. Principle risks presented to DHCW Board at the May Board meeting, and first draft Board Assurance Report/update on Board Assurance Report.	May 2022	Principle risks re-drafted and planned for presentation to the May 2022 Board, the proposed Board Assurance Report template was received and endorsed by the Audit and Assurance Committee. Principal risks were approved at the May 2022 SHA Board meeting.

	11. DHCW risk appetite statement to be presented to Board if ready to go to the November Board.	November 2021	See action point 9.
	12. DHCW risk appetite statement to be added to Risk Management and BAF Strategy.	27 January 2022 or 31 March 2022	This has been completed in readiness for the January SHA Board final approval.
	13. DHCW objectives agreed via the IMTP process for 2022/23 – 2024/25.	March 2022	The objectives(missions) and the vision, mission and core purpose were approved at the March Board Development Session for inclusion in the IMTP 22-25.
	14. Principal risks considered and agreed against the DHCW plan for 2022/23	March – May 2022	Included in the Annual Cycle of Business for the SHA Board.

DIGITAL HEALTH AND CARE WALES
WELSH HEALTH CIRCULARS COMPLIANCE UPDATE REPORT

Agenda Item	5.2

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Laura Tolley, Corporate Governance Manager
Presented By	Laura Tolley, Corporate Governance Manager

Purpose of the Report	For Assurance

Recommendation

The Audit and Assurance Committee are being asked to:
NOTE the update provided and take ASSURANCE on the process for recording and monitoring the organisation's compliance with Welsh Health Circulars.

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Globally Responsible Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	WHC	Welsh Health Circular
WG	Welsh Government		

2 SITUATION/BACKGROUND

2.1 The purpose of this report is to provide an update to the Audit and Assurance Committee on the organisations compliance with Welsh Health Circulars (WHC) that are issued by Welsh Government.

2.2 The Corporate Governance Team maintain a tracker for monitoring and recording the WHC's that are received by DHCW. The WHC's are sent to the Weekly Executive Directors meeting for review and to agree the relevant Executive Lead for action.

2.2 A monthly progress report is presented to the Weekly Executive Directors for information, monitoring and assurance purposes.

2.3 A bi-annual report will be presented to the Audit and Assurance Committee to provide assurance of compliance with WHC's.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Appendix A (5.2i) details the WHC's received in the period 2021/2022, these have been reported to Weekly Executive Directors and Management Board.

3.2 All WHC's are completed and have been signed off by the Executive Leads. There are no outstanding circulars on the register for the 2021/22 period.

4 RECOMMENDATION

4.1 The Audit and Assurance Committee are asked to:
NOTE the update provided;
Be ASSURED on the process for recording and monitoring the organisation's compliance with the Welsh Health Circulars.

5 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Weekly Executive Directors	01/06/2022	Noted
Management Board	23/06/2022	Noted

Circular Number	Title	Date of Issue	DHCW Lead	What is it for?	Action/Sent to	Confirmation of receipt/actions to be carried out	Status	Due Date	Date closed	Link to Document
WHC/2021/002	Board Champion Roles	19/01/2021	Board Secretary	Welsh Government guidance on new role of Board Champion	Interim Chair of DHCW	Include in Induction Pack information for Independent Members and establish Board Champion Roles in new Governance structure	Closed	31/03/2021		WHC Document 002
WHC/2021/005	The National Health Service (Cross Border Healthcare) (Wales) (Amendment Directions 2021 and the N	06/04/2021		The purpose of the WHC is to inform you of the NHS (Cross-Border Healthcare) (Wales) (Amendment) Directions 2021 and the National Health Service (Reimbursement of the Cost of EEA Treatment (Wales) (Amendment) Directions 2021 which were adopted on 25th March 2021.	Sent to Weekly Directors (21/04/21) for review.	CD to ask Darren Lloyd to review the National Health Service (Cross Border Healthcare (Wales) (Amendment) Directions 2021. DL confirmed little reference to DHCW current responsibilities or a requirement for any further actions at this stage. Confirmed closed.	Closed		25/08/2021	WHC Document 005
WHC/2021/008	Revised National Steroid Treatment Card	01/05/2021		Health Service Circular 1998/056 required a standard steroid treatment card to be issued to patients prescribed steroid treatment (adults and children)	Sent to Weekly Directors for review and agreed action/non action.	RH advised at 3/06/21 Weekly Directors' meeting that this had no implication for DHCW.	Closed		03/06/2021	WHC Document 008
WHC/2021/009	School Entry Hearing Screening Pathway	25/03/2021	Board Secretary	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022	Sent to Weekly Directors for review and agreed action/non action.	Confirmed at Weekly Directors that there was no action for DHCW	Closed			WHC Document 009
WHC/2021/010	Amendments to Model Standing Orders, Reservation and Delegation of Powers and Model Standing Fi	16/09/2021	Chris Darling (Board Secretary)	NHS bodies in Wales must agree Standing Orders (SOs) that, together with a set of Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board; a scheme of delegations to officers and others; and a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities. The Standing Orders should be based upon the model determined by the Welsh Government	Reviewed at Weekly Directors (22/09/21) where agreed no action for DCHW but would sit with Chris Darling (Board Secretary)	Confirmed at Weekly Directors that there was no action for DHCW	Closed		27/09/2021	WHC Document 010
WHC/2021/011	2021/22 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	23/04/2021	Claire Osmundsen-Little Executive Director of Finance	2021/22 LHB, SHA and Trust monthly financial monitoring return guidance and associated submission templates	Sent to Weekly Directors for review and agreed action/non action.	Confirmed at Weekly Directors that there was no action for DHCW	Closed		07/09/2021	WHC Document 011
WHC/2021/012	Implementing the Agreed Approach to Preventing Violence and Agression Towards NHS Staff in Wales	22/04/2021	Sarah Jane Taylor, Director of Workforce and OD	To set out plans and a timeline to fully embed the requirements to implement and report upon violent incidents as set out in the NHS Anti-Violence collaboratives Obligatory Response to Violence in Healthcre within all NHS Organisations	Reviewed at WD 06/05/21 Sent to Michelle Sell for cascading to Shikala Mansfield for any action by DHCW.	WHC sent to Shikala Mansfield by CD on 24/08/21. Chased 7/03/22 WP sent e-mail to SM/MS on the 15th April requesting an update. SM emailed 5/05/22 confirming who was responsible for the recommendations. CD responded he would take forward the actions for Corporate Governance and liaise with the Director of Workforce on the Board Champions proposals and responsibilities. Confirmation provided the actions were being taken forward.	Closed		09/05/2022	WHC Document 012
WHC/2021/014	List of Welsh Health Circulars - 1st February 2020 to 30th April 2021	18/05/2021	Chris Darling (Board Secretary)	For information full list of WHC for 1st Feb 2020 to 30th April 2021 no action required.	For information.	Confirmed at Weekly Directors that there was no action for DHCW	Closed		20/07/2021	
WHC/2021/015	NHS Pay Bonus for Primary Care	28/05/2021	Chris Darling (Board Secretary)	Bonus for those in primary care for period 17/03/20 to 28/02/21	Sent to Weekly Directors for review and agreed action.	At 3/06/21 Weekly Directors' meeting CD agreed to discuss with Shikala Mansfield. Email from CD confirming the matter had been discussed and was now closed with no action from DHCW required.	Closed		27/07/2021	WHC Document 015
WHC/2021/022	Publication of the Quality Safety Framework	17/09/2021	Rhidian Hurle (Medical Director)	A Heathier Wales was published in 2018 and set out the ten-year vision for health and social care in Wales, with quality and safety of care the primary focus in the provision of healthcare across Wales. The Quality and Safety Framework now published will be a key driver to ensure quality and safety is firmly placed at the heart of NHS healthcare provision, from community care right through to acute services	Sent to Weekly Directors (22/09/21) where it was agreed this sits with Rhidian Hurle for oversight. It was agreed the document would be circulated to all staff.	WHC sent to all staff 1st October 2021.	Closed	03/04/2023	01/10/2021	WHC Document 022
WHC/2021/024	NHS Wales' contribution towards a net-zero Public Sector by 2030: NHS Wales Decarbonisation Strate	08/09/2021	Julie Ash (Head of Corporate Services)	In 2019, the Welsh Government declared a Climate Emergency supported by Members of the Senedd and have since set out an ambition for the public sector to be net zero by 2030.	Sent to Weekly Directors (15/09/21) where agreed this sits with Julie Ash for oversight and implementation. Sent to JA 15/09/21 for action. JA continues to work on this, presentation provided to A&A 18/01/22	Julie Ash confirmed on her workplan and a key focus over the coming months.	Closed	31/03/2023		WHC Document 024
WHC/2021/025	Carpal Tunnel Syndrome Pathway	15/09/2021	Rhidian Hurle	The Clinical Programme for Orthopaedics has developed a national Carpal Tunnel Syndrome pathway.	Sent to Rhidian Hurle for confirmation if an action for DHCW.	Rhidian Hurle informed no action required for DHCW.	Closed		13/10/2021	WHC Document 025
WHC/2021/026	OVERSEAS VISITORS' ELIGIBILITY TO RECEIVE FREE PRIMARY CARE	06/10/2021	Rhidian Hurle (Medical Director)	This circular clarifies the circumstances when overseas visitors are entitled to free primary care. In all other circumstances further advice must be sought from Local Health Board (LHB) Overseas Visitors Managers (OVMs) to determine free primary and secondary care. It replaces WHC(99)32	Reviewed at Weekly Directors 20/10/21	Confirmed at Weekly Directors that there were no implications for DHCW.	Closed			
WHC/2021/027	NHS WALES BLOOD HEALTH PLAN	27/09/2021	Rhidian Hurle (Medical Director)	The purpose of this Welsh Health Circular is to highlight the publication of the NHS Wales Blood Health Plan ("BHP") that has been developed by staff across NHS organisations, supported by the Health Board/Trust Medical Directors, and coordinated by the Welsh Blood Service ("WBS")	Sent to Rhidian Hurle for confirmation if any action for DHCW.	Rhidian Hurle confirmed that no action for DCHW.	Closed		30/09/2021	WHC Document 027
WHC/2021/028	AMR & HCAI IMPROVEMENT GOALS FOR 2021-22	27/09/2021	Rhidian Hurle (Medical Director)	Infection Prevention and Control (IP&C) measures have never been so important. The pandemic has demonstrated the need for adequate resources to support IP&C in both hospital and community settings. Implementation of key guidance (listed nearer the end of this document) will continue to be vital in mitigating the risk of transmission of harmful micro-organisms to both patients and staff. Reducing healthcare associated infections will reduce the need for using our precious antimicrobials and will preserve their effectiveness.	CD confirmed RH lead. Requested to pick this up and any action to take forward associated with the WHC.	Rhidian Hurle confirmed no further action for DCHW.	Closed	01/10/2021	30/09/2021	WHC Document 028
WHC/2021/031	NHS WALES PLANNING FRAMEWORK 2022-2025	09/11/2021	Michelle Sell	This framework sets the Ministerial directions for the year ahead and confirms the Ministerial priorities, which have been communicated to the NHS in Wales regularly over the past few months.	Action sent to MS. Working to sign off IMTP at January Board.	Chief Operating Officer aware of due date for IMTP. Closed.	Closed	01/11/2022	12/11/2021	WHC Document 031
WHC/2021/032	Role and Provision of Dental Public Health in Wales	16/11/2021	Rhidian Hurle (Medical Director)	The purpose of this Welsh Health Circular is to describe the expected: national dental public health functions; and provision of dental public health specialist advice and support to NHS organisations and others oral health stakeholder in Wales.	Reviewed at Weekly Directors 05/01/2022 and agreed there were no implications for DHCW.	Confirmed at Weekly Directors that there was no action for DHCW	Closed	16/11/2021	05/01/2022	WHC Document 032
WHC/2021/033	Role and Provision of Oral Surgery in Wales	14/12/2021	Rhidian Hurle (Medical Director)	The purpose of this Welsh Health Circular is to describe the expected national Oral Surgery function. It provides the vision for patient centric care utilising prudent health care principles by suitably trained dental registrants using a standardised pan-Wales approach	Reviewed by Rhidian Hurle via email 22/12/21	Confirmed at Weekly Directors that there was no action for DHCW	Closed		23/12/2021	WHC Document 033

DIGITAL HEALTH AND CARE WALES
WELSH LANGUAGE COMPLIANCE REPORT

Agenda Item	5.3

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Eleri Jenkins, Welsh Language Manager
Presented By	Eleri Jenkins, Welsh Language Manager

Purpose of the Report	For Assurance
Recommendation	
The Audit and Assurance Committee is being asked to: Receive the report for ASSURANCE and ENDORSE the Welsh Language Compliance and Improvement Framework	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	DHCW0208

WELL-BEING OF FUTURE GENERATIONS ACT	A Wales of Vibrant Culture and Thriving Welsh Language
If more than one standard applies, please list below: A More Equal Wales	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Not Required	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	Compliance with Welsh Language Standards Regulations no7 2018
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below
	There are potential financial penalties for non-compliance with the standards.
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below
	There is an impact on the workforce in terms of working practices and facilities for ensuring compliance.
SOCIO ECONOMIC IMPLICATION/IMPACT	Yes, please detail below
	Implementation of the Welsh Language Standards has a positive socio economic impact by: (a) providing opportunities for persons to use the Welsh language, and

	(b) treating the Welsh language no less favourably than the English language (As outlined in the policy making Welsh language standards regulations)
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
WLCO	Welsh Language Commissioners Office	NWIS	NHS Wales National Informatics Service

2 SITUATION/BACKGROUND

2.1 DHCW is a bilingual organisation and is committed to maintaining its compliance with the Welsh Language Standards (the standards) which were imposed by the Welsh Language Commissioner prior to becoming a Special Health Authority on NWIS via its hosting arrangement with Velindre NHS Trust. From the 1 April 2021, as a new Special Health Authority, one of the first actions was to ensure the organisation's compliance was maintained and therefore DHCW have directed the creation of a Welsh Language Scheme.

2.2 Ongoing discussions with the Welsh Language Commissioner to approve the content of the Welsh Language Scheme have taken place since November 2021. The aim is to publish the final version of the Welsh Language Scheme later this year and launch it in conjunction with the Welsh Language Commissioner's Welsh language rights day on 7th December 2022.

2.3 The Welsh Language Standards Regulations (no7) were imposed on DHCW's NHS Wales partners in 2019. DHCW is therefore committed to supporting them to maintain compliance with these standards by ensuring digital services and systems are compliant with these regulations.

2.4 This report outlines the steps taken to monitor compliance and gives an overview of:

- The Welsh language compliance action plan that identifies areas for improvement and actions required to achieve compliance with the standards
- Progress of the Welsh Language Scheme
- The current Welsh Language skills dashboard showing staff's self-assessment of their Welsh skills
- Activity undertaken in the organisation to promote the use of the Welsh language and improve training provision

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Welsh Language Compliance Action Plan

The DHCW Board have outlined clear intentions and commitments in relation to the organisation being bilingual. The Welsh Language Services Manager monitors compliance with the Welsh Language Standards and reports non-compliance and areas for improvement to the Welsh language group. As there are 120 standards, it has been agreed via the Welsh language group that the standards be put into a new action plan to provide the Audit and Assurance Committee an assurance summary. This action plan is included at item 5.3i Appendix A. It is reviewed for progress by the Welsh language group on a bi-monthly basis.
The summary findings are below:

Type of Standards	Approximate % compliance / RAG rating
Service Delivery Standards	50%
Policy Making Standards	25%
Operational Standards	50%
Record Keeping Standards	75%

3.2 Welsh Language Scheme Progress

The Welsh Language Scheme (the scheme) has now been approved by the Welsh Language Commissioner's office and is currently being formatted by the graphic design department. A 12- week public consultation period will begin in July 2022. In preparation for the consultation period the following activities are planned:

- A new webpage to collect feedback on the scheme
- Social media posts to promote the scheme and direct followers to the website to provide feedback
- Email communication with stakeholders including Welsh language managers in the public sector and third sector organisations.

3.3 Organisational Welsh Language Skills Dashboard

Work is currently being undertaken to support staff with updating their Welsh language skills. Activities include:

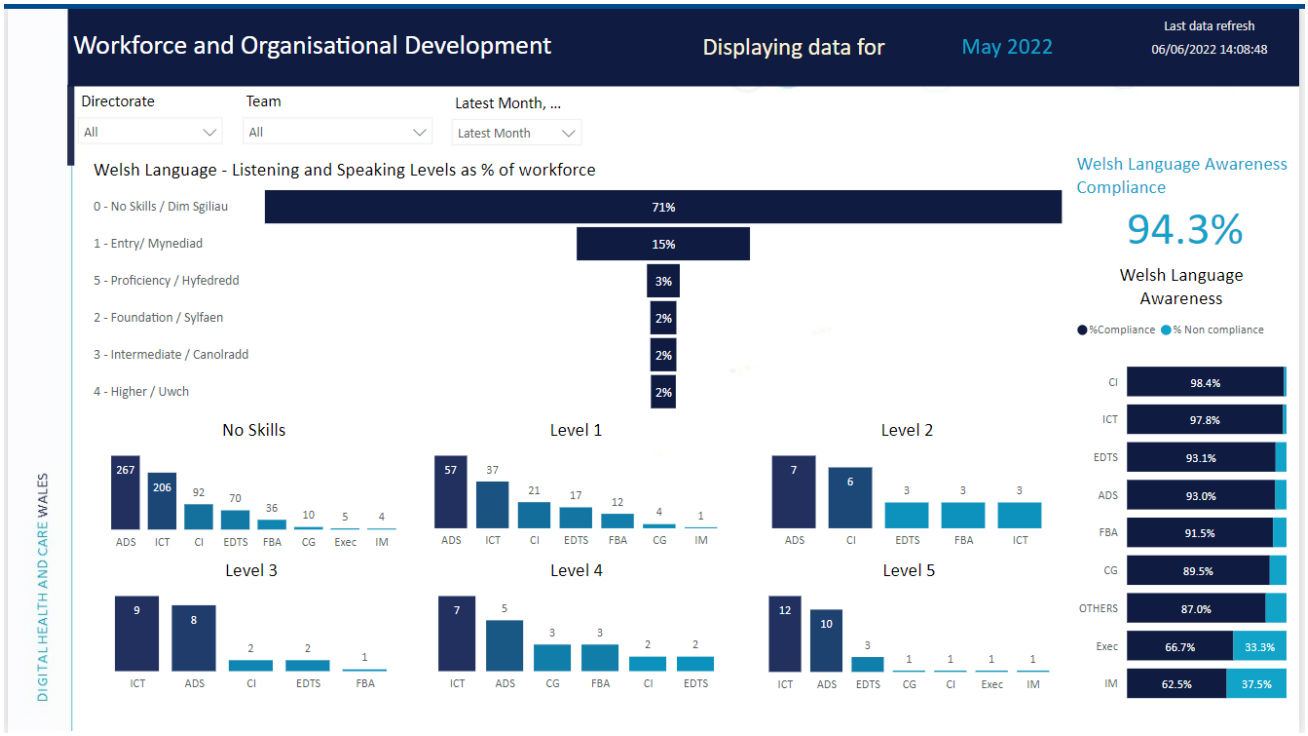
- Manually updating skills on behalf of staff
- Drop-in sessions with the Welsh Language Manager
- Awareness raising sessions at directorate away days

The percentage of staff at level 0 has decreased by 1% over the last month due to these activities.

A new Welsh language awareness course is due to be released by Welsh Government. The new course includes information about the Welsh Language Standards and will be mandatory for all

staff.

The dashboard below gives the breakdown of the levels within the organisation at the different levels.



3.4 Developing the Welsh language skills of staff

The following activities have taken place over the last month to promote Welsh language learning with staff:

- Welsh language awareness induction sessions for new staff
- Welsh language awareness sessions at directorate team building sessions
- A new 'confidence building group' for staff with level 3+ Welsh language skills
- A 'duolingo challenge' yammer group to encourage staff to network with other learners
- Collaborative work with NHS Wales partners to provide new courses for staff (starting in September 2022)

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 Plans are in place to ensure all DHCW jobs are advertised bilingually from July 2022. A programme of translation will also begin in July, focussing on new and updated job descriptions. Compliance with the recruitment related Welsh Language Standards will take at least two years. The Committee is asked to approve and accept this risk.

4.2 Attached at item 5.3ii Appendix B is the Welsh Language Compliance and Improvement Framework, the framework sets out the vision of DHCW as a bilingual organisation and is designed to support the implementation and promotion of the Welsh language as well as

ensure compliance against the standards.

4.3 There are three pillars within the framework to support the vision:

- Training and Resources
- Events and Support
- Compliance and Reporting

The aim of the pillars is to ensure that as well as compliance, a proactive and supportive culture is fostered across the organisation to encourage the learning and development of existing Welsh skills as well as share more culturally Welsh messages across the organisation.

5 RECOMMENDATION

5.1 The Audit & Assurance Committee is being asked to receive the report for **ASSURANCE** and **ENDORSE** the Welsh Language Compliance and Improvement Framework

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Welsh Language Group	13.06.22	APPROVED

Agenda item 5.3

Welsh Language Scheme Monitoring Action Plan

Compliance Area	Type of Standard	Action Required	Progress	Date	RAG Rating
Operational	Bilingual Skills Strategy	1. New Welsh language skills assessment process needs Workforce approval and implementation	1. Meetings with Workforce staff to agree the process have taken place.	Jul-22	
Operational	Workforce Policies	1. Workforce policies need to be available in Welsh and accessible to staff - need to be included in Welsh Language and Workforce SharePoint page	1. All Wales workforce policies are translated and available on IMS	Sep-22	
Service Delivery	Education Courses	1. New SOP required for arranging education (not training). This applies to the education of students or persons outside of NHS Wales 2. Raise awareness of this standard with staff who are likely to organise education courses		Sep-22	
Operational	Welsh Language Training	1. New prospectus to be created to make it easier for staff to decide which course is suitable for them 2. Managers need to support staff learning Welsh by allowing time to attend courses 3. Set up purchase orders for training providers	1. Welsh language training information is available on the Welsh language SharePoint page. 2. New courses provided by local FE colleges available. 3. Funding available for staff to access courses free of charge. 4. Yammer support groups set up. 5. New confidence building group set up	Sep-22	
Record Keeping	Complaints Procedure and Monitoring	1. New area on DHCW website to be created when Welsh language scheme is published	1. New webpage drafted ready to include information about making a complaint	Nov-22	
Service Delivery	Website and Social Media	1. Forward planning of social media will enable the translation team at NWSSP to provide an efficient service. 2. Close monitoring of usage of Welsh website and social media pages required. 3. Merge English and Welsh social media accounts to ensure the bilingual organisation message is clear. 4. Welsh language complaints section to be added to website	1. The DHCW website is bilingual and a new Welsh language page will be published to assist with the public consultation of new Welsh Language Scheme	Dec-22	
Record Keeping	Publication of Welsh Language Scheme	1. Draft approved by Welsh Language Commissioner. 2. Graphic Design support required to format the document. 3. Communications support required with consultation period.	1. New webpage drafted ready to support with public consultation. 2. List of contact created in preparation for consultation	Dec-22	
Service Delivery	Telephone and Reception	1. Audit to ensure Welsh language calls are not treated less favourably to English calles. 2. KPIs need to be included for service desk as part of IOPR to monitor the number of calls requiring a Welsh language service and how they are dealt with 3. Welsh speaking staff to attend a residential course to gain confidence speaking Welsh on the telephone	1.Corporate Services staff have attended a reception skills course with Merthyr College. 2. New Welsh language skills confidence building group set up. 3. Video created to demonstrate dealing with a telephone call in Welsh. 4. Promotion of video at directorate away days. 5. New recruitment assessment process created to ensure all service desk jobs are advertised as Welsh essential when numbers of Welsh speakers fall in the team 6. Confidence builiding group set up to support staff with using their Welsh language skills at work	Dec-22	
Policy Making	Policies / EQIA	1. Process for reviewing policy EQIA needs to be formalised with support from the Welsh Language Manager	1. Collaborative work with Workforce started	Dec-22	

Policy Making	Consultation and Research	As above	1. EQIA included in Welsh language scheme in preparation for public consultation	Dec-22	
Operational	Using Welsh Internally	1. New Welsh language scheme launch and promotion with staff. 2.New SOP required which will refer to the new Welsh language scheme	1. Staff guides created and available on Welsh language SharePoint page	Jan-23	
Service Delivery	Meetings and Public Events	1. New SOP for arranging public events needs to be approved by the Welsh language group and communications team. 2. Regular communication with staff via SharePoint news. 3. Promotion of SOP on Welsh language SharePoint page	1. Arranging External meetings Standard Operating Procedure (SOP) reviewed and updated.	Mar-23	
Operational	ESR/ PADR	1. Issues with ESR Welsh language skills recording need to be resolved. 2. The PADR document needs to be available in Welsh and staff informed that they can request their PADR in Welsh.	1. Manually collection of staff Welsh language skills planned. 2. Promotion of Welcome courses to support staff at level 0 at directorate team building days	Mar-23	
Service Delivery	Correspondence - Email/Letters	1. All staff are required to enter bilingual email signatures and out of office replies. 2. Extend pilot of language recording system to projects/programmes. 3. Letters within systems need to be audited to ensure they are compliant with Welsh language standards.	1. New staff guides created on the Welsh language SharePoint page. 2. New language preference recording system piloted by corporate services. 3. Welsh Language Manager working with WIS and Gov.uk notify to amend vaccination letters. 4. Translation service budget increased to meet demand	Sep-23	
Service Delivery	Documents and Forms	1. Ensure all stakeholder surveys/documents and forms are bilingual (particulary project surveys) 2. Translate 25% of Board papers	1. New staff guide to advise staff on what needs to be in Welsh created and stored on the Welsh language SharePoint page. 2. Welsh Language Manager working closely with DSPP to ensure future surveys and forms are bilingual	Sep-23	
Operational	Recruitment - Adverts and JDs	1. All job adverts need to be translated and advertised bilingually from 1st July 2022. 2. All new/ evaluated job descriptions will be translated and advertised bilingually from 1st July 2022. 3. All job descriptions to be translated and advertised bilingually by March 2024	1. Meetings with Workforce staff to agree the process have taken place. 2. New skills assessment process needs approval	Mar-24	
Operational	Complaints and Disciplinary	No action required	1. Information about complaints and disciplianry procedures are available on the IMS	Completed	
Operational	Use of Work Welsh Logo	No action required	1. The use of the Work Welsh logo is widespread across the organisation. 2. The logo is available to add to email signatures and MS Teams backgrounds. 3. Promoted during staff induction	Completed	
Operational	Contracts of Employment	No action required	1. Contracts of employment are provided bilingually unless it is know that the member of staff requires it in English only	Completed	
Operational	Intranet	No action required	1. The Intranet homepage is bilingual and fully complaint	Completed	
Operational	Internal Signage	1. Bi-annual auditing of signage required	1. Recently audited	Completed	
Record Keeping	Annual Report	1. ESR data needs to be accurate in preparation for 22-23 Annual report. 2. Annual report to include detail of implementation of the new Welsh language scheme	1. 21-22 Annual Report includes progress with Welsh language	Completed	

FRA-DHCW-002

WELSH LANGUAGE COMPLIANCE AND IMPROVEMENT FRAMEWORK

This framework outlines DHCW's commitment to bilingualism and the steps the organisation will take to support our staff and citizen in using the Welsh language

Document Version	0.1

Status	Draft

Document author:	Eleri Jenkins, Welsh Language Services Manager
Approved by	Chris Darling, Board Secretary
Date approved:	
Review date:	

TŶ GLAN-YR-AFON 21 Heol Ddwyreiniol Y Bont-Faen, Caerdydd CF11 9AD

TŶ GLAN-YR-AFON 21 Cowbridge Road East, Cardiff CF11 9AD

STRATEGIC OBJECTIVE	All Objectives apply

WELL-BEING OF FUTURE GENERATIONS ACT	A Wales of vibrant culture and thriving Welsh language
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A

HEALTH CARE STANDARD	Governance, leadership and acccountability
Effective Care; Safe Care;	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: April 2022
Yes, applicable	Outcome: Positive
Statement: The Framework supports the delivery of the Welsh Language Scheme which in turn promotes and encourages the use of the Welsh language and therefore contributes greatly to the goal of 'A Wales of vibrant culture and thriving Welsh Language'. The aim is for Digital Health and Care Wales to be a bilingual organization that considers the Welsh language and culture in all aspects of its work and this framework has a positive impact on that for the citizens of Wales.	

APPROVAL/SCRUTINY ROUTE: Person/Committee/Group who have received or considered this		
COMMITTEE OR GROUP	DATE	OUTCOME
Welsh Language Group	13.06.22	TBC
Management Board	23.06.2022	TBC
Audit and Assurance Committee	04.07.2022	TBC

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	Noncompliance with the with Welsh Language Standards (No. 7) Regulations 2018 as a result of the Welsh Language Act 1993 may have legal consequences.
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below
	Noncompliance with the with Welsh Language Standards (No. 7) Regulations 2018 as a result of the Welsh Language Act 1993 may have financial consequences.
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below
	There are workforce requirements within the standards. Including provision of Welsh at work and bilingual recruitment.
SOCIO ECONOMIC IMPLICATION/IMPACT	Yes, please detail below
	Promoting compliance against the Welsh language standards and ensuring the Welsh language is not treated less favourably to the English language benefits the Welsh speaking citizens of Wales.

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1 DOCUMENT HISTORY

1.1 REVISION HISTORY

Date	Version	Author	Revision Summary
02.04.2022	0.1	Sophie Fuller	Initial draft
13.06.2022	1	Eleri Jenkins	Approved 1st publication

1.2 REVIEWERS

This document requires the following reviews:

Date	Version	Name	Position
13.06.2022	0.1	Eleri Jenkins	Welsh Language Manager
13.06.2022	0.1	Chris Darling	Board Secretary

1.3 AUTHORISATION

Signing of this document indicates acceptance of its contents.

Author's Name:	Eleri Jenkins
Role:	Welsh Language Services Manager
Signature:	X Author

Approver's Name:	Chris Darling
Role:	Board Secretary
Signature:	X Approver

1.4 DOCUMENT LOCATION

Type	Location
Electronic	Integrated Management System

2 PURPOSE

The purpose of the framework is to provide an overview of how DHCW will deliver their vision to be a

bilingual organisation and how it will be supported, promoted, monitored and reported.

3 SCOPE

Welsh language standards and the elements of this framework apply to all DHCW activities and staff.

4 VISION

5 OBJECTIVES

- Provide opportunities to learn or develop existing Welsh Language skills
- Increase awareness of the Welsh language standards and the DHCW responsibilities for compliance
- Create and ensure opportunities for the use of Welsh
- Ensure bilingual service provision from DHCW
- Ensure systems support language preference

6 PILLARS OF THE FRAMEWORK

6.1 Training and Resources

Training and resources are central to enabling staff in promoting and using Welsh both internally and to our wider stakeholders. We will utilise third party suppliers and existing relationships across the NHS in Wales to identify efficiencies in training that can be accessed by our staff.

6.1.1 Training

We will provide access to a range of courses ranging from self-directed to residential. Up to date training course details are available via the Welsh Language SharePoint page. If you need any help on this please email DHCW.CorporateGovernance@wales.nhs.uk or LlywodraethuCorfforaethol.IGDC@wales.nhs.uk. Below are some examples of current training available.

Training Provision	Examples
Self-directed Online	Duolingo Say Something in Welsh 'Welcome' Course (Part 1) 'Welcome' Course (Part 2)
Classroom	Croeso - welcome | Learn Welsh
Residential	Learn Welsh Language Courses, Residential, Intensive (nantgwrtheyrn.org)

6.1.2 Resources

In order to support the deployment of the Welsh Language Scheme, standard operating procedures will be developed on an ongoing basis and the policy for the use of Welsh internally will establish a sound operating base for supporting staff in their compliance against the Welsh language standards. All can be found in the Integrated Management System.

DOCUMENT	VERSION
DHCW Welsh Language Scheme	1
DHCW Policy for Using Welsh internally	1
Accessing Translation Services	1
Arranging External Meetings	1
Translation Request Form	1
Arranging External Events	1
Arranging Education Courses	1

6.2 Events and Support

There are a number of events throughout the year that the organisation will give various levels of support to. What is important about all the events and support on offer is to promote and encourage the use of Welsh across the organisation.

Events	Support
St David's Day - March	Yammer Groups for different learner levels
Diwrnod Shwmae - October	Cynllun Siarad - Buddy scheme for learners
Welsh Language Right's Day - December	Cysgliad / Cysill – Welsh language spelling and grammar support
St Dwynwen's Day - January	Codi Hyder (Confidence building) support group
Dydd Miwsig Cymru - February	ESR Welsh language skills support
	Welsh language awareness training/ induction
	Welsh language SharePoint page

6.3 Compliance and Reporting

Compliance and reporting are important elements of ensuring DHCW as an organisation is adhering to and promoting compliance with the standards. Compliance is a guiding light in highlighting areas that require more support and training in their application of the standards. We have highlighted below the how each of the elements of compliance specific to DHCW will be monitored and measured.

6.3.1 Compliance

Product/Activity	Welsh Language Standards/Scheme	Non-compliance log	Wales Informatics Assurance Process
How the activity is undertaken	Review if the organisation has sufficient processes and facilitation in place to enable compliance with the standards	Any non-compliances found will be added to the log and development plan agreed with the organisational lead	As part of the Informatics assurance process bilingual provision will be considered
How is the activity measured	Red, Amber, Green will be awarded by the Welsh Language Services Manager as to the operational resilience for each standard	Due date agreed with the organisational lead and a Red, Amber, Green assigned to the status	Assurance Quality Plans and the Safety Case and Readiness Report will include the considerations of Welsh language preference capture and sharing
Where is it monitored and reported	Monitored by the Welsh Language Group and reported to the Audit and Assurance Committee	Monitored by the Welsh Language Group and reported to the Management Board. Summary information reported to Audit and Assurance Committee	Monitored by the Wales Informatics Assurance Group and the overall compliance stats are reported to the Digital Governance and Safety Committee

6.3.2 Reporting

Reporting on the progress we are making to deliver the vision of DHCW as a bilingual organisation provides assurance to the Board and ensures that is being properly managed at an operational level.

Group	Incident Review and Learning Group	Welsh Language Group	Wales Informatics Assurance Group	Directorate Management Meetings	Management Board via IOPR	Audit and Assurance Committee	Local Partnership Forum
What is reported?	• Welsh Language Complaints • Non-compliance incidents	• Welsh Language Standards Compliance Action Plan • Welsh Language Complaints • Non-compliance incidents • Non-compliance log • Non-compliance action plans agreed with leads • New training available • ESR language self-assessment	• No reporting required – need to take part in the assurance assessment as part of the process	• Self-assessment breakdown • Local Welsh Language risks • Non-compliance development plans • Achievements and training • What's next?	• Dashboard as agreed with Organisational Performance Team • WLSM to provide high level narrative	• Welsh Language Compliance Report to include summary of key areas and themes that are being addressed	• Utilise this meeting as a tool to report what needs addressing across the organisation and key activity that helps deliver the vision of DHCW as a bilingual organisation
Frequency	Monthly	Bi-monthly	Monthly	Monthly	Monthly	Quarterly	Bi-monthly
Author	Welsh Language Services Manager	Welsh Language Services Manager	Welsh Language Services Manager	Welsh Language Services Manager	Welsh Language Services Manager	Welsh Language Services Manager	Welsh Language Services Manager
Approver	Head of Corporate Governance	Board Secretary	N/A	Head of Corporate Governance	Board Secretary	Board Secretary	Board Secretary

7 ROLES AND RESPONSIBILITIES

7.1 Staff

Must comply with the Welsh language standards and promote the use of Welsh at work.

7.2 Managers

Managers are required to provide support to staff who wish to learn Welsh as part of the personal development and encourage the use of Welsh at work.

7.3 Project and Programmes

Both projects and programmes are required to comply at all times with the Welsh language standards and seek guidance and support should they be in doubt as to their responsibilities for compliance.

7.4 Welsh Language Services Manager

The Welsh Language Services Manager (WLSM) is operationally responsible for developing systems and process that support compliance with the Welsh language standards and ensure the delivery of DHCW vision to be a bilingual organisation including training, events, support groups and controlled documents. The WLSM will undertake ongoing review of organisational activity and identify areas of non-compliance, in collaboration with the area lead the WLSM will create a development plan to rectify the non-compliance.

7.5 Audit and Assurance Committee

The Audit and Assurance Committee provide oversight and scrutiny of the arrangement for Welsh Language and seek assurance on a quarterly basis of the organisational activity.

7.6 Welsh Language Board Champion

The Welsh language Board Champion will be the advocate for Welsh language both within the organisation and across the wider health and care sector in relation to key partnerships required and encouraged to deliver truly bilingual health and care in Wales.

7.7 SHA Board

The Board share responsibility for the effective management of compliance against the Welsh language standards. In this case the Board have delegated responsibility for overseeing the effectiveness of the arrangements to the Audit and Assurance Committee.

8 TRAINING

Up to date training course details are available via the Welsh Language SharePoint page. If you need any help on this please email DHCW.CorporateGovernance@wales.nhs.uk or LlywodraethuCorfforaethol.IGDC@wales.nhs.uk.

9 DEFINITIONS

TERM	DEFINITION
WLCO	Welsh Language Commissioners Office
SHA	Special Health Authority
KPI	Key Performance Indicator
IOPR	Integrated Organisational Performance Report

10 WELSH LANGUAGE FRAMEWORK

The Vision: DHCW is a bilingual organisation

Welsh Language Standards Compliance and Improvement Framework

Strategies, policies and other controlled documents	Define what success looks like	Ongoing compliance assessment	Reporting to Meetings	Development plans for improvement
Welsh Language Scheme	**Key Performance Indicators for:** Recruitment Training figures Welsh language self-assessment Bilingual resources Bilingual services	Non-compliance log	Incident Review and Learning Group - Monthly	Training plans
Welsh Language Compliance and Improvement Framework		Wales Informatics Assurance Process	Welsh Language Group – bi-monthly	Investigation outcome action plans
Policy on the use of Welsh internally			Wales Informatics Assurance Group - Monthly	Communications plans
Standard Operating Procedures			Directorate Meetings - Monthly	
Resource and Support documents			Management Board via IOPR - Monthly	
			Audit and Assurance Committee - Quarterly	
			Local Partnership Forum – Bi-monthly	

DIGITAL HEALTH AND CARE WALES
STANDARDS OF BEHAVIOUR REPORT

Agenda Item	5.4

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Laura Tolley, Corporate Governance Manager
Presented By	Laura Tolley, Corporate Governance Manager

Purpose of the Report	For Noting
Recommendation	
The Audit & Assurance Committee is being asked to: NOTE the Standards of Behaviour Report.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below The declarations of interests process ensures DHCW staff adhere to the organisation's statutory responsibilities.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
DOI	Declaration of Interest	SoB	Standards of Behaviour

2 SITUATION/BACKGROUND

2.1 In accordance with the requirements of the DHCW's Standing Orders and Standards of Behaviour Policy, which was approved by the DHCW Board on 1 April 2021, a report is required to be received by the Audit & Assurance Committee as a standing agenda item, which details the Declarations of Interest, Gifts, Honoraria, Hospitality and Sponsorship activities.

2.2 All Board members declarations of interest have been captured on the register for 2022/23 and the information is included as part of the organisations Declarations of Interest Register, which is published on the DHCW Website.

2.3 All declarations of interest are reviewed and checked by the Corporate Governance team and any queries are addressed prior to entry on the register.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Included at 5.4i Appendix A is the 2022/23 Declarations of Interest Register, this features all DHCW Board members. The register focuses initially on staff band 8a and above, however, DHCW are pursuing best practice and asking all staff to complete a declarations of interest form and this will now be reported to DHCW Management Board on a monthly basis from July 2022.

3.2 Work is ongoing to capture the declarations of interest of all DHCW staff band 8a and above,in line with the SOB Policy requirement. As of 24 June 2022, 34% of band 8a and above declarations of interest have been received and captured on the register.

3.3 As work is continuing, we would expect to see the number of captured declarations increase significantly by the October 2022 Committee meeting.

3.4 In line with other NHS Trusts, Health Boards and Special Health Authorities, DHCW have agreed from April 2022 onwards, to operate a 3-year declaration of interest form. However, DHCW

Board members will be required to complete an annual declaration of interest form.

3.5 It is also DHCW's intention to enable all staff to declare interests via ESR, this is a national approach with an expected update in July 2022. An update on progress will be brought to the next Committee meeting in October 2022

3.6 An escalation process has been put in place by the Corporate Governance team to address if staff banded 8a and above have been requested to complete a declaration form, but it has not been submitted.

3.5 The Committee are asked to note that 9 declarations of gifts, hospitality, honoraria and sponsorship were received since the last meeting summarised in the table below.

Nature of Declaration	Accepted	Declined	Grand Total	Value accepted	Value of declined
Gifts	0	0	0	£0	£0
Honorarium	0	0	0	£0	£0
Hospitality	9	0	9	*£2755.63 +VAT	£0
Grand Total	9	0	0	*£2755.63 +VAT	£0

*NB Grand total includes some Euro conversion based on standard exchange rate at time of reporting.

3.6 The gifts, hospitality, honoraria and sponsorship register can be found in full at item 5.4ii Appendix B.

3.7 The Committee are asked to note the acceptance of the below hospitality, which was accepted on 28 February 2022, however, was not reported in the January – May 2022 reporting period:

Nature of Declaration	Accepted	Value accepted
Hospitality	1	£495

3.8 Since the last meeting, the Corporate Governance team have revised the process for submitting declarations to ensure enhanced adherence to the Standards of Behaviour policy. All forms are required to include an email of authorisation from the relevant lead Director, prior to acceptance of the gift, hospitality, honorarium and sponsorship. These are all kept centrally for audit purposes. Where gifts, hospitality, honorarium and sponsorship have been accepted prior to Director approval, individuals are contacted to remind and advise of the standards of behaviour policy and process.

3.9 To actively promote the Standards of Behaviour Policy and Declarations of Interests, Gifts, Hospitality and Honoraria across the organisation, the Corporate Governance team deliver a presentation at the monthly DHCW Corporate Induction and Standards of Behaviour is a regular feature in the Corporate Governance section of the 'Insider'.

3.10 Since the last meeting, targeted communications have been sent to Tier 3 and above staff to remind them of the Standards of Behaviour process and obligations to adhere to the policy.

3.11 Additional Standards of Behaviour promotion work is planned, and updates will be provided at the next Committee meeting in October 2022:

Promotion	Timeframe	Comments
DoI Guide to be published on Intranet	July 2022	This is currently in development
Directorate Training	July – September 2022	Corporate Governance attendance at Directorate meetings to raise awareness
SoB TensTalk	September 2022	A dedicated TensTalk for all staff to attend to raise awareness and include Q&A

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 Work continues to raise awareness of the Standards of Behaviour Policy and requirements.

5 RECOMMENDATION

5.1 The Audit & Assurance Committee is being asked to NOTE the Standards of Behaviour Report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Agenda Item 5.4i Appendix A – Declarations of Interest Register 22_23

Date Received	Name	Title	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
6/4/22	Simon Jones	Chair	Nil Declaration		Ongoing		
6/4/22	Aaron Williams	Infrastructure Design Architect	Nil Declaration		Ongoing		
6/4/22	Ifan Evans	Executive Director, Strategy	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Questions 8, 9, 10,11; Interest in Companies and Securities - Substantial interest is ownership or part ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies - Questions 12,13,14, 15; Other - Questions 20, 21, 22, 23;	(1) 1994 (2) 2014	Ongoing	(1) Evannance Investment Co Ltd (2) (2) Jemico Cyfyngedig (3) Spouse is Chief Marketing Officer of Ogi Fibre, a fibre to the premises provider in south Wales	None of the companies transact or have a relationship with DHCW. Will continuously monitor and should I become aware of any potential conflict I would immediately make Board Secretary and CEO aware and discuss appropriate actions to manage potential conflict
14/4/22	Victoria O'Higgins	Principal Project Manager	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Questions 8, 9, 10,11;	2019	Ongoing	Changeabilities Limited	There is no conflict in my current role.
14/4/22	Amy Vaughan-Thomas	Senior Solutions Architect	Nil Declaration		Ongoing		
14/4/22	Mike Prasad	Cyber Resilience Lead	Nil Declaration		Ongoing		
14/4/22	Joanne Forster	Senior Product Specialist	Nil Declaration		Ongoing		
14/4/22	Jake Plumley	Senior Solutions Architect	Nil Declaration		Ongoing		
14/4/22	Andrew Fletcher	Associate Board Member	Nil Declaration		Ongoing		
14/4/22	Marc Cole	Networking Team Technical Lead	Nil Declaration		Ongoing		
14/4/22	Geraint Jones	Infrastructure Design Architect	Nil Declaration		Ongoing		
14/4/22	Paul Speyer	Service Management Lead	Nil Declaration		Ongoing		
14/4/22	Chris Darling	Board Secretary	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Questions 8, 9, 10,11		Ongoing	Chair of Tir a Mor Scouting	
18/4/22	Rhidian Hurle	Medical Director	Nil Declaration		Ongoing		
18/4/22	Elizabeth Sayce	Planning and Coordination Lead	Nil Declaration		Ongoing		
19/4/22	Keith Farrar	Deputy SRO / Strategic Adviser	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Questions 8, 9, 10,11;	1/07/2014	Ongoing	Director, Intelligent Care Solutions Ltd	
19/4/22	Jamie Manning	Validation Manager	Nil Declaration		Ongoing		

19/04/22	Ruth Glazzard	Vice Chair	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Questions 8, 9, 10,11;		Ongoing	Centre for Digital Public Services Wales	CDPS is a paid position at £198/day with a 2 day a month commitment.
19/04/2022	Ruth Glazzard	Is-gadierydd Aelod Anibynnol Iechyd a Gofal Digidol Cymru/Vice Chair and Independent Member Digital Health and Care Wales	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies	25/08/2020	Ongoing	Non-executive director and Chair of Governance, Remuneration and Audit Committee – Coastal Housing	Paid
19/04/2022	Ruth Glazzard	Is-gadierydd Aelod Anibynnol Iechyd a Gofal Digidol Cymru/Vice Chair and Independent Member Digital Health and Care Wales	Other position of authority not included in Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies	1/03/2020	Ongoing	Non-Executive Director at Greenstream Flooring CIC	Unpaid
21/4/22	Rowan Gardner	Independent Member	Interest in Companies and Securities - Substantial interest is ownership or part ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies -Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies	05/03/2021	Ongoing Ongoing	Biolauncher Ltd Precision Life Ltd	As a founder of the company, I hold shares in this private company. PrecisionLife has raised capital from external investors and myself. The Company announced the first close of an investment round on January 31, 2022. This transaction did not change the number of shares that I hold nor did I receive any proceeds from the investment round.
25/4/22	David Selway	Independent Board Member	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care -	1 Sept 2019 2 Oct 2021	Ongoing Ongoing	1 Amey Consulting 2 Bron Afon Community Housing	
25/04/22	Helen Thomas	Chief Executive Officer	Nil Declaration		Ongoing		
26/04/2022	Gareth Davis	Executive Director of Operations	Nil Declaration		Ongoing		
30/04/2022	Grace Quantock	Independent Member	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care -	Since inception	Ongoing	Trailblazing Wellness Ltd.	Paid a wage and draw dividends.
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Interest in Companies and Securities - Substantial interest is ownership or part ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies;	2016	Ongoing	Trailblazing Wellness Ltd	Paid
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care;		Ongoing	Spouse is Access to Elected Office Fund Wales Panel Member – Disability Wales	Unpaid
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care;		Ongoing	Spouse is Access to Elected Office Fund Wales Panel Member – Disability Wales	Unpaid

30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other		Ongoing	Spouse is Social Care Worker – Mirus Wales	Paid
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other		Ongoing	Brother is Social Care Worker – National Autism Society	Paid
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other		Ongoing	Brother-in-law is Social Care Manager – Pobl	Paid
30/04/2022	Grace Quantock	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other		Onging	Cousin is Social Worker – Caerphilly County Council	Paid
27/05/2022	Julie Ash	Head of Corporate Services	Nil Declaration			Nil Declaration	
03/05/2022	Marian Wyn Jones	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social car		Ongoing	Chairs the 'More than Just Words' Task and Finish Group on the Strategic Welsh Language Framework	
03/05/2022	Marian Wyn Davies	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care;		Ongoing	Cadeirydd y Cyngor/ Chair of Council, Prifysgol Bangor University	Paid
03/05/2022	Marian Wyn Davies	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care;		Ongoing	Aelod o Fwrdd/Board Member Canolfan Gerdd William Mathias, Ymddiriedolwr/ Trustee	
03/05/2022	Marian Wyn Davies	Aelod Anibynnol Iechyd a Gofal Digidol Cymru/ Independent Member Digital Health Care Wales	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care;		Ongoing	Family member is a BBC Journalist	Paid
20/06/2022	Laura Tolley	Corporate Governance Manager	Nil Declaration		Ongoing		
21/06/2022	Donald Kennedy	Lead Infrastructure Design Architect	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care - Questions 16,17,18, 19;	October 2010	Ongoing	SAIL Databank	My wife is business manager for the SAIL databank (Swansea University), and so has workplace dealings with other parts of DHCW
21/06/2022	Rhys Dauncey	Client Services Development Lead	Nil Declaration		Ongoing		
21/06/2022	Ben Rowlands	Programme Manager	Nil Declaration		Ongoing		
21/06/2022	Lindsey Price	Planning Lead	Nil Declaration		Ongoing		
21/06/2022	Alison Maguire	Programme Lead	Nil Declaration		Ongoing		
21/06/2022	G Huw Jones	Principal Integration Architect	Nil Declaration		Ongoing		

21/06/2022	Noel Bevan	Service Management Lead	Nil Declaration		Ongoing		
21/06/2022	Paul Williams	Network Services Manager	Nil Declaration		Ongoing		
21/06/2022	Matthew Thomas	Lead Applications Design Architect	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies -	Since Feb 2020 - but it is inactive (not dormant as there is expenditure)		Architrace Ltd	
21/06/2022	Sarah Brooks	OD, Culture & Engagement Lead	Nil Declaration		Ongoing		
21/06/2022	Cora Suckley	DPO Service Manager	Nil Declaration		Ongoing		
21/06/2022	Naveen Madhavan	Senior Product Specialist	Nil Declaration		Ongoing		
21/06/2022	Karen Shepard	Clinical Specialist Configuration	Nil Declaration		Ongoing		
21/06/2022	Sarah Roberts	Business Lead Client Service	Nil Declaration		Ongoing		
21/06/2022	Rachael Watson	Senior Solution Architect	Nil Declaration		Ongoing		
21/06/2022	Richard Matthews	Lead Infrastructure Design Architect	Nil Declaration		Ongoing		
21/06/2022	Darren Lloyd	Associate Director for Information Governance	Nil Declaration		Ongoing		
21/06/2022	Joanna Dundon	National Clinical Informatics	Nil Declaration		Ongoing		
21/06/2022	Alyson Smith	Head of Organisation Performance	Nil Declaration		Ongoing		
21/06/2022	John Meredith	Head of Application Design	Other position of authority not included in Directorships - A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care - Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies	June 2022 - 2019	May 2024 (2 year term) ongoing	openEHR International (OPENEHR CIC) Co-chair Apperta Foundation Open Platforms Committee Co-chair of a Community Interest Company Workgroup, unpaid	Both positions align with DHCW objectives and with sign-off from line management.
21/06/2022	Heather Wallace	Lead Application Design Architect	Nil Declaration		Ongoing		
22/06/2022	Martin Prosser	Head of Operational Infrastructure	Nil Declaration		Ongoing		
22/06/2022	Kevin Seaward	Compliance Lead	Nil Declaration		Ongoing		
22/06/2022	Mat Friedlander Moseley	Programme Manager	Nil Declaration		Ongoing		
22/06/2022	Jennifer Selby	Senior Product Specialist	Nil Declaration		Ongoing		
22/06/2022	Eluned Cousins	Rheolwr Arweiniol Gwybodaeth (Gofal Sylfaenol)	Nil Declaration		Ongoing		
22/06/2022	Gillian Bell	Clinical Specialist Configuration	Nil Declaration		Ongoing		

Agenda Item 5.4i Appendix A – Declarations of Interest Register 22_23

22/06/2022	Nadia Simpson	Senior Business Change Facilitator	Nil Declaration		Ongoing		
22/06/2022	Paul Evans	Interim Head of Regulatory	Nil Declaration		Ongoing		
22/06/2022	Andy Shanahan	Cyber Security	Nil Declaration		Ongoing		
22/06/2022	Simon Williams	Head Service Management	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies - Interest in Companies and Securities - Substantial interest is ownership or part ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies - Questions	2011		Pulse Form & Fitness Ltd	I manage company accounts in my own time - there is no relationship between the company and the NHS
22/06/2022	Kelly Tremlett	Planning and Coordination Manager	Directorships - Public or private appointments, employment or consultancies. Company directorships in private or limited companies	March 2018	Ongoing	Skate Fitness LTD	No direct conflict of interest
22/06/2022	Gavin Jones	Service Management Team Manager	Nil Declaration		Ongoing		
22/06/2022	Oliver Morrissey	Infrastructure Technology	Nil Declaration		Ongoing		
22/06/2022	Sandra Oliver	National Clinical Informatics Lead	Nil Declaration		Ongoing		
22/06/2022	Ruth Chapman	Assistant Director of Planning	Nil Declaration		Ongoing		
22/06/2022	Geoff Norton	Software development Manager	Other			My wife is considering applying for a post advertised within my department. It is unlikely this needs to be declared as my wife has not applied and I would not be appointing a manager. But I am including it here for transparency.	I do not believe there is any action required to manage any potential conflict of interest. Nonetheless, I have read the guidance given to Appointing Officers in section 6.6. of Digital Health & Care Wales' STANDARDS OF BEHAVIOUR POLICY
22/06/2022	Sophie Kift	Principal Project Manager	Nil Declaration		Ongoing		
22/06/2022	Roberta Houghton	Primary Care IT Support	Nil Declaration		Ongoing		
22/06/2022	Laura Panes	Strategic Procurement and Contracts Manager	Nil Declaration		Ongoing		
22/06/2022	George Olney	Assistant Chief Architect	Nil Declaration		Ongoing		
22/06/2022	Stephen Price	Application Manager	Nil Declaration		Ongoing		
23/06/2022	Frances Beadle	Chief Nursing Information Officer	Nil Declaration		Ongoing		
23/06/2022	Rachael Powell	Associate Director of Information, Intelligence and Research	Nil Declaration		Ongoing		
23/06/2022	Tim Dawe	Senior Product Specialist	Nil Declaration		Ongoing		
23/06/2022	Rebecca McGrane	Programme Manager	Nil Declaration		Ongoing		
23/06/2022	Caroline Busby	Programme Manager	Nil Declaration		Ongoing		
24/06/2022	Amy Mumford	Medicines Nurse Clinical Informatics Lead	Nil Declaration		Ongoing		

24/06/2022	Alex Percival	Strategic Contracts & Commercial Manager	Nil Declaration		Ongoing		
24/06/2022	Claire Osmundsen-Little	Executive Director of Finance	Nil Declaration		Ongoing		

Item 5.4ii Appendix B

REGISTER FOR DHCW GIFTS, HOSPITALITY, SPONSORSHIP AND HONORARIA

DIGITAL HEALTH AND CARE WALES

To date 24 June 2022

Date entered on Register	Name	*Designation or Department*	Provided by / From	Date Gift, Hospitality, Honoraria or sponsorship received/to be received	Details	Value	Type	Authorised by	Accepted or Declined
16/06/2022	Claire Osmundsen-Little	Executive Director of Finance	Healthcare IT Expert Hub Strategy	12-13/07/2022	Accommodation – Norton Park Hotel	£990		Helen Thomas	Accepted
16/06/2022	Claire Osmundsen-Little	Executive Director of Finance	The Richmond Finance Directors' Forum	8/06/2022	Accommodation – The Royal Horseguards' Hotel	£495		Helen Thomas	Accepted
16/06/2022	Helen Thomas	Chief Executive	HIMSS22 Conference	14/06/2022	1 Night accommodation at the Holiday Inn Helsinki Expo for speaking at the HIMSS22 Conference	130 euros		Simon Jones	Accepted
16/06/2022	Helen Thomas	Chief Executive	HIMSS22 Conference	14/06/2022	Travel expenses to Helsinki	250 euros		Simon Jones	Accepted
17/06/2022	Rhidian Hurle	Executive Medical Director	HIMSS22 Conference	14/06/2022	1 Night accommodation at the Holiday Inn Helsinki Expo for the HIMSS22 Conference	130 euros		Helen Thomas	Accepted
17/06/2022	Ifan Evans	Executive Director of Strategy	HIMSS22 Conference	14/06/2022	1 Night accommodation at the Holiday Inn Helsinki Expo for the HIMSS22 Conference and travel costs	380 euros		Helen Thomas	Accepted
17/06/2022	Rhidian Hurle	Executive Medical Director	HIMSS22 Conference	14/06/2022	1 Night accommodation at the Holiday Inn Helsinki Expo for the HIMSS22 Conference	130 euros		Helen Thomas	Accepted
17/06/2022	Fran Beadle	Chief Nursing Information Officer	HIMSS22 Conference	14/06/2022	1 Night accommodation at the Holiday Inn Helsinki Expo for the HIMSS22 Conference and travel costs	380 euros		Rhidian Hurle	Accepted
20/06/2022	Rhidian Hurle	Executive Medical Director	AHMEDIA UK	26/04/2022	Clinical Strategy Forum Accommodation and Meal	£180		Helen Thomas	Accepted

DIGITAL HEALTH AND CARE WALES
HIGH VALUE PURCHASE ORDERS REPORT

Agenda Item	5.5

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Mark Cox, Associate Director of Finance
Presented By	Mark Cox, Associate Director of Finance

Purpose of the Report	For Noting
Recommendation	
The Audit and Assurance Committee is being asked to **NOTE** the details of major procurements reported since the last Audit Committee meeting.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	N/A
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement:N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
VAT	Value Added Tax	DHCW	Digital Health and Care Wales
GP	General Practitioners	SHA	Special Health Authority

2 SITUATION/BACKGROUND

2.1 The purpose of this report is to provide the Audit & Assurance Committee with an update in relation to high value purchase orders over £0.750m (excluding VAT) raised and issued to suppliers over the stated period. The relevance of the £0.750m threshold is that this is consistent with the scheme of delegation financial limits for All Wales Digital Contracts & Agreements (detailed within Schedule 1 page 56 of the organisations Standing Orders). As previously reported, due to the sensitive nature of the transactions, exact order amounts are not detailed within the public portion of this report in order to minimise any possible fraud activity.

2.2 The report also details instances where cumulative order values to suppliers have amounted to over £0.750m during the financial year.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 During the period April 1st 2022 and 16th June 2022 three orders over £0.750m were raised totalling £8.277m giving a cumulative total of £8.277m for the financial year.

3.2 Of the three orders raised since the last audit report, one relates to the All Wales Microsoft Enterprise agreement (ref A1). The second to the relates to COVID-19 Response (ref A2) covering Microsoft CRM licencing supporting Test, Trace & Protect Services and the final order for the provision of Data Quality services within GMS (ref A3).

3.3 The details of all orders raised to date and individual governance approval is presented within

5.5i Appendix A – High Value Purchase Order Tracker. An extract is detailed within table 1.

Table 1: High Value Orders (redacted extract) April 1st 2022 – 16th June 16th 2022

Ref	Date Raised	Area	Supplier	Description
A1	13/06/2022	All Wales Licence Provision	TRUSTMARQUE SOLUTIONS LTD	All Wales Microsoft Enterprise Agreement
A2	29/04/2022	COVID-19 Response	SOLGARI LTD	Microsoft Dynamics Integrated Telephony Solution for Test Trace Protect (TTP), Feb 2022 to May 2023
A3	13/04/2022	GP Systems	INFORMATICA SYSTEMS LTD	P307 DQS CONTRACT, EXTENSION 01/07/2022 TO 30/06/2023

3.4 As requested at Audit Committee of 06/07/21, the details of suppliers whose cumulative orders for the year have also reached the £0.750m threshold are also presented within this report and itemised further in 5.5ii Appendix B and within table 2 of this report. During the period April 1st 2022 and June 16th 2022 there are 2 suppliers that have a cumulative order request of over £0.750m (excluding single orders/contracts reported with Appendix A).

For note the only supplier not reported in previous periods and excluded from Appendix A with cumulative orders which combine to over £0.750m includes:

- Provision of PSBA rental agreement and some circuits enhancements (ref B1) and for computer hardware and licences (ref B2).

Table 2: Cumulative Supplier Orders reaching £0.750m for the financial year April 1st 2022 – 16th June 16th 2022

Ref	No of Orders	Area	Supplier	Description
B1	11	Networking	BRITISH TELECOMMUNICATIONS PLC	PSBA Circuit Upgrade and rental costs
B2	6	Computer Hardware	COMPUTACENTER (UK) LTD	Computer Infrastructure, Licences & Support

3.5 DHCW Commercial Services department is undertaking an exercise reviewing past procurement activity and forward spend plans to ascertain whether efficiencies can be gained in future procurements where there are similar levels of historical activity.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee

5 RECOMMENDATION

5.1 The Audit and Assurance Committee are asked to **NOTE** the contents of this report and the high value & cumulative high value orders raised to date.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Agenda item 5.5i App A

HIGH VALUE PURCHASE ORDER TRACKER

Ref	Area	Supplier	Service/Good Detail	Date Order Raised	Amount £	Procurement Approved by DHCW Board (Date)
			2022/23 Purchase Orders			
	Reported at Audit & Assurance Committee 4th July 2022					
A1	All Wales Licence Provision	TRUSTMARQUE SOLUTIONS LTD	All Wales Microsoft Enterprise Agreement	13/06/2022	>£0.750m	26th May Board
A2	COVID-19 Response	SOLGARI LTD	Microsoft Dynamics Integrated Telephony Solution for Test Trace Protect (TTP), Feb 2022 to May 2023	29/04/2022	>£0.750m	31st March Board
A3	GP Systems Maintenance Support	INFORMATICA SYSTEMS LTD	P307 DQS CONTRACT, EXTENSION 01/07/2022 TO 30/06/2023	13/04/2022	>£0.750m	Jan 2022 Mgt Board
	Total				**25,473**	
Grand Total High Value Purchase Orders					**25,473**	

* Covers orders during the period April 1st 2022 to 16th June 2022

Agenda item 5.5i App A

HIGH VALUE PURCHASE ORDER TRACKER

Ref	Area	Supplier	Service/Good Detail	Date Order Raised	Amount £	Procurement Approved by DHCW Board (Date)
			2021/22 Purchase Orders			
	Reported at Audit & Assurance Committee 6th July 2021					
A1	GP Systems	HEWLETT PACKARD	Managed Print Service	14/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A2	GP Systems	IN PRACTICE SYSTEMS LTD	GP Software Systems Maintenance (Vision) 2021-22	14/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A3	Datacentres	BT PLC	Datacentre 1 Rental to 2023	14/04/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A4	Datacentres	CDW LTD	Datacentre 2 Rental to 2026	14/04/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
	Total				**£8.277**	
	Reported at Audit & Assurance Committee 5th October 2021					
A5	COVID-19 Response	TRUSTMARQUE SOLUTIONS LTD	TTP 3500 Microsoft CRM licences for 12 mth coverage	18/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A6	COVID-19 Response	SOLGARI LTD	Microsoft Dynamics Integrated Telephony Solution for Test Trace Protect (TTP), 1 year Extension	02/07/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A7	COVID-19 Response	CABINET OFFICE	Vaccination Programme GOV Notify Platform	21/07/2021	>£0.750m	May-21
A8	All Wales Licence Provision	TRUSTMARQUE SOLUTIONS LTD	All Wales Microsoft Enterprise Agreement Year 3	28/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
	Total				**£27.762**	
	Reported at Audit & Assurance Committee 4th January 2022					
A9	GP Systems Maintenance Support	EGTON MEDICAL INFORMATION SYSTEMS LTD (EMIS HEALTH)	System Provision & Supprt Apr - July	21/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A10	GP Systems Maintenance Support	EGTON MEDICAL INFORMATION SYSTEMS LTD (EMIS HEALTH)	System Provision & Supprt August - December	17/11/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A11	Networking	BRITISH TELECOMMUNICATIONS PLC	GP PSBA Connectivity Services 2021-22	21/06/2021	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A12	Datacentres	COMPUTACENTER (UK) LTD	Citrix Software Provision & Support	14/12/2021	>£0.750m	Nov-21
A13	Subscriptions & Electronic Knowlegdebases	ELSEVIER LTD	Access to Clinical Key : September 2021 - December 2022	22/12/2021	>£0.750m	Nov-21
	Total				**£4.576**	

Grand Total High Value Purchase Orders						
	Reported at Audit & Assurance Committee 3rd May 2022					
A14	COVID-19 Response	HP INC UK LTD	ORDER TO COVER THE COSTS OF HP MANAGED PRINT PER CLICK COSTS QTR 1 -4 P428 2022-23	21/03/2022	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A15	GP Systems Maintenance Support	IN PRACTICE SYSTEMS LTD	IPS SUPPORT & MAINTENANCE	25/03/2022	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
A16	DSPP	KAINOS SOFTWARE LTD	P659 Lot 1 DSPP Application Partner Work Package 3 (Milestone 1)	18/03/2022	>£0.750m	Board meeting of the 29th of July 2021
A17	DSPP	KAINOS SOFTWARE LTD	P659 Lot 1 DSPP Application Partner Work Package 2	18/03/2022	>£0.750m	Board meeting of the 29th of July 2021
A18	COVID-19 Response	MICROSOFT LTD	P647 VALUE CALL OFF FOR DEVELOPMENT RESOURCES FOR MS DYNAMICS CRM SOLUTION FOR TTP.	20/01/2022	>£0.750m	N/A Velindre NHS Trust novated approved NWIS contract
	Total				**£5.136**	
Grand Total High Value Purchase Orders					**£45.75**	

CUMULATIVE HIGH VALUE PURCHASE ORDER TRACKER

Ref	Area	Supplier	Service/Good Detail	Number of Orders	Amount £
			2022/23 Purchase Orders		
	Reported at Audit & Assurance Committee 5th October 2021				
B1	Networking	BRITISH TELECOMMUNICATIONS PLC	PSBA Circuit Upgrade and rental costs	11	>£0.750m
B2	Computer Software and hardware	COMPUTACENTER (UK) LTD	Computer Infrastructure, Licences & Support	6	>£0.750m
	Total				**£1.643m**

* Covers orders during the period April 1st 2022 to 16th June 2022

CUMULATIVE HIGH VALUE PURCHASE ORDER TRACKER

Ref	Area	Supplier	Service/Good Detail	Number of Orders	Amount £
			2021/22 Purchase Orders		
	Reported at Audit & Assurance Committee 6th July 2021				
			Emerging Requirement - None Reported		
	Total				
	Reported at Audit & Assurance Committee 5th October 2021				
B1	Networking	BRITISH TELECOMMUNICATIONS PLC	PSBA Circuit Upgrade and rental costs	41	>£0.750m
B2	Computer Hardware	DELL COMPUTER CORPORATION	Misc. hardware, laptops and server support	33	>£0.750m
B3	All Wales Office 365 Implementation	REDCORTEX LTD	Misc. Professional Technical Services	4	>£0.750m
	Total				**£3.256m**
	Reported at Audit & Assurance Committee 18th January 2022				
B4	Networking	BRITISH TELECOMMUNICATIONS PLC	PSBA Circuit Upgrade and rack rental costs	51	>£0.750m
B5	Computer Hardware	DELL COMPUTER CORPORATION	Misc. hardware, laptops and server support	74	>£0.750m
B6	All Wales Office 365 Implementation	REDCORTEX LTD	Misc. Professional Technical Services	6	>£0.750m
B7	Computer Software	COMPUTACENTER (UK) LTD	Computer Infrastructure, Licences & Support	27	>£0.750m
B8	Computer Software	INTERSYSTEMS CORPORATION	WLIMS Systems Provision & Support	16	>£0.750m
B9	Vehicles	NORTHUMBRIA HC NHS TRUST	NHS Fleet Solutions Employee Lease Scheme	119	>£0.750m
B10	Computer Software	TRUSTMARQUE SOLUTIONS LTD	Cloud Services/Storage & Miscellaneous Software Licences	87	>£0.750m
B11	Application Development	ALEXANDER MANN SOLUTIONS LTD	Misc. Professional Technical Services	38	>£0.750m
B12	Subscriptions & Electronic Knowledgebases	EBSCO INFORMATION SERVICES	Electronic Journals, Databases and Subscriptions	5	>£0.750m

B13	Computer Software	INFORMATICA SYSTEMS LTD	Data Quality Standards System Maintenance & SAIL Data extracts	6	>£0.750m
	Total				**16.090m**
	Reported at Audit & Assurance Committee 3rd May 2022				
B14	Networking	BRITISH TELECOMMUNICATIONS PLC	PSBA Circuit Upgrade and rack rental costs	51	>£0.750m
B15	Computer Hardware	DELL COMPUTER CORPORATION	Misc. hardware, laptops and server support	113	>£0.750m
B16	All Wales Office 365 Implementation	REDCORTEX LTD	Misc. Professional Technical Services	7	>£0.750m
B17	Computer Software	COMPUTACENTER (UK) LTD	Computer Infrastructure, Licences & Support	27	>£0.750m
B18	Computer Software	INTERSYSTEMS CORPORATION	WLIMS Systems Provision & Support	19	>£0.750m
B19	Vehicles	NORTHUMBRIA HC NHS TRUST	NHS Fleet Solutions Employee Lease Scheme	147	>£0.750m
B20	Computer Software	TRUSTMARQUE SOLUTIONS LTD	Cloud Services/Storage & Miscellaneous Software Licences	89	>£0.750m
B21	Application Development	ALEXANDER MANN SOLUTIONS LTD	Misc. Professional Technical Services	55	>£0.750m
B22	Subscriptions & Electronic Knowledgebases	EBSCO INFORMATION SERVICES	Electronic Journals, Databases and Subscriptions	42	>£0.750m
B23	Computer Software	INFORMATICA SYSTEMS LTD	Data Quality Standards System Maintenance & SAIL Data extracts	6	>£0.750m
B24	Computer Software	KAINOS SOFTWARE LTD	P659 Lot 1 DSPP Application Partner Work Package 3-A078, work package 2 -A078, work package 1 dev/test/prod	5	>£0.750m
	Total				**24.513m**

DIGITAL HEALTH AND CARE WALES
STANDING FINANCIAL INSTRUCTIONS ANNUAL REVIEW

Agenda Item	5.7

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Mark Cox, Associate Director of Finance
Presented By	Mark Cox, Associate Director of Finance

Purpose of the Report	For Noting
Recommendation	
The Audit & Assurance Committee is being asked to: **ENDORSE** the Standing Financial Instructions Review and proposed changes. **NOTE** the progress to date in their implementation and compliance.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission:
Yes, applicable	Outcome:
Statement:	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	The Standing Financial Instructions form the basis upon which DHCW's governance and accountability framework is developed and, together with the adoption of DHCW's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	The SFI's are designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report

WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
SFI	Standing Financial Instructions	SO	Standing Orders

2 SITUATION/BACKGROUND

2.1 The SHA standing orders require that the DHCW Board must consider and agree to adopt the Standing Orders (SOs) for the regulation of their proceedings and business. They are designed to translate the statutory requirements set out in legislation into day-to-day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of DHCW.

These SFIs detail the financial responsibilities, policies and procedures adopted by DHCW. They are designed to ensure that DHCW's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by DHCW.

2.2 The DHCW Board considered and agreed to adopt the Standing Financial Instructions in April 2021.

2.3 This paper presents the outcome of the annual Standing Financial Instructions content and implementation/compliance review.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Standing Financial Instructions – Content Review

The Audit and Assurance Committee are asked to note the following changes to the Standing Financial Instructions attached Standing Financial Instructions with tracked changes:

- Allocations And Financial Duty: Section 4 (Page 19) 4.1
  Amendment: "Revenue and capital allocations are determined by Welsh Ministers in accordance with its allocated budget and distribution policy" Deleted as superfluous and not explicitly relevant to DHCW.

- Non-Pay Expenditure: Section 11 (Page 34) 11.2
  Amendment: Section amended to "Ensure the Board are advised regarding the NHS Wales national procurement and payment systems thresholds" rather than "Advise the Board regarding the NHS Wales national procurement and payment systems thresholds".

- Non-Pay Expenditure: Section 11 (Page 36) 11.5.1
  Amendment: replaced "behalf of the DHCW" to "behalf of DHCW".

- Non-Pay Expenditure: Section 11 (Page 37) 11.6.2
  Amendment: revised wording from " on the DHCW" to "on DHCW".

- Procurement And Contracting For Goods And Services: Section 12 (Page 38) 12.2.1
  Amendment: revised schedule reference from "2" to "1".

- Agreements And Contracts For All Wales Digital Solutions & Services Section 13 (page 53) 13.1.4
  Amendment: revised schedule reference from "2" to "1".

- Capital Plan, Capital Investment, Fixed Asset Registers And Security of Assets: Section 16 (Page 68) 16.7.3
  Amendment: "Director of Planning" reference removed.

- Revised General Consent To Enter Individual Contracts: Schedule 1 (Page 77)

  Amendment: Updated to reflect latest Welsh Government issue of 31st March 2022 (replacing November 2020 version with DHCW now explicitly referenced within the latest letter).

Details of the review can be found in Appendix A.

3.2 Standing Financial Instructions – Implementation & Compliance Review

To ensure compliance with Standing Financial instructions DHCW has implemented a number

of controls and established governance and assurance arrangements presented within the table below:

Policies/Financial Controls & Standard Operating Procedures	Governance & Control Forums	Financial Performance Governance & Scrutiny Forums	Assurance & Compliance
All Wales Counter Fraud Policy	Internal Controls Group	DHCW Directorates	Audit & Assurance Committee
Development, Approval & Submission of Business Cases	Capital & Non-Pay Delivery Group	Management Board	Internal Audit
Integrity & Control of Financial Systems	Financial Planning Pay Group	SHA Board	Audit Wales
Accounts Payable	Remuneration and Terms of Service Committee	Finance Delivery Unit	
Accounts Receivable	DHCW SHA Board	Welsh Government	
Credit Card Processes			
Budgetary Control			
Cash & Banking			
Fixed Asset			
Capital Management Policy			
IT Asset Management Policy			
Information Asset Policy, Fixed Asset Policy and			
IT Hardware removal, redeployment and disposal policy.			

DHCW can report no instances of non-compliance with SFI's.

Details of the review of Standing Financial Instruction implementation and compliance can be found in Appendix B.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 All DHCW Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within DHCW. If approved by the Board the amended SFI's will be uploaded to the DHCW Internet site and DHCW SharePoint site.

4.2 Proposed amendments once endorsed will be required to be presented to the SHA Board on July 28th 2022 for approval (under the consent agenda).

5 RECOMMENDATION

5.1 The Audit and Assurance Committee is being asked to:
ENDORSE the changes to the Standing Financial Instructions and NOTE the progress/compliance to date in their implementation.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
DHCW Management Board	23/06/2022	Noted

5.7i Appendix A: Standing Financial Instructions - Review

Ref	Section	Lead	Comment	Proposed Change
1	**INTRODUCTION**	Mark Cox	None	None
1.1	General	Mark Cox	None	None
1.2	Overriding Standing Financial Instructions	Mark Cox	None	None
1.3	Financial provisions and obligations of DHCW	Mark Cox	None	None
2	**RESPONSIBILITIES AND DELEGATION**	Mark Cox	None	None
2.1	The Board	Mark Cox	None	None
2.2	The Chief Executive and Director of Finance	Mark Cox	None	None
2.3	The Director of Finance	Mark Cox	None	None
2.4	Board members and DHCW officers, and DHCW Committees and Advisory Groups	Mark Cox	None	None
2.5	Contractors and their employees	Mark Cox	None	None
3	**AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT**	Mark Cox	None	None
3.1	Audit Committee	Mark Cox	None	None
3.2	Chief Executive	Mark Cox	None	None
3.3	Internal Audit	Mark Cox	None	None
3.4	External Audit	Mark Cox	None	None
3.5	Fraud and Corruption	Mark Cox	None	None
3.6	Security Management	Mark Cox	None	None
4	**ALLOCATIONS AND FINANCIAL DUTY**	Mark Cox	Revenue and capital allocations are determined by Welsh Ministers in accordance with its allocated budget and distribution policy	Delete as superfluous and not explicitly relevant to DHCW
5	**INTEGRATED PLANNING**	Mark Cox	None	None
6	**FINANCIAL MANAGEMENT AND BUDGETARY CONTROL**	Mark Cox	None	None
6.1	Budget Setting	Mark Cox	None	None
6.2	Budgetary Delegation	Mark Cox	None	None
6.3	Financial Management, Reporting and Budgetary Control	Mark Cox	None	None
6.4	Capital Financial Management, Reporting and Budgetary Control	Mark Cox	None	None
6.5	Reporting to Welsh Government - Monitoring Returns	Mark Cox	None	None
7	**ANNUAL ACCOUNTS AND REPORTS**	Sian Williams	None	None
8	**BANKING ARRANGEMENTS**	Ian Taylor	None	None
8.1	General	Ian Taylor	None	None
8.2	Bank Accounts	Ian Taylor	None	None
8.3	Banking Procedures	Ian Taylor	None	None
8.4	Review	Ian Taylor	None	None
9	**CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS**	Ian Taylor	None	None
9.1	General	Ian Taylor	None	None
9.2	Petty Cash	Ian Taylor	None	None
10	**INCOME, FEES AND CHARGES**	Ian Taylor	None	None
10.1	Income Generation	Ian Taylor	None	None
10.2	Income Systems	Ian Taylor	None	None
10.3	Fees and Charges	Ian Taylor	None	None
10.4	Income Due and Debt Recovery	Ian Taylor	None	None
11	**NON-PAY EXPENDITURE**			
11.1	Scheme of Delegation, Non Pay Expenditure Limits and Accountability	Sian Williams	None	None

11.2	The Director of Finance's responsibilities	Sian Williams	a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;	a) Ensure the Board are advised regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;
11.3	Duties of Budget Holders and Managers	Sian Williams	None	None
11.4	Departures from SFI's	Sian Williams	None	None
11.5	Accounts Payable	Sian Williams	11.5.1 wording " behalf of the DHCW"	"behalf of DHCW"
11.6	Prepayments	Sian Williams	11.6.2 wording " on the DHCW" rather than "on DHCW"	"on DHCW"
12	**PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES**	Mark Cox	None	None
12.1	Procurement Services	Mark Cox	None	None
12.2	Policies and Procedures	Mark Cox	None	None
12.3	Procurement Principles	Mark Cox	None	None
12.4	Procurement Regulations and Legislation Governing Public Procurement	Mark Cox	None	None
12.5	Procurement Procedures	Mark Cox	None	None
12.6	Procurement Consent/Notification	Mark Cox	12.6.1 The guidance process for DHCW to notify their intent to enter into contracts exceeding £1 million is at Schedule 2. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.D73	12.6.1 The guidance process for DHCW to notify their intent to enter into contracts exceeding £1 million is at Schedule 1. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.
12.7	Sustainable Procurement	Mark Cox	None	None
12.8	Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)	Mark Cox	None	None
12.9	Planning Procurements	Mark Cox	None	None
12.1	Procurement Process	Mark Cox	None	None
12.11	Procurement Thresholds	Mark Cox	None	None
12.12	Designing Competitions	Mark Cox	None	None
12.13	Single Quotation Application or Single Tender Application	Mark Cox	None	None
12.14	Disposals	Mark Cox	None	None
12.15	Evaluation, Approval and Award	Mark Cox	None	None
12.16	Contract Management	Mark Cox	None	None
12.17	Extending and Varying Contracts	Mark Cox	None	None
12.18	Requisitioning	Mark Cox	None	None
12.19	No Purchase Order, No Pay	Mark Cox	None	None
12.2	Official orders	Mark Cox	None	None
13	**AGREEMENTS AND CONTRACTS FOR ALL WALES DIGITAL SOLUTIONS & SERVICES**	Mark Cox	None	None
13.1	Digital Solution Agreements	Mark Cox	13.1.4 For all agreements entered into in the form of a contract, the process for notifying the Welsh Ministers of NHS contracts set out in section 12 and Schedule 2 of these SFIs must be followed.	13.1.4 For all agreements entered into in the form of a contract, the process for notifying the Welsh Ministers of NHS contracts set out in section 12 and Schedule 1 of these SFIs must be followed.
13.2	Statutory provisions	Mark Cox	None	None

13.3	Application of delegated limits	Mark Cox	None	None
14	**GRANT FUNDING,**	Sarah Szmidt	None	None
14.1	Legal Advice	Sarah Szmidt	None	None
14.2	Policies and procedures	Sarah Szmidt	None	None
14.3	Corporate Principles underpinning Grants Management	Sarah Szmidt	None	None
14.4	Grant Procedures	Sarah Szmidt	None	None
15	**PAY EXPENDITURE**	Sian Williams	None	None
15.1	Remuneration and Terms of Service Committee	Sian Williams	None	None
15.2	Funded Establishment	Sian Williams	None	None
15.3	Staff Appointments	Sian Williams	None	None
15.4	Pay Rates and Terms and Conditions	Sian Williams	None	None
15.5	Payroll	Sian Williams	None	None
15.6	Contracts of Employment	Sian Williams	None	None
16	**CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**	David Palmer	None	None
16.1	Capital Plan	David Palmer	None	None
16.2	Capital Investment Decisions	David Palmer	None	None
16.3	Capital Projects	David Palmer	None	None
16.4	Capital Procedures and Responsibilities	David Palmer	None	None
16.5	Capital Financing with the Private Sector	David Palmer	None	None
16.6	Asset Registers	David Palmer	None	None
16.7	Security of Assets	David Palmer	16.7.1 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.	16.7.1 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.
17	**STORES AND RECEIPT OF GOODS**	David Palmer	None	None
17.1	General position	David Palmer	None	None
17.2	Control of Stores, Stocktaking, condemnations and disposal	David Palmer	None	None
17.3	Goods supplied by an NHS supplies agency	David Palmer	None	None
18	**DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**	David Palmer	None	None
18.1	Disposals and Condemnations	David Palmer	None	None
18.2	Losses and Special Payments	David Palmer	None	None
19	**DIGITAL, DATA and TECHNOLOGY**	Mark Cox	None	None
19.1	Digital Data and Technology Strategy	Mark Cox	None	None
19.2	Responsibilities and duties of the responsible Director	Mark Cox	None	None
19.3	Responsibilities and duties of the Director of Finance	Mark Cox	None	None
19.4	Contracts for data and digital services with other health bodies or outside agencies	Mark Cox	None	None
19.5	Risk assurance	Mark Cox	None	None
20	**RETENTION OF RECORDS**	Sian Williams	None	None
20.1	Responsibilities of the Chief Executive	Sian Williams	None	None
	SCHEDULE 1	Sian Williams		
	Revised General Consent to Enter Individual Contracts	Sian Williams	March 2020 Version	Updated for March 22 and dates, version now references DHCW. Note applicable to DHCW (but explicit to HEIW) the following was added "Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent. "

5.7ii Appendix B: Standing Financial Instructions - Compliance Review

(DHCW Responses in bold italic)

Ref	Section	Key Points to Note
1		
1.1	General	Sections 1.2.1 identifies the requirement to report full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit and Assurance Committee "Audit Committee" to formally consider the matter and make proposals to the Board on any action to be taken. Whilst 1.2.2 stipulates failure to comply being a disciplinary matter. ***DHCW can report no instances of non compliance with SFI's***
1.2	Overriding Standing Financial Instructions	
1.3	Financial provisions and obligations of DHCW	
2	**RESPONSIBILITIES AND DELEGATION**	**RESPONSIBILITIES AND DELEGATION**
2.1	The Board	2.1.1The Board exercises financial supervision and control by: a)Formulating and approving the Medium Term Financial Plan (MTFP) as part of the developing and approving medium term plan, reflecting longer-term planning and delivery objectives; ***As part of the IMTP process the medium term financial plan was approved.*** 2.3.1The Director of Finance is responsible for: a)Implementing DHCW's financial policies and for co-coordinating any corrective action necessary to further these policies; ***DHCW has implemented the following policies/controls, performance reporting forums and Governance/Scrutiny Forums to ensure compliance*** ***All Wales Counter Fraud Policy*** ***Development, Approval & Submission of Business Cases*** ***Integrity & Control of Financial Systems*** ***Accounts Payable*** ***Accounts Receivable*** ***Credit Card Processes*** ***Budgetary Control*** ***Cash & Banking*** ***Fixed Asset*** ***Capital Management Policy*** ***IT Asset Management Policy*** ***Information Asset Policy, Fixed Asset Policy and*** ***IT Hardware removal, redeployment and disposal policy***
2.2	The Chief Executive and Director of Finance	
2.3	The Director of Finance	
2.4	Board members and DHCW officers, and DHCW Committees and Advisory Groups	
2.5	Contractors and their employees	
3	**AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT**	**AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT**
3.1	Audit Committee	Section 3.1.1 identifies the requirement for an independent Audit Committee as a central means by which a Board ensures effective internal control arrangements are in place and to provide a form of independent check upon the executive arm of the Board. ***A formal Audit & Assurance Committee has been established in accordance with guidance set out within the NHS Wales Audit Committee handbook.*** Section 3.2.1 & 3.2.2 presents the Chief Executive responsibilities pertaining to establishing arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective Internal Audit function and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer. ***DHCW has an secured Internal Audit Services via an SLA with NHS Wales Shared Services which agree an annual audit plan, attend Audit & Assurance Committee and present findings/recommendations.*** Section 3.5.1 identifies the responsibilities of DHCW Chief Executive and Director of Finance in monitoring and ensuring compliance with Directions issued by the Welsh Ministers on fraud and corruption. ***DHCW has Local Counter Fraud Specialist services provided by Cardiff & Vale UHB with an approved counter fraud plan. This is supported via an internal DHCW nominated senior lead.***
3.2	Chief Executive	
3.3	Internal Audit	
3.4	External Audit	
3.5	Fraud and Corruption	
3.6	Security Management	

4	**ALLOCATIONS AND FINANCIAL DUTY**	4.1The Director of Finance of DHCW will: a)Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve; ***DHCW 2022 Financial plan and high level Directorate Delegated Expenditure Limits was approved by the SHA Board on March 31st.*** 4.2 DHCW is required by statutory provision not to breach its financial duty to secure that its expenditure does not exceed the aggregate of its resource allocations and income received. This duty applies separately to capital and revenue resource allocations. The Chief Executive has overall executive responsibility for DHCW's activities and is responsible to the Board for ensuring that it meets its financial duty as set out in section 172 of the National Health Service (Wales) Act 2006. ***DHCW has net this statutory target for the financial year 2021/22 and a balanced financial plan for 2022/23.***
5	**INTEGRATED PLANNING**	Section 5.1 requires DHCW to prepare appropriate plans as required by legislation and the Welsh Government. ***DHCW has produced an Annual Plan for 2021/22 and a 3 Year 2022/23 IMTP approved by the board.***
6	**FINANCIAL MANAGEMENT AND BUDGETARY CONTROL**	**FINANCIAL MANAGEMENT AND BUDGETARY CONTROL**
6.1	Budget Setting	Section 6.1 requires that prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. ***The DHCW budget plan was submitted and approved by the Board as part of the IMTP on March 31st 2022.*** Section 6.3.1 requires for the Director of Finance to monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every Board meeting. ***DHCW submits financial performance reports on a monthly basis to Management Board and Welsh Government. With SHA Board reporting presented for each session. The internal audit review of Core Financial Systems resulted in an option of Moderate Assurance for reporting processes.***
6.2	Budgetary Delegation	
6.3	Financial Management, Reporting and Budgetary Control	
6.4	Capital Financial Management, Reporting and Budgetary Control	
6.5	Reporting to Welsh Government - Monitoring Returns	
7	**ANNUAL ACCOUNTS AND REPORTS**	Section 7.1 requires that the Board must approve DHCW's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable. ***The SHA Board approved the 2021/22 annual accounts on 14/05/2022.***
8	**BANKING ARRANGEMENTS**	**BANKING ARRANGEMENTS**
8.1	General	Section 8.1.1 requires that the Director of Finance is responsible for managing DHCW's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. ***DHCW has established banking arrangements and Financial Control Procedures duly reviewed via the Internal Audit review of Core Financial Systems***
8.2	Bank Accounts	
8.3	Banking Procedures	
8.4	Review	
9	**CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS**	**CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS**
9.1	General	Section 9.1.1 requires that the Director of Finance is responsible for approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable. Ensuring effective control systems are in place for the use of payment cards, Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation. 9.2.1The Director of Finance will issue instructions restricting the use and value of petty cash purchases. ***Whilst DHCW has chosen not to implement a petty cash provision for 2021/22 a full financial control procedure has been established to manage credit card usage and transactions.***
9.2	Petty Cash	
10	**INCOME, FEES AND CHARGES**	**INCOME, FEES AND CHARGES**
10.1	Income Generation	10.1.1 DHCW shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the NHS (Wales) Act 2006 (c.42). 10.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. 10.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received. ***DHCW has established robust processes and Financial Control Procedures to ensure compliance.***
10.2	Income Systems	
10.3	Fees and Charges	
10.4	Income Due and Debt Recovery	

11	**NON-PAY EXPENDITURE**	**NON-PAY EXPENDITURE**
11.1	Scheme of Delegation, Non Pay Expenditure Limits and Accountability	11.1.1. Requires that the Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers, whilst 11.1.2. stipulates that the Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the DHCW scheme of delegation. ***A scheme of delegation has been approved with controls via the procurement approval process and Oracle financial System approval heirachy. There have been no instances of departure from SFI's.*** 11.2.1. Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. ***Processes to comply with the PSPP are in place and successful with the organisation recording 98% compliance against a target of 95%.*** 11.4.1Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. DHCW must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the DHCW Scheme of Delegation. ***The operational scheme of delegation for non pay spend is consistent with those set out within the Standing Orders delegated financial limits.***
11.2	The Director of Finance's responsibilities	
11.3	Duties of Budget Holders and Managers	
11.4	Departures from SFI's	
11.5	Accounts Payable	
11.6	Prepayments	
12	**PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES**	**PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES**
12.1	Procurement Services	***DHCW has a robust Procurement Approval Process underpinned by monitoring via its internal controls forum. Single Tenders are approved by Director of Finance & Chief Executive in all instances and reported to Audit & Assurance committee.*** ***There are no known instances of non compliance with SFI procurement rules.***
12.2	Policies and Procedures	
12.3	Procurement Principles	
12.4	Procurement Regulations and Legislation Governing Public Procurement	
12.5	Procurement Procedures	
12.6	Procurement Consent/Notification	
12.7	Sustainable Procurement	
12.8	Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)	
12.9	Planning Procurements	
12.1	Procurement Process	
12.11	Procurement Thresholds	
12.12	Designing Competitions	
12.13	Single Quotation Application or Single Tender Application	
12.14	Disposals	
12.15	Evaluation, Approval and Award	
12.16	Contract Management	
12.17	Extending and Varying Contracts	
12.18	Requisitioning	
12.19	No Purchase Order, No Pay	
12.2	Official orders	
13	**AGREEMENTS AND CONTRACTS FOR ALL WALES DIGITAL SOLUTIONS & SERVICES**	**AGREEMENTS AND CONTRACTS FOR ALL WALES DIGITAL SOLUTIONS & SERVICES**
13.1	Digital Solution Agreements	13.1.1 The Chief Executive is responsible for ensuring DHCW enters into suitable agreements for its provision of all Wales digital and information solutions. ***DHCW has an established Procurement Approval process which assures alignment with the approved plan and that commercial/financial processes are followed.***
13.2	Statutory provisions	
13.3	Application of delegated limits	
14	**GRANT FUNDING,**	**GRANT FUNDING,**
14.1	Legal Advice	It is a matter for DHCW to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to
14.2	Policies and procedures	
14.3	Corporate Principles underpinning Grants Management	

14.4	Grant Procedures	delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.) ***DHCW does not have any qualifying grant funding.***
15	**PAY EXPENDITURE**	**PAY EXPENDITURE**
15.1	Remuneration and Terms of Service Committee	15.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.3. ***DHCW has established a Remuneration and Terms of Service Committee to 1-Approve on behalf of the Board matters relating to the appointment, termination, remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government in accordance with the scheme of delegation. This may relate to terms of service upon appointment or during service.*** **2-Approve proposals regarding termination arrangements, including those under the Voluntary Early Release Scheme, ensuring the proper calculation and scrutiny of *termination payments in accordance with the relevant Welsh Government guidance.*** ***3-Provide assurance to the Board in relation to the Special Health Authority's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.***
15.2	Funded Establishment	15.3.1Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment. ***DHCW has an established Financial Pay Planning Group (Scrutiny Panel) which assures recruitment requests to ensure that funding is in place, the IMTP relationship is known and that the correct recruitment processes have been followed before approving, rejecting or escalating to directors.***
15.3	Staff Appointments	
15.4	Pay Rates and Terms and Conditions	
15.5	Payroll	
15.6	Contracts of Employment	
16	**CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**	**CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**
16.1	Capital Plan	16.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Plan for the organisation. The capital plan and programmes must be delivered within Welsh Government capital finance resource limits. ***Capital plans for 2021/22 and 2022/23 have been approved by the Board. Capital Programme for 2021/22 was delivered within the Capital Resource limit agreed with Welsh Government. The Capital and Non Pay Delivery Group provides a key role in assessing investment proposals for approval and monitoring spend.***
16.2	Capital Investment Decisions	16.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. ***Robust business cases or Digital Investment Templates (as directed by Welsh Government) are submitted to Welsh Government for all potential investments***.
16.3	Capital Projects	16.3.2 When capital investment decisions are taken and a Capital Programme approved the Project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance. Management control and financial reporting systems must be established to ensure that the project is delivered on time, on budget and within contractual obligations. ***No capital expenditure takes place until authority to commit expenditure has been formally delegated to a manager. All projects procured in line with standard procurement procedures. Procedures and controls in place to ensure the project stays within budget and is completed within the agreed timescales via budget meetings and monitored by the Capital & Non Pay Delivery Group.***

16.4	Capital Procedures and Responsibilities	16.4.1 For every capital expenditure proposal the Chief Executive shall ensure: a) That a business case is produced with Welsh Ministers' guidance and where appropriate the 5 case model b) that the Director of Finance has sought professional advice from DHCW and external agencies in the preparation of capital expenditure costs and on that basis professionally certifies the capital costs and revenue consequences detailed on the business case ***DHCW has a range of Developing Business Case policies that ensures that business cases are produced where appropriate for all capital expenditure and professional advice is sought where appropriate both within DHCW and from external agencies***
16.5	Capital Financing with the Private Sector	16.5.1 DHCW must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers. ***DHCW has no capital financing arrangements with the private sector***
16.6	Asset Registers	16.6.1 DHCW shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts. ***DHCW has implemented and maintains an asset register for all fixed assets owned by the SHA. The MRI Asset 4000 fixed asset register is used. The minimum data set is fully compliant with the requirements of Welsh Government and the Annual Accounts***
16.7	Security of Assets	16.7.1 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for recording managerial responsibility for each asset, identification of assets and disposals, identification of all repairs and maintenance expenses, physical security of assets, regular verification of the existence of, condition of, and title to of assets recorded and identification and reporting of all costs associated with the retention of an asset and reporting, recording and safekeeping of cash,cheques and negotiable instruments. ***DHCW has implemented an IT Asset Management Policy, an Information Asset Policy, Fixed Asset Policy and an IT Hardware removal, redeployment and disposal policy.***
17	**STORES AND RECEIPT OF GOODS**	**STORES AND RECEIPT OF GOODS**
17.1	General position	17.1General position 17.1.1Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be: a)Kept to a minimum; b)Subjected to annual stock take; c)Valued at the lower of cost and net realisable value. ***DHCW does not hold items for stock purposes.***
17.2	Control of Stores, Stocktaking, condemnations and disposal	
17.3	Goods supplied by an NHS supplies agency	
18	**DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**	**DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**
18.1	Disposals and Condemnations	18.2.8The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.). ***Losses and special payments are collected for the annual accounts and reported to DHCW Audit & Assurance committee. As per guidance the information is recorded on a database (in DHCW's case via the LASPAR system). The Remuneration and Terms of Service Committee will notify the finance team of any instances of staff related losses and special payments to the finance team if they arise. No instances of fraud have arisen in DHCW.***
18.2	Losses and Special Payments	
19	**DIGITAL, DATA and TECHNOLOGY**	**DIGITAL, DATA and TECHNOLOGY**

19.1	Digital Data and Technology Strategy	19.1.2 DHCW shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. The ***DHCW Information Governance department (as part of the Access to Information Policy) manages processes and monitors compliance with the Freedom of Information Act 2000. A log of all requests and performance is kept. with performance reported to the Management Board on a monthly basis.***
19.2	Responsibilities and duties of the responsible Director	19.3.1The Director of Finance shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases. ***DHCW has implemented the MRI Fixed Asses Register system during 2021/22 with the content and output reviewed as part of the Audit Wales Annual Accounts process. There are no instances of non compliance with SFI's***
19.3	Responsibilities and duties of the Director of Finance	
19.4	Contracts for data and digital services with other health bodies or outside agencies	
19.5	Risk assurance	
	SCHEDULE 1	**SCHEDULE 1**
	Revised General Consent to Enter Individual Contracts	***DHCW is compliant with the requirements outlined within this letter which forms a core part of procurement process, limits and reporting.***

DIGITAL HEALTH AND CARE WALES
PROCUREMENT & SCHEME OF DELEGATION COMPLIANCE REPORT MAY 2022

Agenda Item	5.8

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Ifan Evans, Executive Director of Strategy
Prepared By	Julie Francis, Head of Commercial Services /Michelle Sell, Director of Planning & Performance, and Chief Commercial Officer
Presented By	Julie Francis, Head of Commercial Services

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to: **NOTE** the content of the report.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Mobilising digital transformation and ensuring high quality health and care data
	Delivering High Quality Digital Services
	Driving value from data for better outcomes

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below: A globally responsible Wales	

DHCW QUALITY STANDARDS	ISO 20000
If more than one standard applies, please list below: ISO 27001 ISO 9001 BS 10008	

HEALTH CARE STANDARD	Effective Care
If more than one standard applies, please list below: Staff and Resources	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome:N/A
Statement: Not Required	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	Appropriate management of procurement activity ensure high quality of commercial activity for the organisation
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	The contracts within the report are legally binding and there could be legal implications arising from activity within the contracts awarded
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below
	There are financial implications from single tenders and potentially change notices.

WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
CCN	Contract Change Note	DHCW	Digital Health and Care Wales
PCR2015	Public Contract Regulations 2015	SHA	Special Health Authority

2 SITUATION/BACKGROUND

2.1 The purpose of this report is to provide the Audit and Assurance Committee with an update in relation to procurement activity undertaken during the period 1st April 2022 – 31st May 2022 and in accordance with reference 1.2 (Schedule 2.1 Procurement and Contracting for Goods and Services) of the standing Financial Instructions.

2.2 An explanation of the reasons, circumstances and details of any further action taken is also included.

SFI Reference	Description	Items
12.9.4	Free of Charge Services	0
12.13	Single Quotation Actions	0
12.13	Single Tender Actions	2
12.13	Single Tenders for consideration following a call for Competition under PCR2015.	0
12.17	Contract Extensions: Award of additional funding outside the terms of the contract (executed via Contract Change Note (CCN) or Variation of Terms)	2

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The single tender and single quotation and change control notes can be found in full within item 5.8i Appendix A

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 There are no key risks / matters for escalation to Board / Committee

5 RECOMMENDATION

5.1 The Committee is being asked to **NOTE** the content of the report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Item 5.8i Appendix A – DHCW Single Tender and Quotation Activity and Change Control Notes

The following all relate to DHCW activity during the period from 01st April 2022 – 31st May 2022

Item 5.8i Appendix A – DHCW Single Tender and Quotation Activity and Change Control Notes

Programme/Directorate	Procurement Reference	Agreement Period	SFI Reference	Agreement Title/ Description	Supplier	Anticipated Value	Reason	Compliance Comment	First Submission or Repeat
Clinical Knowledge Services	P21.49	01/04/2022-31/03/2024	STA	IRefer Guidelines	Royal College of Radiologists	£33,150.00	Sole Supplier - DHCW required access to the IRefer Guidelines. The IRefer guidelines is an essential evidence based/practical resource for referring GPs, radiographers, clinicians and other healthcare professionals to determine the most appropriate imaging investigation(s) or intervention for patients.	Approved	Repeat Submission (P21.45)
Corporate Governance	P775	18/04/2022-17/04/2025	STA	Research and Advisory Service	The Advisory Board	£99,379.50	DHCW required membership to the Global eHealth Executive Council. The route to securing this membership is via the Advisory Board which is the sole supplier to provide this access. Key strategic and operational issues such as organisational and system level strategy, workforce, service line strategy and healthcare IT is provided via this contract.	Approved	Repeat

Item 5.8i Appendix A – DHCW Single Tender and Quotation Activity and Change Control Notes

Cyber Security	P326.06	22/05/2020-22/08/2022	CCN	Penetration Testing	Aristi Ltd	£0.00	Due to recent legislative changes the procurement for a new Penetration Testing contract has been delayed. DHCW therefore required a three-month extension to the existing contract outside of its initial term whilst a new procurement is undertaken. The current contractual agreement still has a value of £58,437.50 (ex VAT) that can be drawn down on. There is no material change to the scope and is compliant with PCR2015 Regulations (72) for Contract Modifications	Approved	First
NDR	P737	01/12/2021-30/11/2024	CCN	API Management Platform	Computacenter	£3,948.59	DHCW's API Management Platform contract included professional services for implementation. A change to the plan was required to complete DHCW tasks which impacted upon Supplier resources.	Approved	First
					Total Value ex VAT	£136,478.09			

DIGITAL HEALTH AND CARE WALES
QUALITY, REGULATORY COMPLIANCE AND CYBER RESILIENCE UNIT REPORT

Agenda Item	5.9

Name of Meeting	Audit and Assurance Committee
Date of Meeting	04 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Paul Evans, Interim Head of Quality and Regulatory Compliance
Presented By	Paul Evans, Interim Head of Quality and Regulatory Compliance

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to: NOTE the content of this report.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	N/A

WELL-BEING OF FUTURE GENERATIONS ACT	A Globally Responsible Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below Ref section 3.2 Impact of internal audits
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
ISO	International Standards Organisation	IMTP	Integrated Medium Term Plan
eQMS	Electronic Quality Management System	MHRA	Medicines and Healthcare Products Regulatory Agency
QIAL	Quality Improvement Action List	DHCW	Digital Health and Care Wales

2 SITUATION/BACKGROUND

2.1 There has been one planned external ISO audit during this period.

- ISO 27001 Information Security Management System Requirements – 4th - 13th May

This re-certification audit was successful with one minor non-conformance and one Opportunity for Improvement raised. All previous non-conformances closed. There have been no notable changes in regulation over this period.

2.2 The Monthly Quality and Regulatory meetings have been held with actions and observations noted. The Quality and Regulatory Team quarter one milestone objectives have been achieved in full and focus has now shifted to quarter two deliverables.

2.3 The quality portal central to improving compliance and increase visibility of quality within DHCW now includes the risk based internal audit programme. The portal continues to be the focal point for all things quality and regulatory based and remains a valuable tool during external audits as it streamlines activities and enables all essential information to be easily located.

2.4 The roll out and on-boarding of the electronic Quality Management System (eQMS) iPassport continues. A plan and implementation strategy have been developed and resourced. The implementation plan has been approved via the monthly Quality and Regulatory Group meeting and by the Executive Director of Finance. Directorates have accepted the milestones relevant to iPassport roll out. DHCW Active Directory has been imported into iPassport which has given all staff access to the system. A support model is now in place utilising Action Point.

This fits with wider Documentation strategy for the whole organisation which is being considered as part of the document management workshops.

2.5 The monthly Quality and Regulatory metrics report is in a period of continual review and improvement and continues to be presented to the monthly Quality and Regulatory Group meetings for consideration.

2.6 There is continuing focus on developing the Medical Devices strategy and an implementation plan. This generates the details and expectations of the regulations and the plan to meet the requirements of an end-to-end compliant software lifecycle including assessment, release, and submission.

Assessment of the existing DHCW Service Portfolio against the requirements of Medical Devices Regulation has commenced using current MHRA guidance. This activity will continue during the next quarter.

2.7 The CRU unit has completed is first set of audits and reports for Welsh Government in these have been shared with Health Boards and Trusts. The Unit is now actively collecting feedback on the process which it plans to share with the Director of Digital Peer Group later in the year. Recruitment to some key vacancies continues.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 There are no upcoming ISO audits planned in Quarter 2 2022/23. The current contract for external audit services expires in October 2022, work has begun with commercial services on the procurement process for a new contract.

3.2 A risk based internal audit programme has been developed to underpin compliance against each of the standard's requirements for internal audit. Supporting this we have a specialist resource who has developed a training programme for internal auditors which is currently being rolled out to standard leads. Self-inspections and internal audits are still being undertaken across the organisation to maintain current schedule.

3.3 Evidence of the review of the legislation register is now under way within the IMS group and Quality and Regulatory Group meetings. The formal procedure and review of the content and structure of the register is now in place.

3.4 Quality Improvement Action List (QIAL) figures have continued to improve over the last 6 months, there is currently 104 open actions and only 9 of them have passed their target dates. As 91% of the actions are currently within their target dates, the monthly target of 90% has been achieved for the first time. As a result, in going forward it has been agreed that the monthly target of actions within date will be 95%. The team are continuing to work with

individuals from each Directorate to improve this further and achieve the new target. Integrated Management Systems (IMS) document reviews noted a decrease in reviews from 94%, the current target that the team are working towards is for 95% of documents to be within their review dates. The team are working with various departments to ensure that all documents are reviewed, signed, and published by the review date.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

In summary:

4.1 In the last period DHCW had one successful recertification audit with one minor non-compliances and one recommendation indicating its adoption of a quality driven culture and improved compliance performance.

4.2 The Quality and Regulatory Group will target a standard and directorate view of quality compliance; focus will be on integrating the quality and regulatory plans as part of the directorate Annual Plans. Further development of metrics will continue in line with organisational performance reporting.

4.3 The importance of good document management practices and the strengthening of the quality management systems is underway alongside the document management strategy and the on-boarding of departments to iPassport. This is now part of the annual plan process with milestones relating to iPassport implementation accepted by directorates. Training videos on the use of iPassport have been uploaded to the Quality Portal to aid staff development across DHCW.

4.4 CRU has completed and reported the first NIS audits on behalf of Welsh Government.

4.5 Improved Compliance and commitment to the internal and external audit programme with a view to becoming more aware of impact of regulatory requirements in the organisation.

4.6 QIAL initial metric target of 90% complete within target date has been achieved, new target metric of 95% set in the interest of continuous quality improvement.

5 RECOMMENDATION

5.1 The Audit and Assurance Committee is being asked to NOTE the content of the report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Claire Osmundsen-Little	01/06/2022	Approved

DIGITAL HEALTH AND CARE WALES
QUALITY ASSURANCE & REGULATORY COMPLIANCE ANNUAL REPORT – 2021/22

Agenda Item	5.10

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Emma Shackell, Quality Facilitator
Presented By	Paul Evans, Interim Head of Quality and Regulatory Compliance

TŶ GLAN-YR-AFON 21 Heol Ddwyreiniol Y Bont-Faen, Caerdydd CF11 9AD

TŶ GLAN-YR-AFON 21 Cowbridge Road East, Cardiff CF11 9AD

Purpose of the Report	For Noting

Recommendation

The Committee is being asked to: **NOTE** the Quality Assurance and Regulatory Compliance Annual Report 2021/21.

Acronyms

DHCW	Digital Health & Care Wales	NWIS	NHS Wales Informatics Service
MDAG	Medical Devices & Alerts Group	SaMD	Software as a Medical Devices
WIAG	Wales Informatics Assurance Group	QIAL	Quality Improvement Action List
IMS	Integrated Management System	SDI	Service Desk Institute
BS	British Standards	ISO	International Organisation for Standardisation
Re-Cert	Re-certification	SV	Surveillance
NC	Non-Conformity	OFI	Opportunity for Improvement
MinNC	Minor Non-Conformity	MajNC	Major Non-Conformity
WRRS	Welsh Results Reporting Services	WCP	Welsh Clinical Portal
eQMS	Electronic Quality Management System	WICIS	Welsh Intensive Care Information System
WLIMS	Wales Laboratory Information Management System	WTAIL	Welsh Transplantation & Immunogenetic Laboratory
CRU	Cyber Resilience Unit		

STRATEGIC OBJECTIVE	All Objectives Apply

WELL-BEING OF FUTURE GENERATIONS ACT	A resilient Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	ISO 9001
If more than one standard applies, please list below: ISO 14001 ISO 20000 ISO 27001 BS 76000/76005 ISO 13485 BS 10008 Service Desk Certification	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: EQIA not required for this Plan	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
Claire Osmundsen-Little	10/06/2022	

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below The Plan will complement the delivery of high-quality safe services
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below The Quality Standards require regular legislative review which is documented and subject to audit
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below The establishment of a Quality & Regulatory Team to support the activity in the plan
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

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1 SITUATION/BACKGROUND

1.1 PURPOSE

The purpose of this report is to provide an overview on the progress, performance and achievements that have been demonstrated by the Quality Assurance and Regulatory Compliance Department during 2021/22.

1.2 BACKGROUND

DHCW is required to comply with the duties of Quality and Candour in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, set out by the Welsh Government. Whilst quality was always featured within the NWIS Organisation, DHCW repositioned quality and regulation as a fundamental contributor to its future strategy and recognised the need for additional improvements in Quality. Alongside this it also acknowledged the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA), who have been tasked with updating UK Medical Device Regulations, which are expected to place a higher regulatory burden on Software as a Medical Device (SaMD).

Therefore, it was made apparent that the existing Quality arrangements were not sufficient to establish the regime required to meet the regulations, strategy and structure to support the organisation. In going forward the Organisation established a new Quality Assurance and Regulatory Compliance Team within the Finance and Business Assurance Directorate, the team was officially formed on the 24th of May 2021.

The role of the Quality Assurance and Regulatory Compliance team within the Organisation is to drive quality standardisation, embedding a quality culture by engaging with all colleagues, across all levels to manage and maintain the various internationally recognised ISO and BS standards which are held by the Organisation. In addition, the Quality and Regulatory team are continually improving the Quality Management System (QMS), implementing new systems, procedures, KPI's and monitoring to drive improvement.

Everyone who works within DHCW is responsible for quality, to support the Organisations Vision and Values, helping deliver improved systems and services to the NHS within Wales.

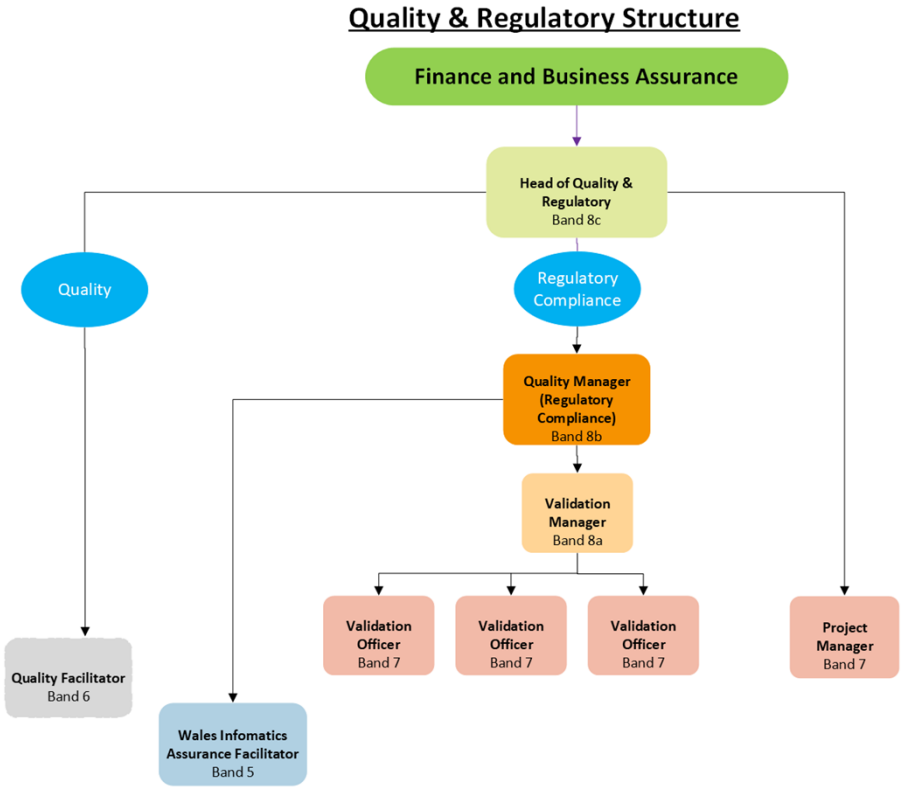
1.2.1 Delivering High Quality Digital Services

From the strategic objectives, DHCW identified the key International Standards that are required to support quality definition and direction. These can be achieved by:

- **Controls** – Through the Quality and Regulatory Group and part of Audit and Assurance Committee.
- **Planning** – Annual Quality and Regulatory Plan an improvement and integrated across the Directorates and supported by the internal audit programme.
- **Improvements** – The organisation has a strong culture of organisation learning and improvement.

1.2.2 Structure

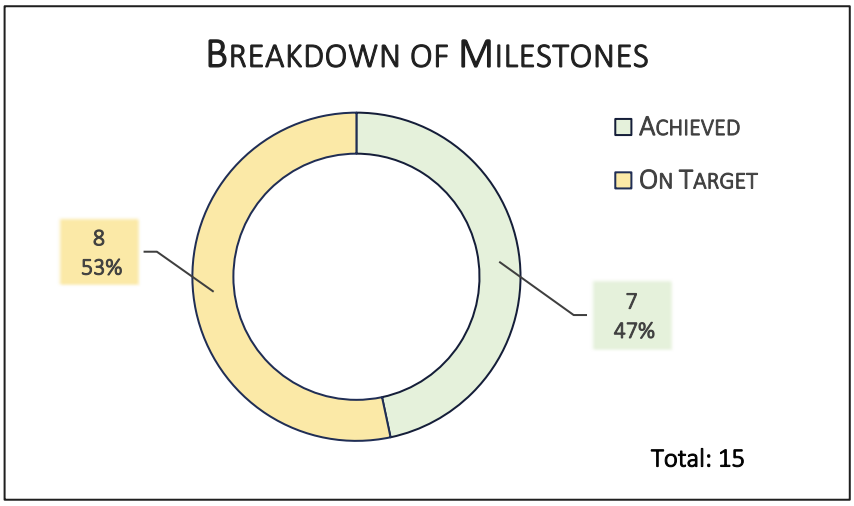
Over the year, the Quality Assurance and Regulatory Compliance Team have strengthened the Quality Management System and supported the organisation by creating more robust working environments for safe, effective, efficient and equitable delivery of products and services.
The below flowchart shows the main roles that are required within the department to support the Quality and Regulatory side of the Organisation:



2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 MILESTONES

Since 2020 there have been 15 milestones identified for Quality and Regulatory to manage and work towards, 7 of those milestones have been successfully delivered and achieved on time. The remaining 8 milestones, 3 of them being CRU, are on target to be delivered throughout 2022-2023.



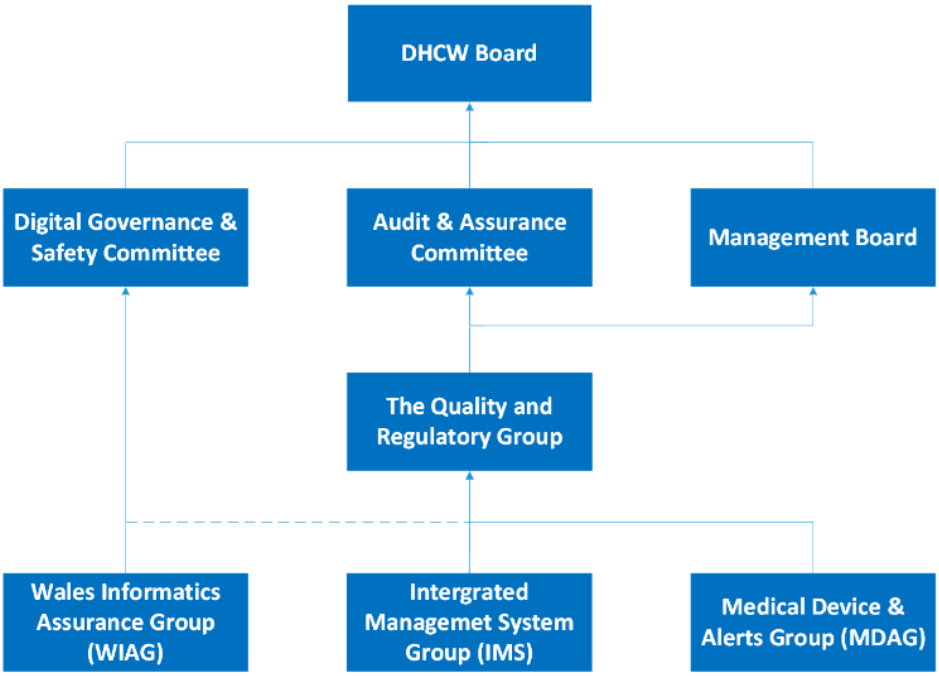
2.2 GOVERNANCE

To increase the support to form part of the governance framework and to meet the requirements for reporting, the Quality Department conduct the following meetings:

- Quality Regulatory Group
- IMS Assurance Group
- Medical Devices and Alerts Group (MDAG)
- Wales Informatics Assurance Group (WIAG)

Quality annual plans and monthly progress reports are produced to support the visibility of Quality and Regulatory. This reporting feeds into the Audit and Assurance Committee for governance and into the Management Board for operational performance, both of these then feed into the DHCW Board.

Quality and Regulatory Governance Framework:



Completion of the quality actions are reviewed in the monthly Quality and Regulatory Meetings, with any outcomes and escalations being fed into the Integrated Operational Performance Report (IOPR) to the management committee and ultimately the Board.

2.3 QUALITY VISIBILITY / PORTAL

To improve compliance and increase the visibility by integrating quality into the organisation, the quality portal has become a valuable tool throughout the year as it streamlines activities and enables access to all essential information. The portal is the main focal point in relation to all Quality and Regulatory areas within the organisation and is under continual development to ensure that

information is kept up to date and accurate, as well as new features being added on a regular basis.

The portal can be accessed and viewed by all DHCW colleagues and is available via laptop/computer or mobile phone. Since the portal went Live on March the 7th 2021, there have been 73,646 visitors in total at the time of writing this report, this at present is an average of over 6,000 per month which continues to increase on a weekly basis:

7 Days Usage

30 Days Usage

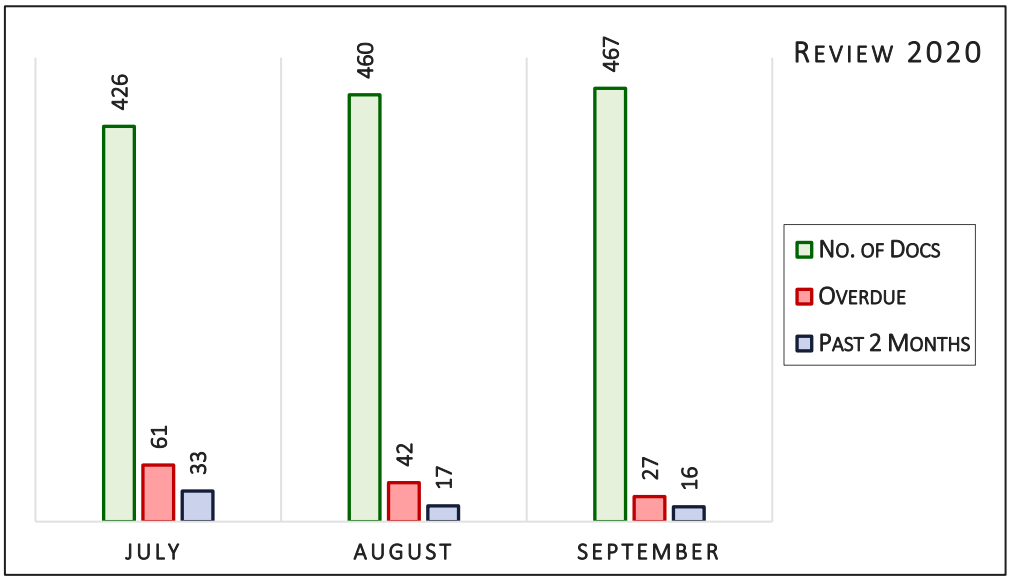
2.4 INTEGRATED MANAGEMENT SYSTEM (IMS)

The organisations internal Quality Framework is known as the Integrated Management System (IMS). All controlled documents within each Department/Directorate can be found published within the IMS, these include Standing Operating Procedures, Process Flowcharts, Templates and other guidance documents. Policies are published on the DHCW public website with a direct link available within the IMS.

In 2020 the organisation migrated to SharePoint Online, this resulted in a new version of the IMS being designed and created. This gave the team the opportunity to conduct a review on the different types of controlled documents and how many there are within each Department, as well as how many were overdue for review.

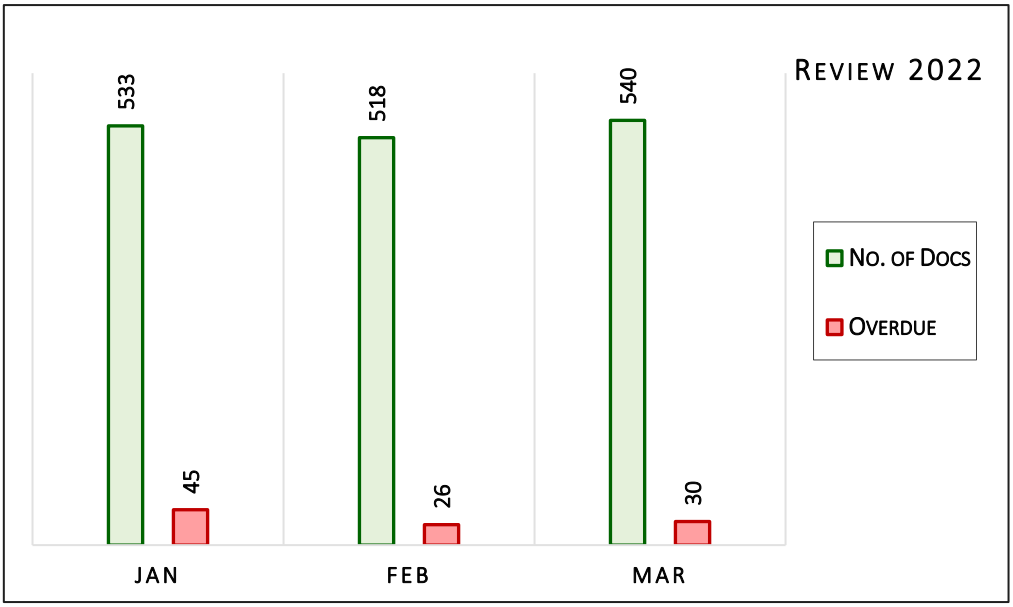
It was found that 14% of the documents were out of date, with 8% of those being at least 2 or more months overdue. Further observations noted that some of the overdue documents were assigned to colleagues that had left the organisation and new ownership hadn't been assigned which resulted in the document not being reviewed. To try and reduce the number of overdue documents, the team met with the Standard Leads and Department Heads to establish if the correct author and approver had been assigned and if the overdue documents were under review or if a new version was available for publishing.

For three months, the team reported on the number of documents that were overdue by two or more months:



Monthly reports are produced and presented at the IMS Assurance Group with any issues being escalated to Quality Group. Due to the Organisation becoming a Special Health Authority, the number of documents that are required have increased over the past year but are closely monitored and managed by the team.

The graph below shows the current position of the IMS:



Over the past year, the number of overdue documents has reduced to 6% with all of them being less than a month out of date. The team's objective is to achieve an overall target of 95% of documents within their review date.

The Quality Team and SharePoint send out reminders to the Authors and Approvers of a document at least 3 months before the review date, to ensure that the new version has been reviewed, approved

and published in time. Before signing, documents are submitted to the team for quality review and if acceptable the document can then be signed and published within the IMS. To manage the system effectively, edit permissions are limited to only the Quality Team with the rest of the Organisation having read only permissions.

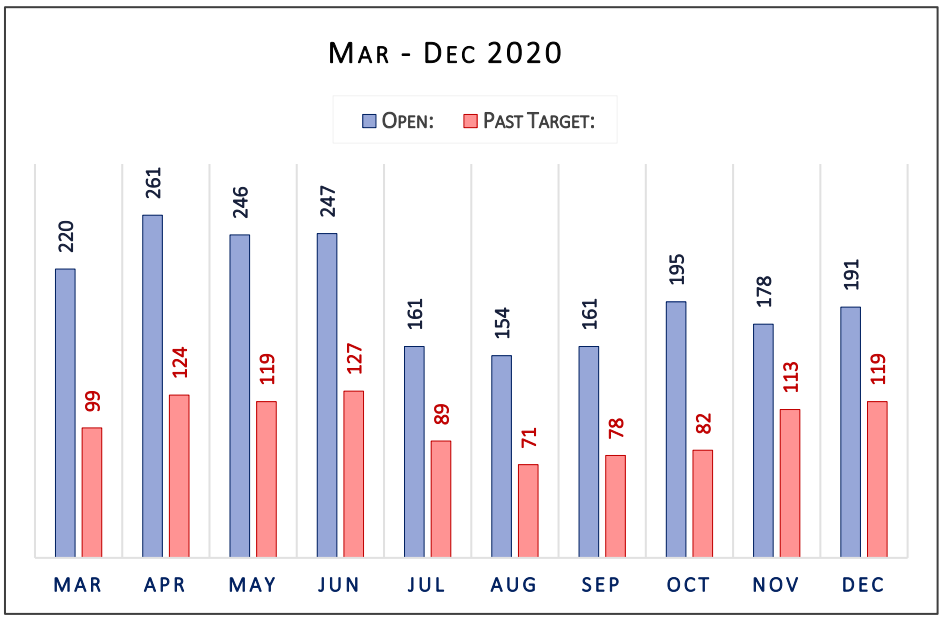
2.5 QUALITY IMPROVEMENT ACTION LIST (QIAL)

All actions that are identified from Internal and External Audits, or other reviews that ensure a quality service, are recorded and monitored on the QIAL. Owners are responsible for ensuring that their actions are being addressed and should follow the progress through to closure, providing updates on a regular basis.

At the beginning of 2020, an in-depth review was conducted on the action list and it was found that out of the 220 open actions, 45% of them had passed their target dates. It was noted that a number of the open and on hold actions were raised in 2014 and the Progress Log had not been updated on a regular basis. Further observations found that some of the actions had incorrect ownership and Standards assigned, where others had the necessary information missing in order for the action to be undertaken.

In moving forward, one-to-one meetings between the action owners and Quality Facilitator took place on a weekly basis to review their open/in progress actions, to ensure that the correct information had been included and to identify any historic or overdue actions. Weekly reports highlighting areas of concern and all the overdue actions within each Directorate/Department, were produced and submitted to the Directors Weekly Meetings for further escalation.

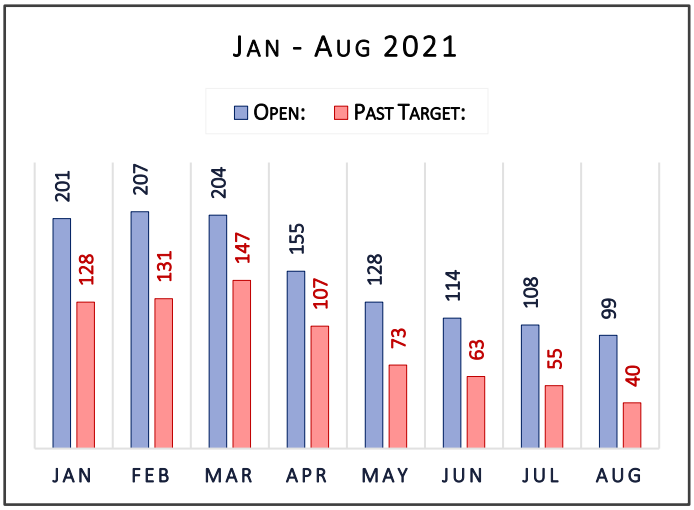
The graph below shows the position of the QIAL from when the in-depth review was conducted in March, and the progress that had been made through to December 2020:

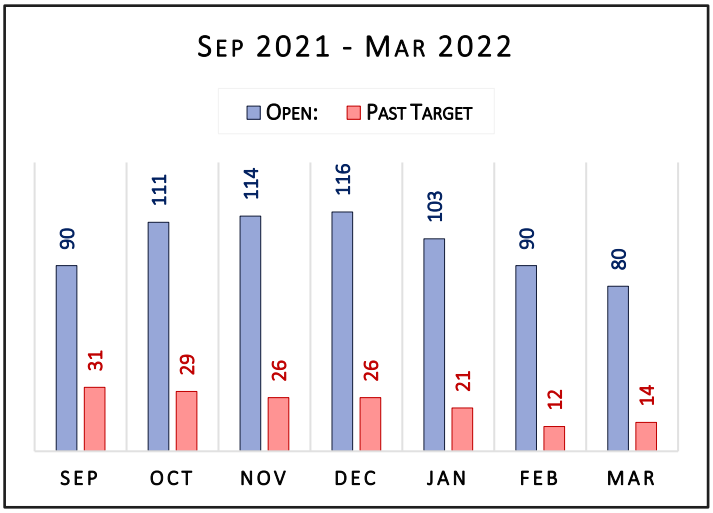


Over the year, work has continued on getting the action list into a manageable position with monthly reports being submitted to the IMS Assurance Group and Quality Group for review and monitoring. To

monitor the number of actions and to ensure that the correct information is included, a Quality approval process has been put into place so that any new or updated actions can be reviewed before displaying in the list.

A 6-month review in 2021, showed that the number of overdue actions had reduced due to historic and completed actions being closed and others being updated with comments in the Progress Log and new target dates assigned.





Progress reports are produced and presented to the IMS Assurance Group on a monthly basis with any issues being escalated to Quality Group. The Quality team continue to work closely with the action owners, with the objective of achieving an overall target of 90% of actions within their target dates.
To ensure that actions are being monitored and successfully closed, additional information boxes have been added to the QIAL so that new target dates, root cause analysis, completion/closed Justifications and effectiveness checks can be monitored to ensure that the action has been carried out and completed with all possible options explored and follow up procedures are in place so that the issue doesn't re-occur.

As a result of the on-going work, the number of actions being logged onto the list has reduced by 63% due to the quality checks being in place. The number of overdue actions has also decreased to 17.5%, making the list more manageable and user friendly. Further monitoring and reporting is being conducted on any open actions that are in relation to ISO/BS Standards and those that have been raised via Internal and External Audits.

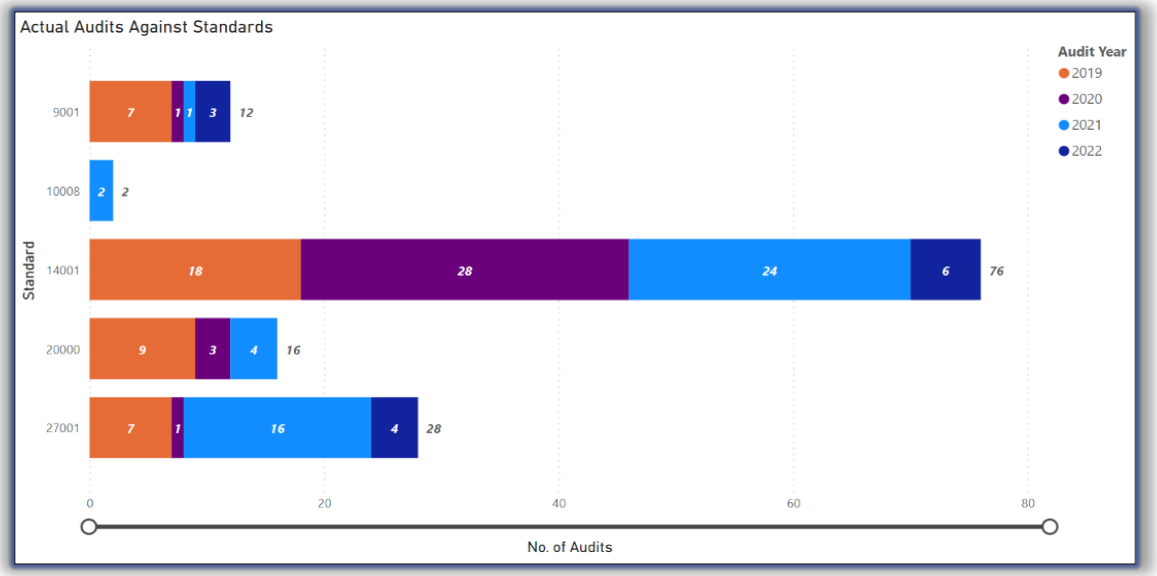
2.6 AUDITS

2.6.1 Internal Audits

Due to global pandemic Covid-19, home working was introduced, and additional projects were put in place across the organisation to support the pandemic. As a result, a number of projects and programmes were put on hold or delayed to accommodate the extra workload, as a result resourcing became challenging and there were a reduced number of internal audits conducted during Q4 2019/20

- Q3 2021/22.

Despite the challenges and issues faced by the Organisation, 58 audits were conducted against a target of 76 across all standards within 2021-22, 76% against target.



During 2021-22 the Quality and Regulatory team worked on improving compliance by embedding standards, building a "quality culture" and developing a stronger network of internal auditors by producing and delivering training workshops and compliance maintenance. Historically internal auditing has taken a clause-by-clause based approach, in line with ISO 9001:2015, a new dynamic, agile risk-based approach and programme have been developed. These highlights areas of organisational risk, helping to minimise non-compliance, optimise best practice, and support continual improvement.

For 2022-23 there are currently 103 planned audits and self-inspections across all standards, the risk-based programme and others. Year-to-date we are 16% on target, planned against actual conducted audits.

2.6.2 External Audits

The compliance with each quality standard is audited during the year on scheduled external audit dates, this is supported by the internal audit plan.

DHCW maintains certification to the following International Standards:

- ISO 9001:2015 Quality Management System
- ISO 14001:2015 Environmental Management System
- ISO 20000-1:2018 IT Service management Systems
- BS 76000:2015 Valuing People
- BS 76005:2017 Valuing People Through Diversity & Inclusion
- BS 10008:2014 Evidential Weight & Legally Admissible Information
- SDI Service Desk Institute

Regulatory focus develops internal processes, systems and standards to enable compliance with medical devices and other future regulatory developments.
Due to Covid-19 all External Audits from 2020 have been successfully conducted via Teams. The following table shows External Audits conducted and the associated findings in 2020 and 2021:

Standard	Audit Date & Outcome							
	2020	OFI	MinNC	MajNC	2021	OFI	MinNC	MajNC
ISO 9001 & ISO 14001	August *(SV)*	2	3	0	January *(SV)*	0	7	1
ISO 20000	November *(SV)*	2	2	0	September *(Re-Cert)*	8	7	0
ISO 27001	November *(SV)*	0	7	6	November *(Focus)*	0	0	0
BS 76000 & BS 76005	October *(Re-Cert)*	0	4	0	October *(SV & Re-Cert)*	0	4	0
BS 10008	January *(Re-Cert)*	3	1	0	December *(SV)*	2	0	0
SDI	November *(SV)*	3 Star Award			December *(SV)*	3 Star Award		

All finding are logged and monitored in the QIAL, with any Major Non-Conformities being dealt with as priority. All past Major and Minor Non-Conformities have been successfully actioned and closed..

External Audits scheduled for 2022:

Standard	Audit Date & Outcome				
	2022	Number of NC Closed:	OFI	MinNC	MajNC
ISO 9001 & ISO 14001	January *(SV)*	6	0	1	0
ISO 27001	May (Re-Cert)	N/A*	1	1	0
ISO 20000	TBC	-	-	-	-
ISO 27001	December *(SV)*	-	-	-	-
BS 76000 & BS 76005	October *(SV)*	-	-	-	-
BS 10008	November *(SV)*	-	-	-	-
SDI	November *(Re-Cert)*	-	-	-	-

(No previous actions open)*

2.7 IPASSPORT

To strengthen and improve the Organisations Quality Management System and have a more robust working environment, it was agreed for a new Electronic Quality Management System (eQMS) to be implemented. iPassport is designed to address all aspects of document control (and other functions) in an orderly and easy-to-use structure for every policy, procedure, plan and more. This software allows DHCW to manage all aspect of documentation, as well as providing full control and availability of the most up-to-date documentation while maintaining control of archived versions. The software ensures complete compliance with International Quality Management Standards with intuitive features for document authorisation, authenticated electronic signatures, staff acknowledgement, change control, document revision and automated history.

The implementation of the system started post pilot phase with early adopters via an "On-Boarding" process. The "On-Boarding" process is a structured plan which identifies key personnel within Organisational Units (teams), provides full training and use of the system within the Document module. The training is then rolled out to subsequent team members.

Following the approval of the iPassport eQMS Implementation Strategy and Roll-out Plan the "On-Boarding" is to be rolled out to the whole of Digital Health & Care Wales during 2022/23.

Departments currently on-boarded:

- Validation
- WLIMS
- Information Services
- Service Management
- Infrastructure Design
- Financial Services

- Quality and Regulation Compliance

2.8 VALIDATION

Digital Health and Care Wales (DHCW) is required to perform Computerised System Validation on the Services, Applications, and supporting infrastructure the Organisation supply and/or host for NHS Wales Services that operate within a regulatory framework.
Validation is key to ensuring that the systems we supply and/or host are fit for their intended purpose throughout the life cycle of the system. The Validation Team support Projects and Operational Services to adopt a life-cycle approach to Validation from the initial concept phase through to retirement of the system.

2.8.1 Completed Validation Projects

Validation	Project	Health Board
BackLoad	TELEPATH results in WRRS	ABuHB
BackLoad	RADCENTRE results Backload	SBuHB
BackLoad	TRAK PATHOLOGY results Backload	ABuHB
Backload	RADIOLOGY Results WRRS	Velindre NHS Trust
Feed	Upload of PDF to the WRRS via WCP eform Genetics and Neurology	C&VuHB & CTMuHB
Feed	Upload of Cwm Taff Medilogik Endoscopy results to the WRRS	CTMuHB
Feed	Upload Velindre Histology Results to the WRRS	Velindre NHS Trust
Feed	Medilogik Endoscopy feed	HDuHB
Full Validation	Wellsky Pharmacy System	All Wales
Full Validation	eQMS iPassport	All Wales

2.8.2 Validation Projects in Progress

Validation	Project	Completion
BackLoad	Cardiff and Vale Radiology Results	TBC
BackLoad	IRIS INDIGO	TBC
BackLoad	Velindre Histology Results	TBC
Feed	Medilogik Cloud Implementation (Powys)	Q2 2022
Feed	All Wales Genetics feed	TBC
Full Validation	Welsh Referral Activity and Patient Pathway Enterprise Repository (WRAPPER)	TBC
Full Validation	Welsh Intensive Care Information System (WICIS)	Q4 2023
Full Validation	Wales Laboratory Information Management System (WLIMS TCL2016)	Q3 2022
Qualification	Welsh Transplantation & Immunogenetic Laboratory (WTAIL)	Q2 2022
Qualification	Haemonetics Infrastructure	Q3 2022

2.8.3 Periodic Review of GxP systems

The purpose of Periodic Review is to assure compliance with DHCW policies and external regulatory bodies is maintained throughout the operational life of the computerised system. Periodic Review is a system focused review that periodically evaluates compliance and addresses identified deviations.

2.8.4 Planned Reviews of GxP Systems 2022/2023

Review Type	GxP System	Completion
Periodic Review	Wellsky Pharmacy System	Q4 2022
Periodic Review	PDF to the WRRS via WCP eform Genetics & Neurology	Q3 2022
Periodic Review	Upload of Cwm Taff Medilogik Endoscopy results to the WRRS	Q3 2022
Periodic Review	Upload Velindre Histology Results to the WRRS	Q3 2022
Periodic Review	Medilogik Endoscopy feed	Q1 2023
Periodic Review	Wales Laboratory Information Management System (WLIMS TCL2016)	TBC 2023
Periodic Review	Welsh Transplantation & Immunogenetic Laboratory (WTAIL)	TBC 2023

2.9 WALES INFORMATICS ASSURANCE GROUP (WIAG)

The DHCW Informatics Assurance process is led by the Executive Medical Director and supported by the Wales Informatics Assurance Group (WIAG). In order for any assurance activity to be planned and proportional, early engagement with WIAG is essential. During the project initiation stage, procurement initiation or proposal to develop an existing service, WIAG should be approached to review the requirement to consider applicability of the assurance process. This will inform requirements and assurance activity milestones which will need to be factored into the schedule of the development/procurement.

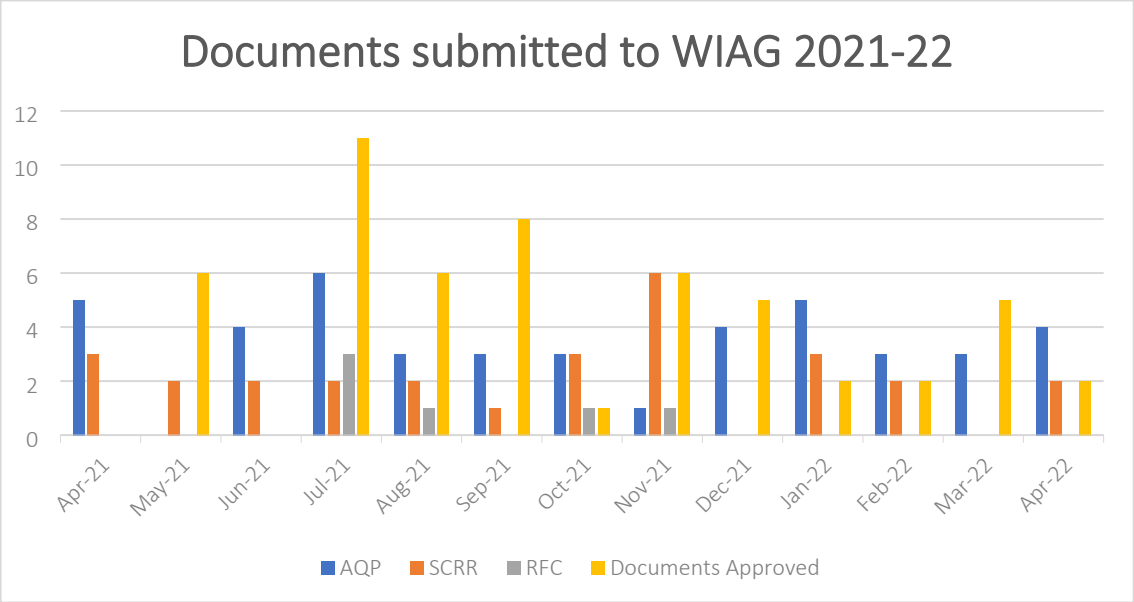
Assurance Quality Plan (AQP)

If the initial WIAG review identifies the service development needs to undertake the assurance process, or it is clear that assurance will be required, an AQP will be completed by the Project Manager/Release Manager and Assurance Leads. This sets out the assurance work streams that the service development must adhere to.

Safety Case & Readiness Report (SCRR)

The SCRR is the primary vehicle for presenting a statement concerning the safety of the informatics service and will highlight the outcome of the assurance work streams and includes recommendations regarding informatics service deployment. Once the report has been updated and endorsed by WIAG, the Quality Manager (Regulatory Compliance) will review the report and present to the Medical Director for approval.

Table 1- Documents submitted to WIAG from April-21 to April-22



9 Day KPI for Assurance Leads to Complete Statements on AQPs/SCRRs (Power Bi Metrics)

In order to improve the efficiency of the WIAG process, the use of metrics has been agreed for the new financial year. There have been ongoing Workshops to improve the efficiency of the WIAG process, and these will be discussed further at the next Workshop in June 2022.

Figure 1 displays a baseline from Q4 2021-22, and Figure 2 demonstrates how the metrics have significantly improved since establishing a KPI of 9 days from Q1 2022-23 for Assurance Leads to complete statement on AQP's/SCRR's.

Figure 1 – January 2022-April 2022

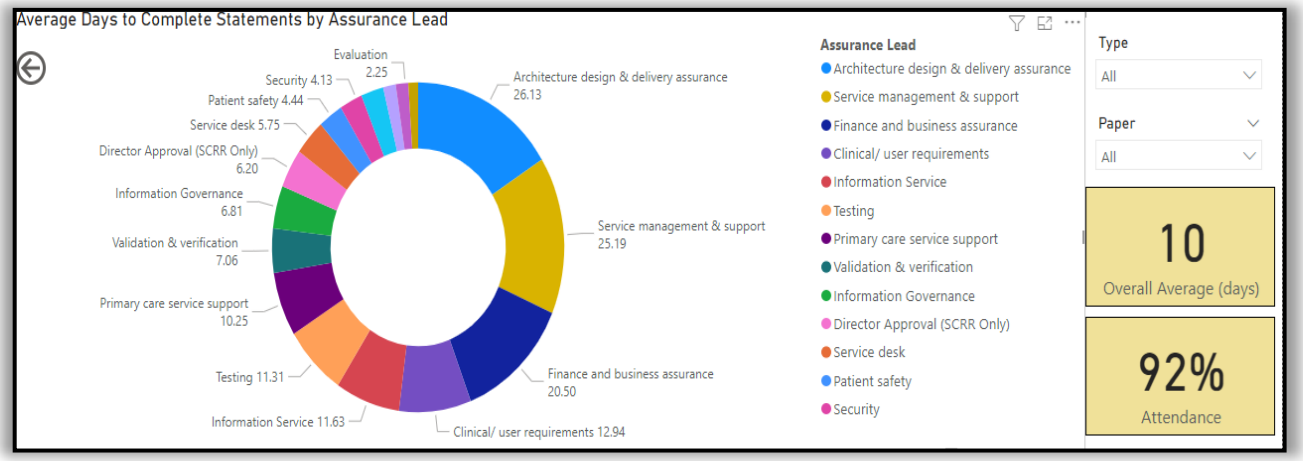
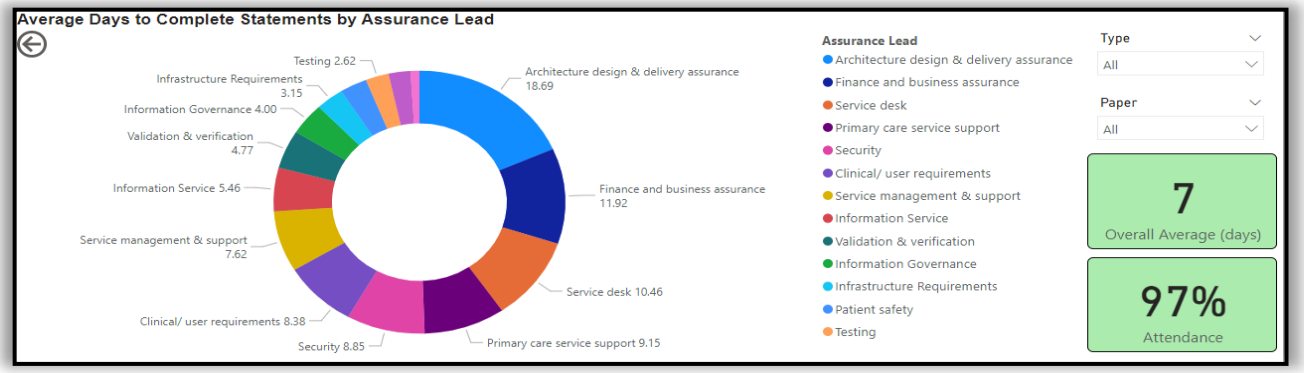


Figure 2 – April 2022-May 2022

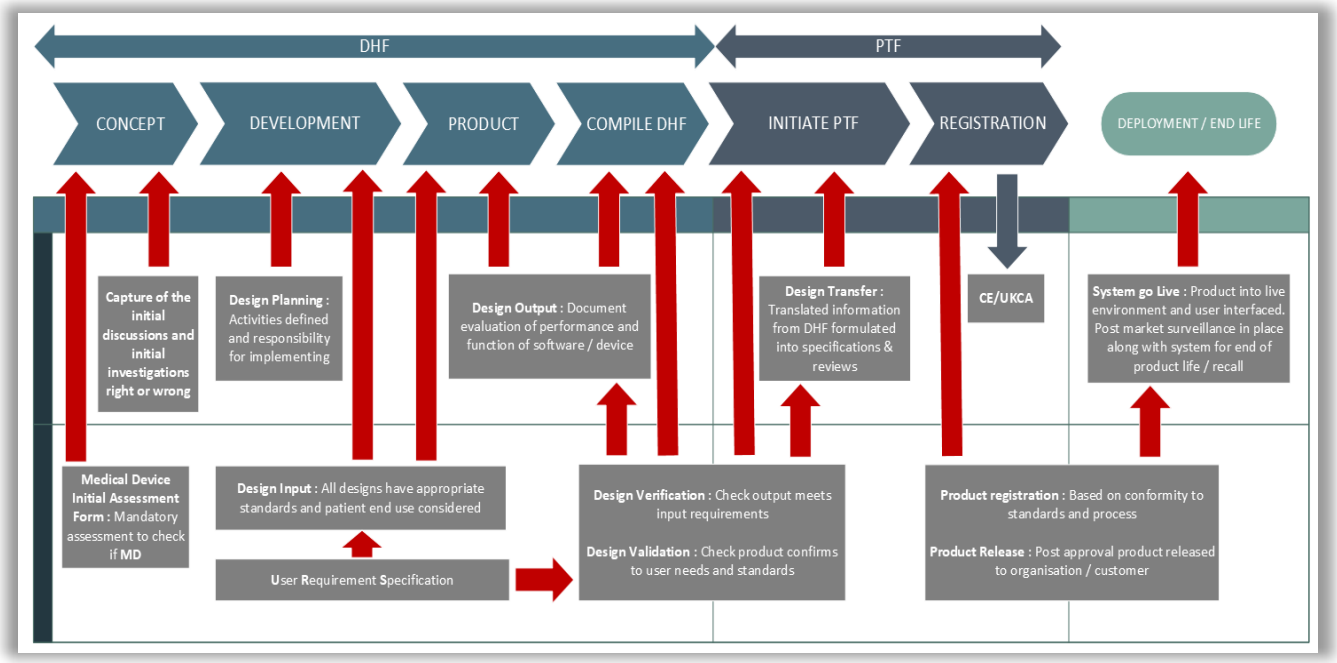


2.10 MEDICINES & HEALTHCARE PRODUCTS REGULATORY AUTHORITY (MHRA)

The Medicines and Medical Devices Act 2021 granted powers to revise the UK Medical Devices Regulations (MDR) 2002 SI 618. The MHRA acting for the Secretary of State, conducted a public consultation to this effect between September and November 2021.

There are substantial legislative changes likely for Software as a Medical Device (SaMD) including a proposed new provision for Artificial Intelligence as a Medical Device (AIaMD). We are currently waiting for the MHRA to publish their consultation analysis, this is expected in June 2022. New legislation will be in place for 1st July 2023 when the UK will no longer recognize CE marking for medical devices but will instead use the new UKCA mark in its place.

Using the consultation papers as a guideline, the Quality team have developed a project plan to ensure DHCW are in a position to meet the expected regulatory requirements for SaMD in the revised MDR. This plan covers the full software life cycle as depicted below:



Actions within the plan are progressing in line with projected timescales, and assessment of DHCW's existing Service portfolio is currently underway. This activity will identify which services will be classified as SaMD using the MHRA's latest guidance for this determination.

The Interim Head of Quality participates in an NHS Wales/Welsh Government group looking at ensuring consistency of application of UK MDR across NHS Wales.

The overall project plan is currently reporting 35% completion of all activities.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD COMMITTEE

3.1 KEY ACHIEVEMENTS OF 2021-22

Over the last year there have been several outstanding achievements made by the team, some of the key points are:

3.1.1 Quality Annual Plans

The development and implementation of the organisations first Annual Plan for Quality and Regulatory, was successfully approved and published for 2021/22. Following on from that, the 2022/23 Annual Plan was submitted to the Audit and Assurance Committee in January 2022, where it was successfully approved.

3.1.2 External Leaders

The department has become the main point of contact and leadership in the organisation for External DHCW bodies for Medical Devices and Quality Management Systems. The team has been providing much needed help and support to several Health Boards within Wales with their Management Systems. This has resulted in two of the Health Boards adopting a copy of the organisations IMS SharePoint System and proposed document structure, to adapt and use to manage their documents within various departments.

3.1.3 DHCW Staff Recognition Awards

The first DHCW Staff Conference was held in April this year, this included the Staff/team Recognition Awards. The Quality and Regulatory Compliance Team were nominated and successfully shortlisted in the categories for '*A Resilient Wales Recognition Award*'. Even though the team didn't win the award, Quality was voted as one of the greatest achievements in DHCW's first year.

3.1.4 Metrics

Introduced monthly monitoring and performance quality reports for presenting at various Boards, Committees and Groups. Continual improvements are being made on increasing the monitoring of regulatory compliance for reports on trending, metrics and measures.

3.1.5 iPassport

Successful Validation, pilot, roll out and implementation of the electronic Quality Management System iPassport. iPassport will support the organisation in delivering high quality digital services, managing controlled documents, supporting the Quality Management System and remaining compliant with our many ISO and BS standards. This also helps to build a quality culture and a continual improvement mindset.

3.1.6 Quality Portal

The development of the Quality portal has helped improve the visibility of quality within the organisation and makes information easier to locate when conducting Internal and External Audits. The portal is the main focus point for Quality and Regulatory activity.

3.1.7 Risk-based internal audit programme

The international Organisation for Standardization (ISO) and the standard 9001:2015 Quality Management Systems directs organisations to take a risk-based thinking approach to their processes and Quality Management System (QMS). A risk-based thinking approach enables the organisation to determine the factors that could cause its processes and its quality management system to deviate from the planned results, to put in place preventive controls to minimise negative effects and to make maximum use of opportunities as they arise In line with the ISO 9001:2015 standard.

In response to this the Quality and Regulatory Compliance Team have developed a new Risk Based Internal Audit Programme. The programme collates data and information from various sources throughout the organisation to capture areas of risk within the Organisation, auditing them to check compliance, correct procedure and adherence within the several standards held by the organisation. The team and programme take an agile approach, reacting to identified and defined risks, therefore is in constant development, auditing where required.

With the global situation and pandemic, the Organisation swiftly reacted to requirements of external audits to continue, adapting to perform remote audits. Optimising the use of information and communication technology (ICT) to audit effectively and efficiently, supporting and maintaining the integrity of the audit process.

3.2 NEXT STEPS

In line with Quality Annual Plan, the following are the key focus areas and next steps for the department in going forward:

- Implementation of a new Corporate and Departmental induction process.
- Secure additional resources to further strengthen the Internal Audit/self-inspection programme in going forward.
- Continued, agile development of the Risk-based Internal Audit Programme.
- Introduction of formal continuous quality improvement plans using e.g., Pareto, DMAIC or PDCA.
- Continue and improve monitoring of metrics and setting targets using Power BI dashboards.
- Finalise development of MDR processes and engagement with various teams within DHCW and

external bodies such as Health Boards and Welsh Government, to ensure readiness for UKCA marking of SaMD.

- Focus on the implementation of iPassport Document Control Module and on-board the whole organisation.
- Encourage and offer Training and Qualification opportunities to support on-going Quality Team development.
- Development and approve the Quality Annual Plan for 2023/24. Including development of implementation plans for further iPassport modules (Audit & Non-Conformity).
- Continue to increase the visibility and integration of quality within the organisation.

4 RECOMMENDATION

4.1 The Committee is being asked to **NOTE** the Quality Assurance and Regulatory Compliance Annual Report 2021/21.

DIGITAL HEALTH AND CARE WALES
AUDIT WALES BASELINE GOVERNANCE REVIEW REPORT UPDATE

Agenda Item	5.11

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Sophie Fuller, Head of Corporate Governance
Presented By	Chris Darling, Board Secretary

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to: NOTE the content of the report.	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	ISO 20000
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below: Staff and Resources	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
Choose an item.	Outcome: N/A
Statement: N/A	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below Good governance practices are integral to quality and safety across the organisation.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below There could be legal implications should the baseline governance review highlight any serious areas of improvement for the organisation.
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below Non-compliance with good governance could have a financial impact for the organisation.
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.

SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority
AG	Auditor General		

2 SITUATION/BACKGROUND

2.1 The Auditor General (AG) has a statutory requirement to satisfy himself that NHS bodies have proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources as set out in Section 61 of the Public Audit Wales Act 2004. To help in the discharge of this responsibility, the AG undertakes annual Structured Assessment work at each NHS body that examines arrangements relating to corporate governance, financial management, strategic planning, and other factors affecting the way in which NHS bodies use their resources.

2.2 As Digital Health and Care Wales is a newly established statutory organisation, it was identified that a baseline assessment via a Baseline Governance Review would be undertaken for 2021/22. This will be followed up with a Structured Assessment in 2022/23.

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 The aim of undertaking a Baseline Governance Review is to aid organisational learning and development whilst still ensuring the AG undertakes the statutory duties charged to him under Section 61 of the Public Audit Wales Act 2004. The work aims to answer the overall question: *is*

DHCW making good progress in putting arrangements in place to support good governance and the efficient, effective, and economical use of resources?

3.2 The Baseline Governance Review overall finding was **"DHCW is making positive progress in putting arrangements in place to support good governance and the efficient, effective, and economical use of resources under challenging operating circumstances"**.

3.3 The findings were considered by the Audit and Assurance Committee on the 18 January 2022 and the report and associated action plan were received by the SHA Board on the 27 January 2022.

3.4 Please note there has been one additional action completed since the last meeting. The conclusion of the Independent Member appointment process to replace Sian Doyle in partnership with the Public Appointments Unit in Welsh Government. Advice to the Minister has been provided to appoint a replacement Independent Member, and approval is awaited.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The action plan is included at item 5.11i Appendix A.

5 RECOMMENDATION

5.1 The Committee is being asked to **NOTE** the content of the report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME
Board Development	06/01/2022	Discussed
Audit and Assurance	03/05/2022	Progress noted

5.11i Appendix A - BASELINE GOVERNANCE REVIEW ACTION PLAN 2022-23

Key	Complete	Underway	Not started

Opportunity	Detail	Planned Activity	Owner(s)	Due Date	Update
Becoming a trusted digital partner	DHCW has an opportunity to extend its brand as a Trusted Digital Partner; capitalising on a diverse range of experienced public and commercial sector independent members to bring new thinking and a fresh leadership approach	• IM Digital Network - LIVE • Strategic Exec to Exec engagement sessions • Board Intelligence Approach – IN DEVELOPMENT	Simon Jones, Chair / Helen Thomas, CEO	June 2022 for the agreed approach to Board soft intelligence gathering	• A pilot approach has been defined and will be undertaken in July with evaluation and reflection to take place after.
Innovation in engagement and communication with stakeholders and partners	The Board could exploit the opportunities to lead innovation in new areas, for example: • Communication and engagement; • Digitally enabling health and care; and • Decision support tools	• Stakeholder engagement strategy plan implementation • Implementation the DHCW communications strategy • Explore decision support tool options	Ifan Evans, Executive Director of Strategy, Rhidian Hurle, Executive Medical Director Chris Darling, Board Secretary	December 2022	• The stakeholder engagement implementation plan was agreed by the Board in January 2022 and is currently being implemented • The Head of Engagement post has closed and interviews are taking place in early July • The DHCW communication strategy is currently being re-drafted with planned sign off for September 2022
Effective reporting and documentation	DHCW is developing a distinctive house style for digestible, easy read reports and documents. This could be further tested and extended.	Marian Wyn Jones and Rowan Gardner have agreed to work with the organisational performance team on the next iteration of the SHA Integrated Performance Report	Ifan Evans, Executive Director of Strategy, Michelle Sell, Director of Planning and Performance	July 2022	• Initial work has begun on the next iteration of the SHA Integrated Performance Report to be presented to the July SHA Board
Openness and transparency	DHCW may want to consider opportunities to further enhance public transparency of Board business by making recordings of Committee meetings available on its website.	Begin to record the Committee meetings from the new financial year and publish to the website	Chris Darling, Board Secretary	April 2022	COMPLETE • Virtual Etiquette training has now been provided
Board membership expansion	• Keep under review the fact that there isn't a qualified accountant amongst the Independent Members.	Utilise the Board member vacancy to proactively recruit to skills gaps and promote diversity	Simon Jones, Chair	September 2022 in collaboration with the Public Appointments	COMPLETE • The recruitment process has been completed and an Independent Member

5.11i Appendix A - BASELINE GOVERNANCE REVIEW ACTION PLAN 2022-23

	• Maximise the benefit of the diversity of Board members experiences			Unit in Welsh Government	appointment advice to the Minister been provided – we are awaiting Ministerial approval.
Long term strategy	DHCW needs to progress work on the organisation's strategy to provide further clarity on its long-term vision and objectives	Production of DHCW long term strategy Board Development sessions on the LT strategy	Ifan Evans, Executive Director of Strategy	November 2022	COMPLETE • The development of the long-term strategy is planned into the Board development programme within 22/23
Co-design and feedback	As DCHW develops its external partnerships there is an opportunity for systematic capture and use of narrative data to support programme co-design and delivery; increasing value creation and benefits realisation as a 'trusted digital partner' and leader of the new digital culture in Wales.	• Implementation of the stakeholder engagement plan – customer relationship management element • Development of DHCW Feedback portal currently limited to service desk but expanding content feeds	Gareth Davies, interim Director of Operations, Ifan Evans, Executive Director of Strategy,	December 2022	• Requirements gathering is complete, evaluation and prioritisation for CRM tool is now underway. • The roll out of the feedback portal across the organisation continues

ONGOING ACTIVITY IDENTIFIED FOR FURTHER DISCUSSION AND OVERSIGHT

Opportunity	Detail	Planned Activity	Owner(s)	Monitoring
Board behaviours	Ensure the importance of maintaining a fresh outlook and culture is retained by the Board	Board Behaviours workshop including effective challenge and strengths and preferences	Chris Darling, Board Secretary	Workshop outcomes and actions
Committee effectiveness	Maintain the progress and momentum of the DG&S Committee with the changeover of Committee Chair	Agenda setting sessions, Committee pre-meets and regular catch ups scheduled with the new Chair	Chris Darling, Board Secretary	Regular check in meetings and effectiveness self-assessment
Leadership and accountability	Ensure clarity on leadership and accountability for critical areas e.g. cyber security, Information Governance etc., with all of DHCW's partners is vital to ensure a coordinated and timely response	Implementation of Executive Structure Development of Directorate sub-structures	Helen Thomas, Chief Executive Officer	Directorate Performance Reviews
Vision and Strategy	Ensure the vision and strategy have the right balance between national consistency and local flexibility. Ensure there is sufficient focus on care	Long term vision work will make these considerations to strengthen existing relationships and forge new	Ifan Evans, Executive Director of Strategy	Board development sessions and SHA Board meetings

5.11i Appendix A - BASELINE GOVERNANCE REVIEW ACTION PLAN 2022-23

	as well as health.	organisational relationships to widen the breadth of input.		
Stakeholder Engagement	Monitor the implementation of the stakeholder engagement plan	Bi-monthly reporting to Board via progress report	Ifan Evans, Director of Strategy	SHA Board meetings
Financial oversight	Monitor the draw-down of programme funds and use of single tenders	• Bi-monthly financial reporting to the SHA Board • Bi-monthly strategic procurement report to the Board	Claire Osmundsen-Little, Executive Director of Finance, Michelle Sell, Director of Planning, Performance and Commercial	SHA Board meeting
Recruitment and Retention	Focus on the workforce challenges facing the organisation including: timely recruitment, staff retention, and succession planning	Quarterly reporting to the Audit and Assurance Committee on activity focused on recruitment and retention	Director of People and Organisational Development	Audit and Assurance Committee Meeting
Workforce Strategy	Enact key aspects of the Draft People Strategy at pace building on key strategic alliances including Wales Institute of Digital Information (WIDI) to further building capacity and capability.	Bi-monthly progress reporting to the Board	Director of People and Organisational Development	SHA Board meetings

DIGITAL HEALTH AND CARE WALES
ESTATES, ENVIRONMENTAL AND HEALTH & SAFETY REPORT

Agenda Item	5.12

Name of Meeting	Audit and Assurance Committee
Date of Meeting	4 July 2022

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Executive Sponsor	Claire Osmundsen-Little, Executive Director of Finance
Prepared By	Julie Ash, Head of Corporate Services
Presented By	Julie Ash, Head of Corporate Services

Purpose of the Report	For Noting
Recommendation	
The Committee is being asked to **NOTE** the DHCW Estates, Environmental and Health & Safety Report	

1 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

CORPORATE RISK (ref if appropriate)	

WELL-BEING OF FUTURE GENERATIONS ACT	A Globally Responsible Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	ISO 14001
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Not applicable	

Workforce EQIA page

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below The report provides details of health and safety incidents and compliance
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below The report demonstrates our progress toward compliance with Welsh Government targets published in their Delivery Plan issued via a Welsh Health Circular and also covers activity required to be undertaken under health & safety and other legislation.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below

	The report details activity necessary to maintain a safe working environment for staff.
SOCIO ECONOMIC IMPLICATION/IMPACT	Yes, please detail below
	Social impacts on health are embedded in the broader environment and shaped by complex relationships between economic systems and social structures.
RESEARCH AND INNOVATION IMPLICATION/IMPACT	No, there is no specific research and innovation implications relating to the activity outlined within this report

Acronyms			
DHCW	Digital Health and Care Wales	NWSSP	NHS Wales Shared Services Partnership
SHE	Safety, Health & Environmental	MTCO2e	Metric tons of carbon dioxide equivalent

2 SITUATION/BACKGROUND

2.1 This report includes information relating to the Estate, including progress made against the DHCW Decarbonisation Strategic Delivery Plan, ISO 14001 certification, compliance statistics and health and safety statistics.

2.2 The latest Estates and Compliance Monthly Report is attached as 5.12i Appendix A for the Committee's attention. The report covers compliance progress to the month of May 2022 and the estates carbon footprint data for 2021/22. DHCW's emissions return for 2021/22 is included as 5.12ii Appendix B.

2.3 Digital Health & Care Wales form part of the Welsh Government Community of Experts on Climate Change and attend regular meetings of this forum. We are due to present an overview of our Decarbonisation Strategic Action Plan at a future meeting.

2.4 Digital Health & Care Wales (DHCW) has a number of Groups in place which manage activities covered within this report:

- Decarbonisation Working Group

- Environmental Awareness Group
- Safety, Health and Environmental (SHE) Group
- Water Safety Group

3 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 DHCW Decarbonisation Strategic Delivery Plan

We have made significant progress in decarbonising our estate in recent years; however, we recognise that there is more to be accomplished. The DHCW Decarbonisation Strategic Delivery Plan allows us to take a fresh look at our building and energy needs, as well as procurement, travel, and other emissions sources. Some of these emissions are beyond our direct control; highlighting the challenge we have in working collaboratively to influence the decisions of others.

DHCW are in a unique position to contribute towards reducing carbon emissions across the wider NHS by providing and improving digital solutions across NHS Wales such as those allowing for digital transfer and storing of information and solutions which allow for remote consultation. We recently presented an overview of DHCW products contributing to decarbonisation to the Health and Social Services Group (HSSG) Climate Change Approach to Healthcare Project Board.

DHCW will work with NHS Wales Shared Services Partnership (NWSSP) Procurement Services through the Welsh Government Procurement and Transport Workstream to develop low carbon procurement strategies which have the potential to have a significant effect on emissions. We have recently reviewed our methodology for calculating procurement emissions to ensure that all procurements are categorised correctly and double-counting does not occur, which has provided a more accurate picture.

Our overall carbon emissions are detailed in the table below demonstrating a 29% reduction compared to the baseline year, with Procurement remaining the significant contributory factor:

Broad Category	Category	Scope	2019/2020 Emissions (T CO2e)	19/20 %	2021/2022 Emissions (T CO2e)	21/22 %
Building Use	Natural Gas	1 & 3	92		58 (-36%)	
	Electricity (Offices)	2 & 3	400		292 (-27%)	
	Water & Waste	3	10		2 (-80%)	
	Electricity (Datacentres)	2 & 3	1,215		660 (-46%)	
	Subtotal		1,717	9%	1012 (-41%)	7%
Procurement		3	17,207	86%	12,399 (-28%)	88%
Transport	Business Travel	3	138		11 (-92%)	
	Fleet	1	21		25 (+16%)	
	Subtotal		159	1%	36 (-77%)	0.3%
Staff	Commuting	3	872		70 (-92%)	
	Homeworking	3	9		601 (+98%)	
	Subtotal		881	4%	671 (-24%)	4.7%

Total	19,964	100%	14,117 (-29%)	100%

Our full emissions return for Welsh Government is attached as 5.12ii Appendix B.

NHS Wales Shared Services Partnership are shortly to commence an audit of our Decarbonisation management arrangements.

3.2 Environmental Management System

DHCW (via its predecessor organisation, the NHS Wales Informatics Service) has held ISO 14001 Environmental Management System certification since 2014.

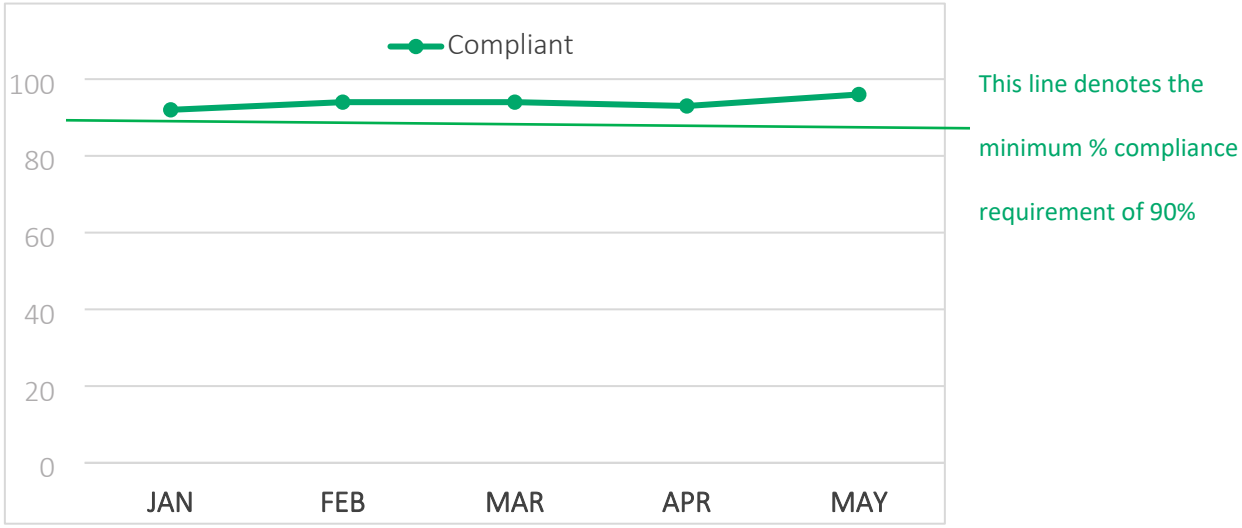
ISO 14001 is an internationally agreed standard that sets out the requirements for an environmental management system. It helps organizations improve their environmental performance through more efficient use of resources and reduction of waste, gaining a competitive advantage and the trust of stakeholders:

QIAL Actions in progress	QIAL Actions Closed	Queries and Complaints	Environmental, Waste and Energy Training
1	8	0	87%

3.3 Estates Compliance

Overall Compliance of plant systems and equipment is it 96%, against our target of 90%.

This means that as of the end of May 2022 we have 236 services complete, 11 with a due date passed and 10 that require testing within one month, to prevent them from going out of date. The graph below shows performance throughout the year:



3.4 Health & Safety

There have been no health & safety incidents reported to date this financial year.

We have received, reviewed and acted upon1 Welsh Government Alerts to date this year.

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The DHCW Decarbonisation Strategic Delivery Plan was approved at the March 2022 Board and submitted with the Integrated Medium Term Plan to Welsh Government on 31st March 2022. Plans are currently being reviewed by Welsh Government and shared across NHS Wales via a portal.

4.2 We are required to report our 2021/22 emissions performance to Welsh Government via an agreed template which is attached. All actions identified within our Decarbonisation Plan have been completed on time and others are ongoing and due to be achieved by the target date.

4.3 NHS Wales Shared Services Partnership Internal Audit are due to commence an audit of our decarbonisation management practices which is welcomed.

5 RECOMMENDATION

5.1 The Committee is being asked to NOTE the DHCW Estates, Environmental and Health & Safety Report.

6 APPROVAL / SCRUTINY ROUTE

Person / Committee / Group who have received or considered this paper prior to this meeting		
PERSON, COMMITTEE OR GROUP	DATE	OUTCOME

Estates Compliance REPORT

May 2022

NHS Digital Health and Care Wales

ESTATES COMPLIANCE REPORT

CONTENTS

3	Executive Summary
4	Estates Compliance
5	Key
6	Overall Compliance
7	Compliance Responsibility
8	Monthly Compliance Trend
9	Key Areas
10	Compliance Action Plan Overview
11	Planned Preventative Maintenance (PPM) Overview
12-20	Environmental Performance

Executive Summary

Estates Compliance

At the end of May 2022 our overall compliance was 96%. This has risen by 3% since last month.

Our overall compliance has been maintained by conducting a large number of testing across all premises and effectively liaising with our landlords to locate documentation. We plan to continue to focus at each site on prioritising the undertaking of out of date services to help to further improve overall compliance.

Planned preventative maintenance is currently at 96%. Actions resulting from water/fire risk assessments and asbestos surveys are being managed.

We are looking at our long term estates strategy and are working with agility during this period following Covid-19 to develop new ways of working.

Environment

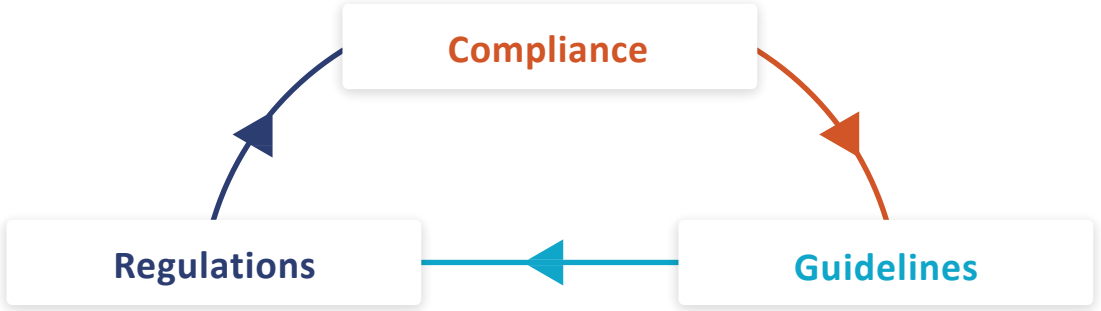
Our Environment annual trend is positive, we are working to our decarbonisation plan road map, to further enhance our controls in this area. We continue to measure water, energy usage and waste disposal in order to reduce CO2 levels. We plan to review the structure and frequency of environment reporting.

Estates Compliance

At DHCW, we are fully aware of our responsibilities for ensuring that the workplace is kept safe by compliance with legislation.

We have a robust programme of planned, preventative maintenance (PPM) and schedule of inspections that need to be undertaken across the entire Estate.

We monitor, on a monthly basis, progress of actions arising as a result of various surveys and inspections, such as Fire, Legionella and Asbestos.



This report details the statutory and mandatory compliance performance of systems and equipment within Digital Health and Care Wales (DHCW) premises, to confirm that they meet with legal requirements, and to safeguard DHCW employees.

Throughout this report compliance is measured by site, type of system or equipment and based on DHCW or Landlord responsibility.

KEY

Green

Systems and equipment that are fully compliant

Yellow

Systems and equipment that are due to be serviced in one month or less

Red

Systems and equipment that are no longer compliant

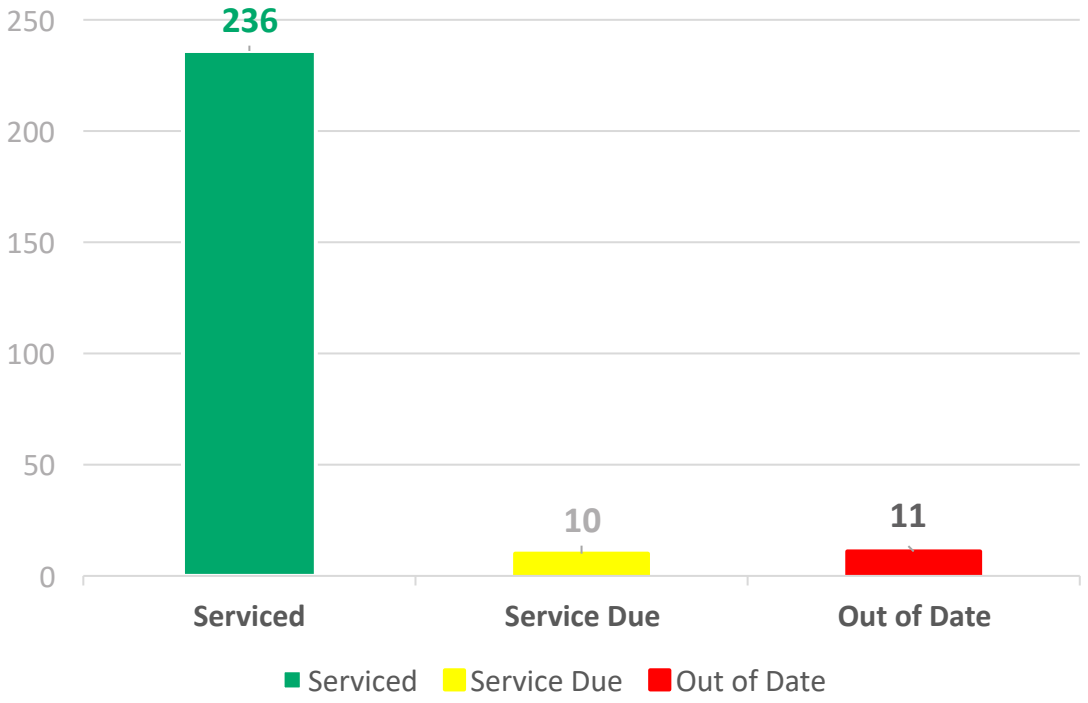
Arrows denote:-

▲ Percentage is higher than previous month

▼ Percentage is lower than previous month

◀ Percentage is the same as the previous month

All percentages include ■ and ■ totals added together.



Overall Compliance of plant systems and equipment is at 96%, against our target of 90%.

This means that as of the end of May 2022 we have 236 services complete, 11 out of date and 10 that require testing within one month, to prevent them from going out of date.

OVERALL COMPLIANCE

Number of System & Equipment that Require Testing.

This Month	Last Month
▲ 96%	93%

COMPLIANCE RESPONSIBILITY

Landlord Compliance Responsibility

SERVICED
SERVICE DUE
OUT OF DATE

DHCW Compliance Responsibility

We plan to liaise with our landlords in order to locate the required compliance documentation.

This Month	Last Month
▲ 96%	89%

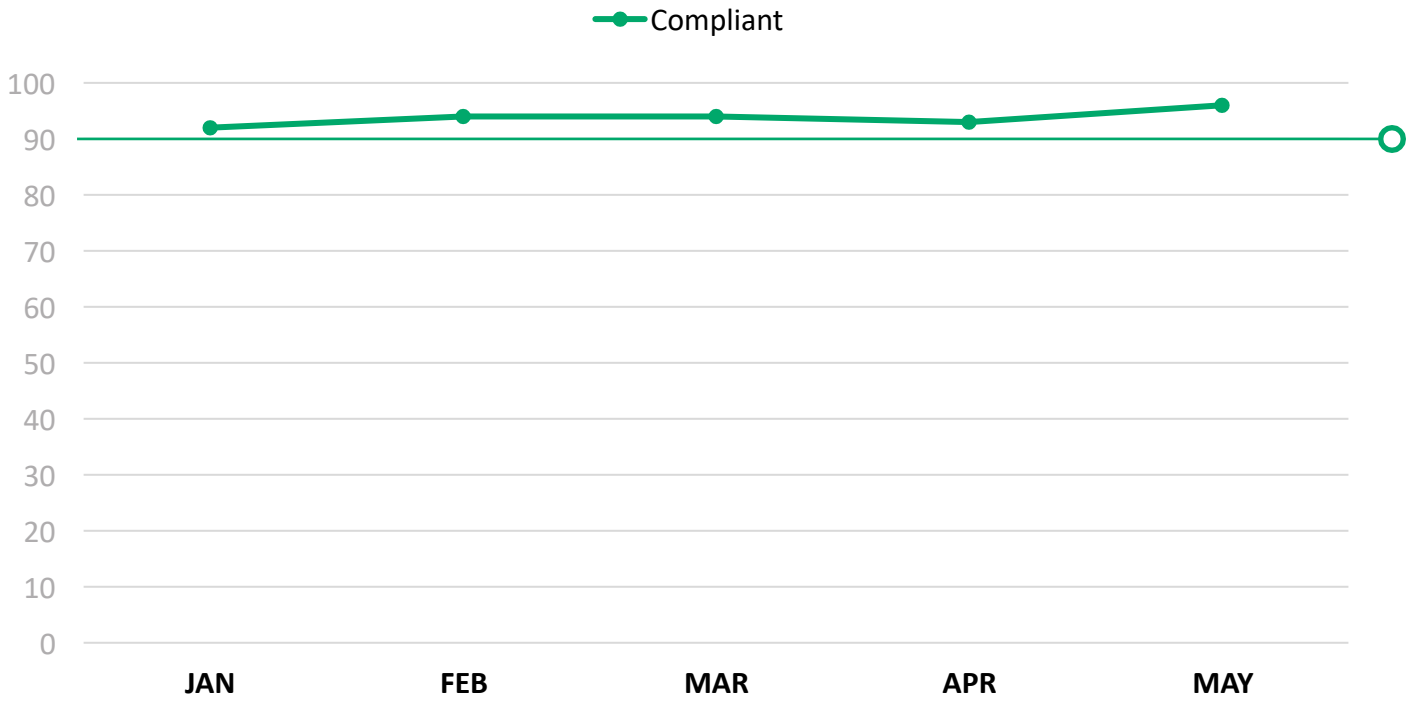
This Month	Last Month
▼ 94%	96%

We are in communication with our contractors in order to arrange required compliance testing.

Bocam	Tŷ Glan-yr-Afon	Mamhilad	Technium 2	Castlebridge	Media Point	Bocam	Tŷ Glan-yr-Afon	Mamhilad	Technium 2	Castlebridge	Media Point
2	2	1	2	3	1	5	0	2	0	2	1

The above chart shows a breakdown per site of the 10 service due and 11 out of date compliance items. We are arranging testing for the 10 service due items. In regards to the out of date services, we are awaiting documentation from our contractors for the 6 services that DHCW are responsible for and we are liaising with our landlords for the remaining 5 out of date services, which are within their areas of responsibility.

MONTHLY COMPLIANCE TREND



This line denotes the minimum % compliance requirement of 90%

JAN	92%
FEB	94%
MAR	94%
APR	93%
MAY	96%

This Month	Last Month
▲ 96%	93%

As you can see in the above chart, thus far in 2022 we have we have maintained an above target compliance performance.

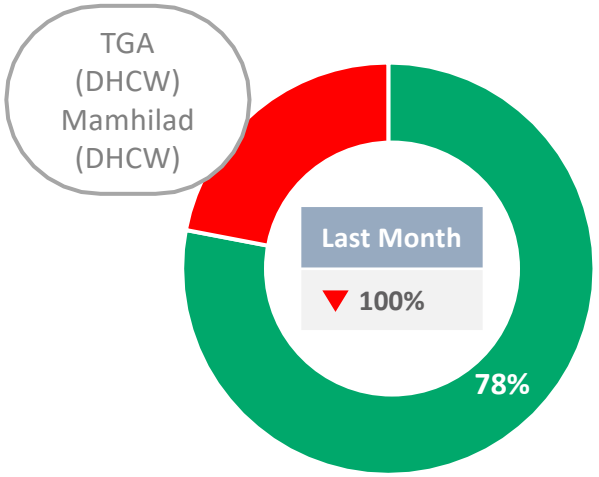
KEY AREAS

Compliance

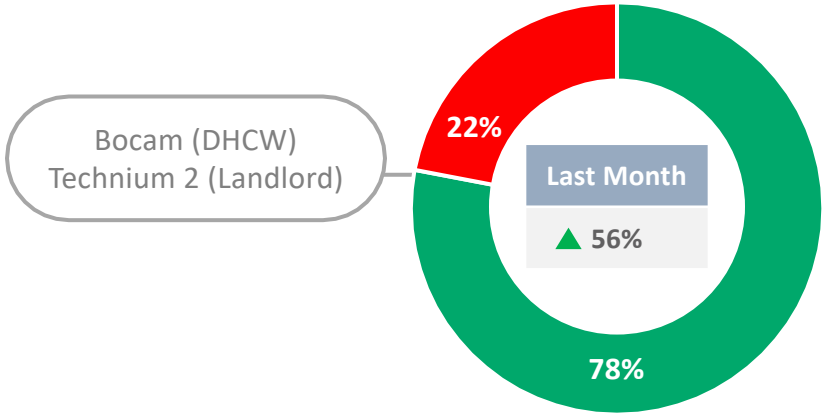
Compliance due / awaiting confirmation

Non Compliance

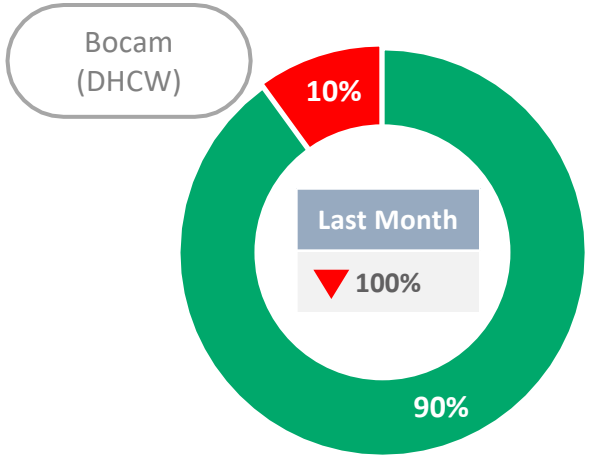
Asbestos Compliance Percentage



Legionella Compliance Percentage



Fire Risk Assessment Compliance Percentage



The graphs show the compliance percentage of Asbestos surveys, as well as Legionella (Water) and Fire risk assessments. We will contact our contractors at TGA and Mamhilad regarding asbestos inspections. At Technium 2 and Bocam we will request the water risk assessment renewal. We will also make arrangements with our contractor for the renewal of the Fire Risk Assessment at Bocam.

Compliance Action Plan Overview

This Month	Last Month
▼ 98%	100%

Compliance Criteria		Overall Compliance
	Green – Action complete	**79%**
	Yellow – Action on target to be completed by agreed date	**19%**
	Orange – Action not on target for completion by agreed date	**2%**
	Red – No Action taken 6 months beyond agreed completion date	**0%**

A number of new actions have been added recently as a result of new assessments having taken place. Our compliance is currently at 79%, with 19% of actions on target. Three low risk actions are now past their target date for completion. 155 actions have been complete and no actions have turned red.

Compliance Category	Compliance Subcategory	Number of Actions across DHCW by Priority											
		High				Medium				Low			
Fire	Fire Risk Assessment	0	0	0	0	21	0	0	0	51	0	3	0
Water	Legionella Risk (and other water related) Assessment	33	14	0	0	10	17	0	0	17	6	0	0
Asbestos	Asbestos Risk Assessment	0	0	0	0	0	0	0	0	23	0	0	0

PLANNED PREVENTATIVE MAINTENANCE (PPM) OVERVIEW

Routine testing has been completed as planned at the majority of sites and is currently at 96%.

Compliance Criteria	
	Green – PPM above 90% compliant
	Yellow – PPM 80% - 89% compliant
	Red – PPM 79% compliant and below

Tŷ Glan-Yr-Afon		% Complete
Total Inspections	262	98%
Total Complete	252	

Bocam		% Complete
Total Inspections	128	99%
Total Complete	127	

Mamhilad		% Complete
Total Inspections	75	92%
Total Complete	69	

Technium 2		% Complete
Total Inspections	89	92%
Total Complete	82	

Media Point		% Complete
Total Inspections	51	96%
Total Complete	49	

Castlebridge 2		% Complete
Total Inspections	123	92%
Total Complete	117	

DHCW – 2021		% Complete
Total Inspections	728	96%
Total Complete	702	

This Month	Last Month
▼ 96%	97%

Environmental Performance

At DHCW, we acknowledge the potential impact that we may have on the environment due to the nature of our business practices; therefore, we are fully committed to reducing this impact across the scope of our operations and the services that we deliver.

This report details how DHCW has performed against our goals to reduce water consumption and energy (gas and electricity) emissions, and increase the amount of waste that we recycle as an organisation.

IT waste and other emission reporting categories performance is also communicated.

ISO 14001 PERFORMANCE

Annual reviews of the Environmental Legislation Register, Environmental Aspects Register and KPI (objectives and targets) performance have taken place.

All 10 KPIs were achieved in 2021/2022. We have now established new KPIs for 2022/2023 in line with our decarbonisation roadmap, which we will be work towards throughout the year.

We are up to date with the EMS Internal Audit Schedule. There are 9 SHE related corrective actions that are in progress, as a result of recent inspections, which primarily relate to compliance documentation.

There is now 1 QIAL action relating to internal audits (Minor NC).

The needs and expectations of interested parties, a SWOT (Strengths, Weaknesses, Opportunities & Threats) analysis of internal and external issues and a PESTLE (Political, Economic, Social, Technological, Legal and Environmental) analysis of external issues have been documented in the Sustainability Strategy.

ISO14001 external audit update – The next ISO 9001 and ISO 14001 combined surveillance 4 external audit visit will take place later this year and preparation for this audit is currently taking place.

QIAL Actions in progress	QIAL Actions Closed	Queries and Complaints	Environmental, Waste and Energy Training
1	8	0	87%

SHE Inspection Actions - Outstanding

Last Month	12
This Month	▼9

Environmental Awareness Campaign

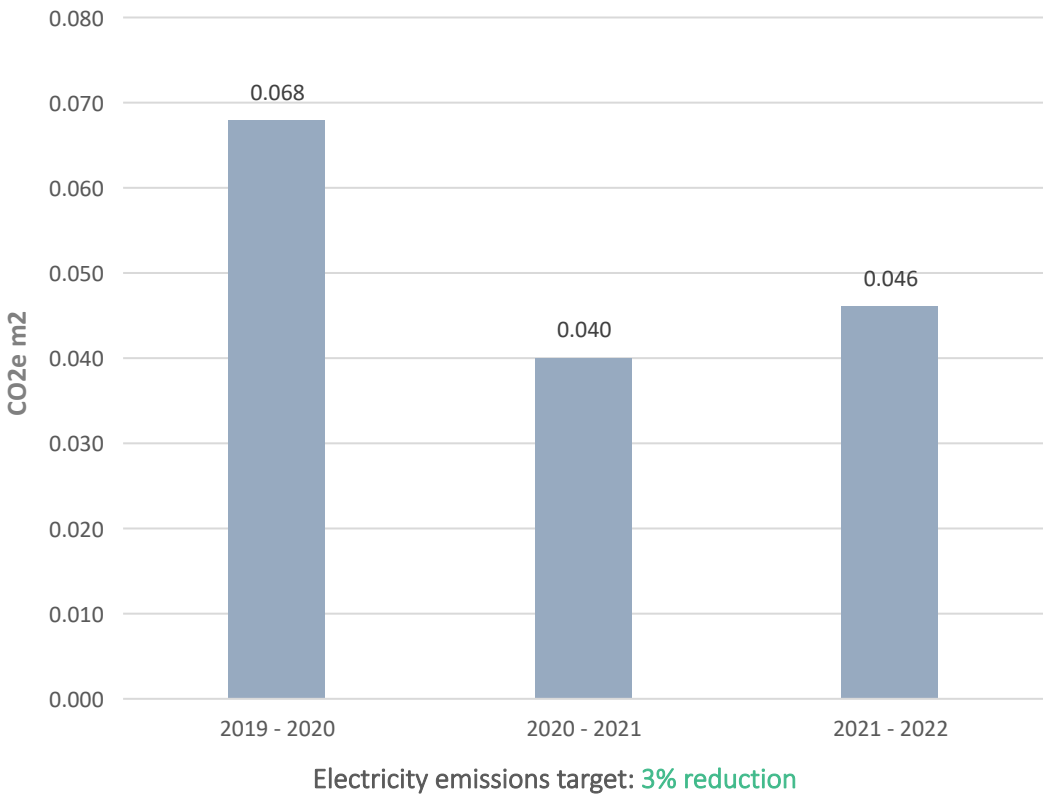
This month's campaign provided guidance for our employees relating to **Sustainable Travel**.

Environmental Training

One member of the Corporate Services team successfully completed a Carbon Literacy Project training course, which was delivered by the Cabinet office.

Training will also be provided by BSI for Road to Net-Zero Training.

ELECTRICITY FIGURES 2021/22 – END OF YEAR



Total Electricity Accumulative CO2 Emissions per m2

The graph shows DHCW's accumulative CO2 emissions, from electricity usage (per m2) during 2021/22, as well as a comparison to previous years.

From the data we can see a:

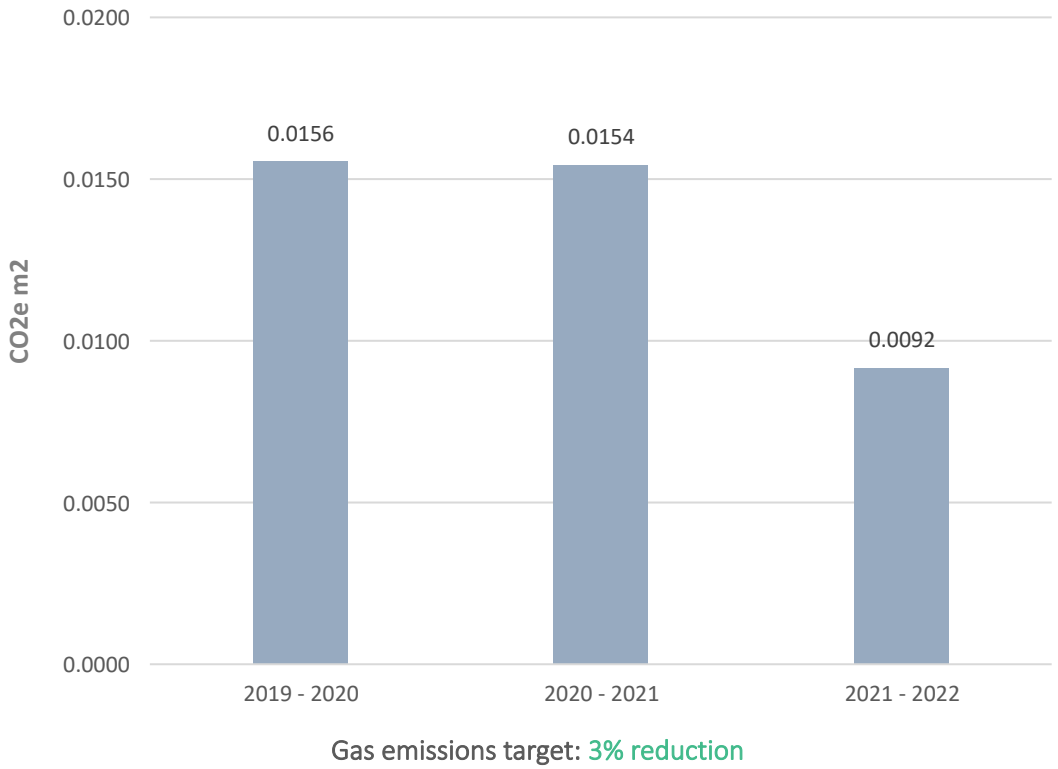
- **15% increase** in 2021/22 compared to 2020/21
- **32% reduction** in 2021/22 compared to our baseline year (2019/20)

F-Gas

We have had NO F-Gas leaks at any of our sites

GAS FIGURES

2021/22 – END OF YEAR



Gas emissions target: 3% reduction

Total Gas Accumulative CO2 Emissions per m2

The graph shows DHCW's accumulative CO2 emissions, from gas usage (per m2) during 2021/22, as well as a comparison to previous years.

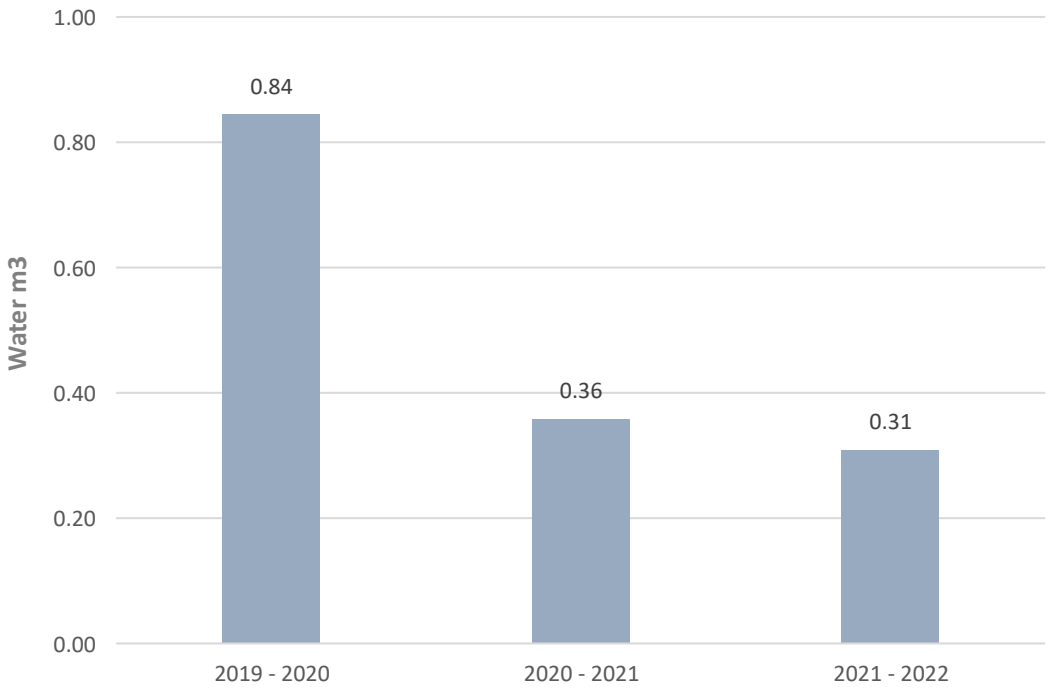
From the data we can see a:

- **40% reduction** in 2021/22 compared to 2020/21
- **41% reduction** in 2021/22 compared to our baseline year (2019/20)

At Tŷ Glan-yr-Afon we experienced a slow gradual gas leak, which had effected our gas emissions. This has now been resolved and emission data has been corrected accordingly.

WATER FIGURES

2021/22 – END OF YEAR



Water consumption target: reduce consumption by at least 4% year on year

Total Water Accumulative Consumption

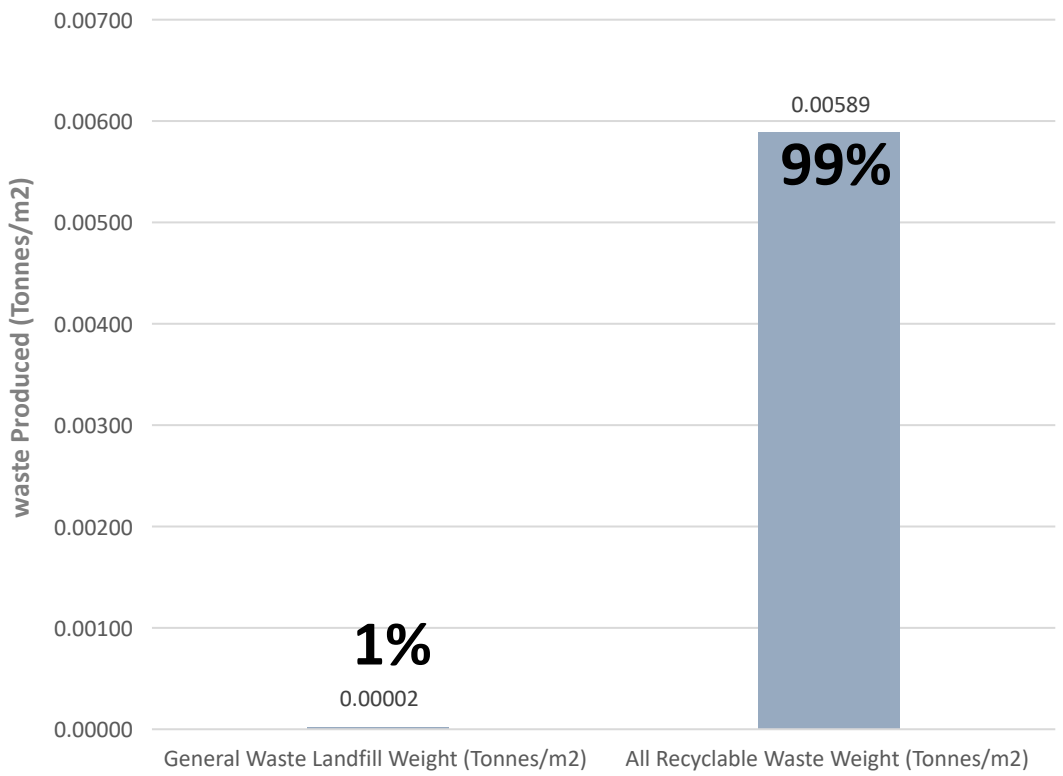
The graph shows DHCW's accumulative water consumption (m3) during 2021/22, as well as a comparison to previous years.

From the data we can see a:

- **14% reduction** in 2021/22 compared to 2020/21
- **63% reduction** in 2021/22 compared to our baseline year (2019/20)

WASTE FIGURES

2021/22 – END OF YEAR



Waste target: at least 68% of DHCW waste to be recycled

The graph shows the accumulative recyclable waste weight (tonnes per m2) during 2021/22, as well as a comparison to general waste weight (tonnes per m2) during 2021/22.

From the data we can see that **99% of DHCW's waste has been recycled, repurposed or reused.**

IT WASTE FIGURES 2021/22 – END OF YEAR

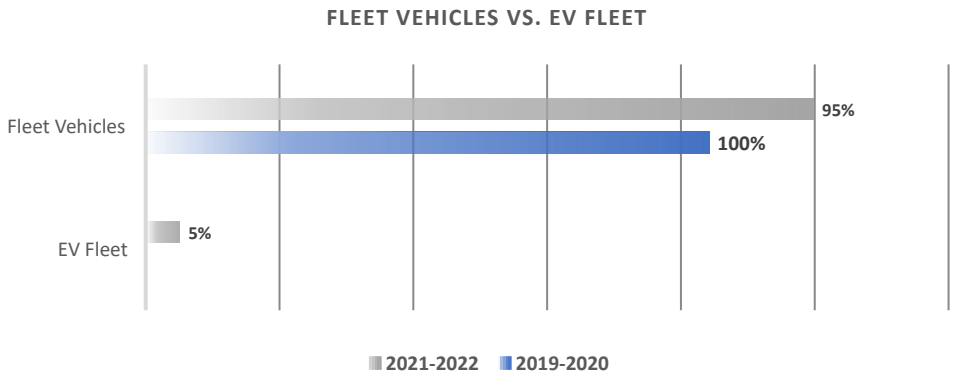
Type	Units Collected
Boxes of cables, chargers, adapters	13
Docking Port	344
HDD Destroy	1
Laptops	317
Mixed WEEE	25
Mobile phones	20
Monitors (CRT)	1
Monitors (flatscreen)	446
Networking gear, switches, hubs	64
Overhead projectors	4
PC's	402
Printers - desktop	138
Printers - free standing	1
Scanners	11
Servers	69
Tablet	8
Telephones	62
TV's	6
UPS	31
User terminals and systems	1
Battery	3
IT Parts	24
Total	**1991**

DHCW IT Waste Disposed

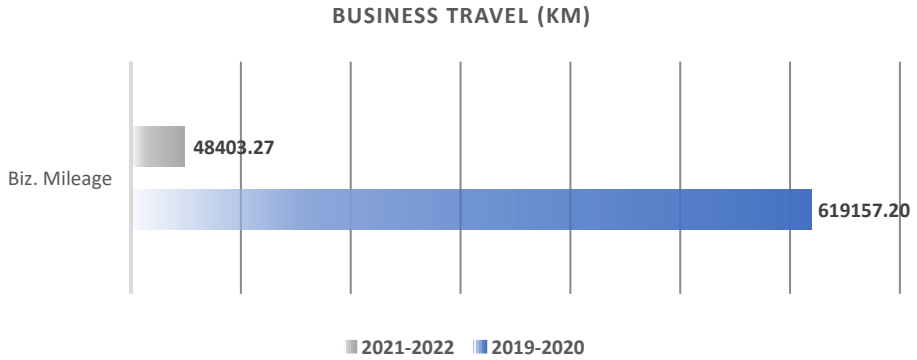
The table (left) shows the total number of IT equipment units (by type) that were recycled, repurposed or reused, in 2021/22.

Total Units
1991

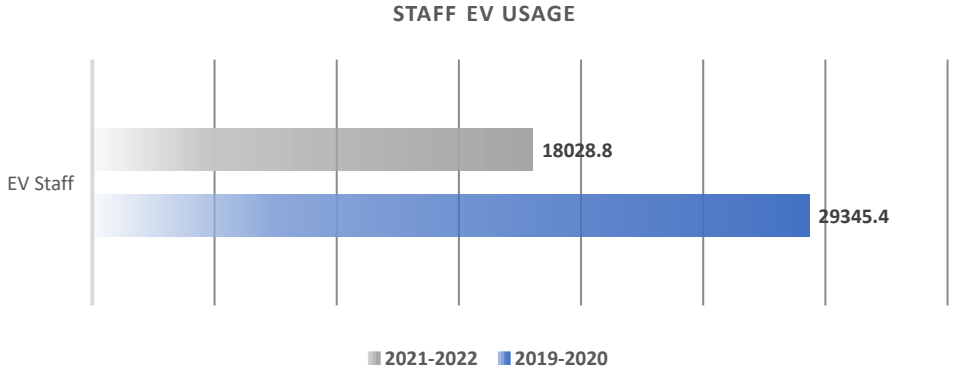
SUSTAINABLE TRAVEL 21/22



The above graph shows a comparison of kilometres travelled by EV Fleet Vehicles vs Internal Combustion Fleet Vehicles in 2021/22 compared to 2019/20. **As you can see, we have increased the distance travelled in EV vehicles by 5% when compared to the baseline year.**



The above graph shows a comparison of business travel in 21/22 compared to 19/20. **As you can see, business travel has reduced by 92% when compared to the baseline year.**



The above graph shows a comparison of Staff EV Charger usage in 21/22 compared to 19/20. **As you can see, the distance travelled in EV vehicles by staff has increased by 39% when compared to the baseline year.**

Sustainable Transport Update

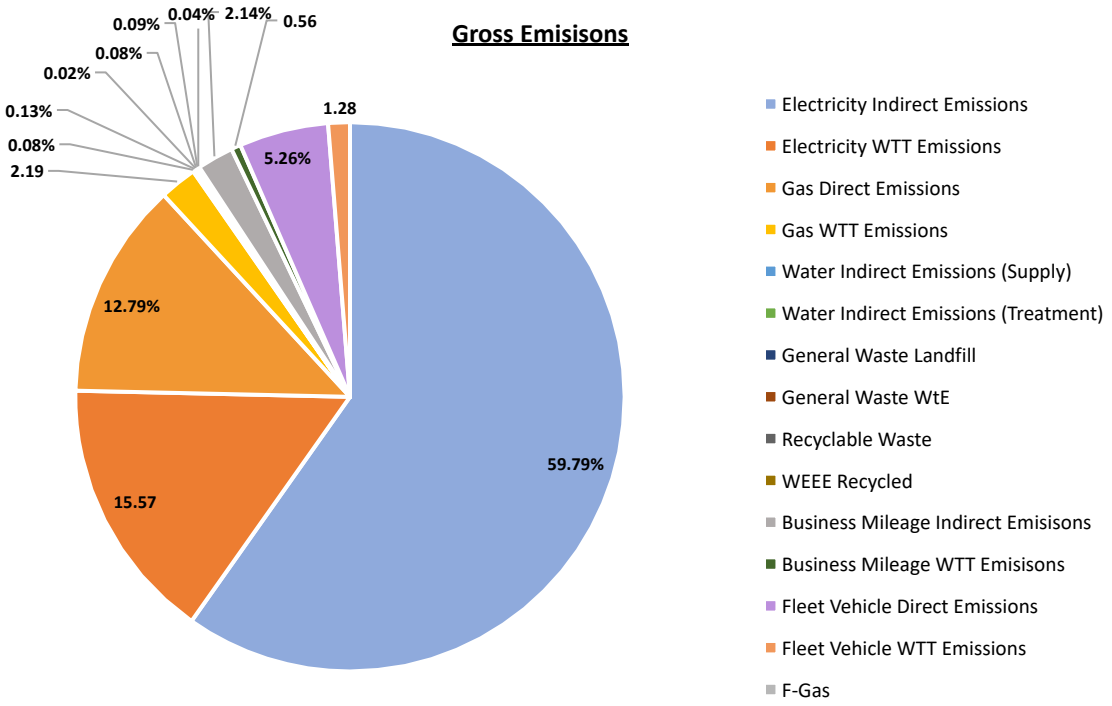
Four sites have EV chargers available for staff to use. DHCW currently has three EV fleet vehicles used by Corporate Services and Client Services.

Facilities such as bicycle racks, showers and changing rooms are available at several sites that enable staff to make more sustainable commutes. In addition to this, the availability of homeworking for all staff has reduced the need for commuting.

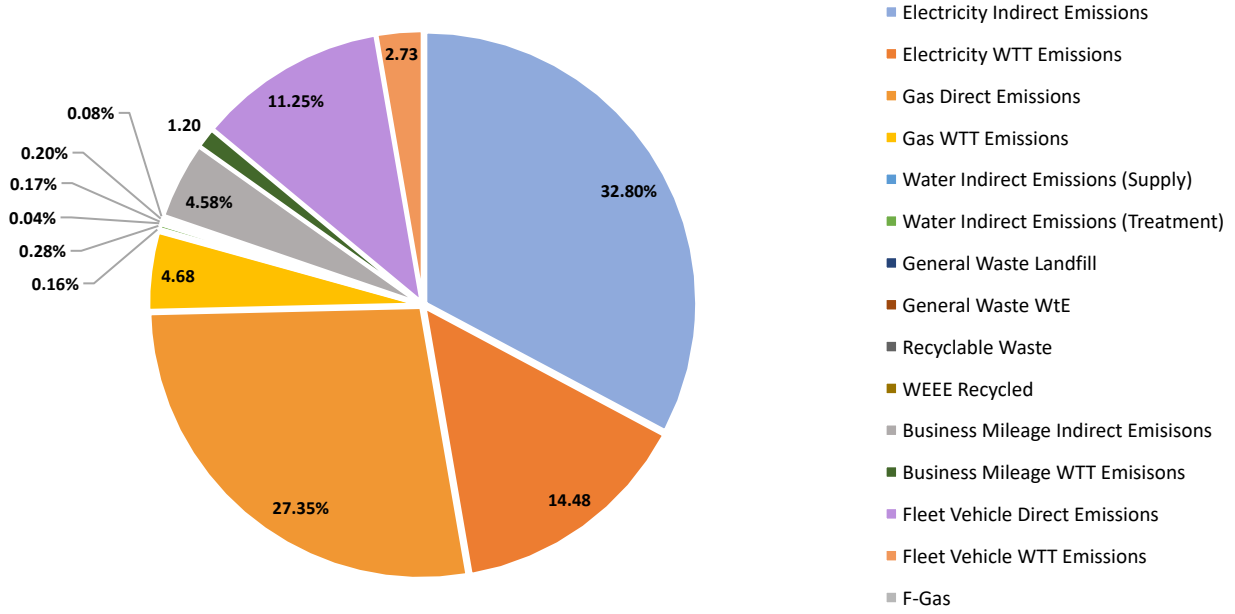
CARBON FOOTPRINT 21/22

Emissions	Performance (21/22) vs Baseline (19/20):	Carbon Footprint 21/22:	Carbon Footprint per m2:	Carbon Footprint per person:
Gross	-41%	387.505 MtCO2e	0.061 MtCO2e	0.437 MtCO2e
Net	-58%	181.152 MtCO2e	0.028 MtCO2e	0.204 MtCO2e

Gross Emisisons



Net Emissions



*Our Net emissions are calculated based on Gross emissions minus REGO supplied electricity.

APPENDIX B

Operational Emmisions

Summary emission reporting format

Summary table where emission sources, consumption data, RSD and emissions per source are listed.

Instructions for users

1) You can keep raw data in separate sheets; this summary sheet is for aggregating your consumption data per emission source or per activity, and applying approprate emission factors.
2) You will need to put in appropriate formulas to calculate the units of kgCO2e from the consumption data in column F and your chosen emission factors in the tab.
3) You should provide one line per emission source and methodology tier e.g. if you have mostly metered gas data with emissions calculated using Tier 3 method but two buildings where you have no metering and therefore you need to use Tier 1, this should be given as two separate lines because the RSD will be different.

Table 22: Summary table for emission reporting format

Category	Description	Consumption data	Standard consumption data units	RSD estimate (+/-%)	Emissions - Units tCO2e	Ease of collection assessment / Reason for not including	Organisational Notes
Diesel - biofuel blend	All organisation fleet vehicles	8,109.45	Litres	+/-2%	25.32	*Data complete and easy to collect and process*	*Diesel Fleet vans*
Grid electricity - buildings	TGA and Bocam	512,252.80	kWh	+/-2%	149.22	*Data complete and easy to collect and process*	*TGA and Bocam both have renewable electricity*
Grid electricity - buildings	Castlebridge, Mamhilad and Swansea	233,084.50	kWh	+/-2%	67.90	*Data complete and easy to collect and process*	*Castlebridge, Mamhilad and Swansea have renewable electricity, as confimred by landlord certificates*

Grid electricity - buildings	Mold	257,053.40	kWh	+/-10%	74.88	*Data complete but requires effort to collect and process*	*Standard electricity supply i.e. NOT supplied from renewable sources*
Grid electricity - buildings	Homeworking	224,613.00	kWh	+/-25%	65.43	*Data unavailable in the timescales*	*Methodology based on EcoAct Whitepaper 2020*
Grid electricity - datacentres	Vantage Datacentre	1,125,981.79	kWh	+/-2%	328.00	*Data complete and easy to collect and process*	*Direct consumption in metered rack space provided on 3rd party site*
Grid electricity - datacentres	Church Village Datacentre	408,570.00	kWh	+/-2%	119.02	*Data complete and easy to collect and process*	*Direct consumption in metered rack space provided on 3rd party site*
Grid electricity - datacentres	Church Village Datacentre	57,199.80	kWh	+/-25%	16.66	*Data complete and easy to collect and process*	*Scope 3 cooling etc. based on PUE of 1.14*
Grid electricity - datacentres	Vantage Datacentre	675,589.07	kWh	+/-25%	196.80	*Data complete and easy to collect and process*	*Scope 3 cooling etc. based on PUE of 1.6*
Natural Gas	*TGA and Mamhilad both invoiced*	233,425.00	kWh	+/-2%	50.07	*Data complete and easy to collect and process*	*Bocam and Mold sites have no Gas on site.*
Natural Gas	*Castlebridge and Swansea are all calculated using floor area*	37,072.78	kWh	+/-10%	7.95	*Data complete but requires effort to collect and process*	*Castlebridge and Swansea are all calculated using TGA floor area*
Natural Gas	Homeworking	2,496,948.00	kWh	+/-25%	535.62	*Data unavailable in the timescales*	*Methodology based on EcoAct Whitepaper 2020*

Travel - bus	Staff commuting	21,249.00	passenger km	+/-25%	3.11	*Data unavailable in the timescales*	*Methodology based on EcoAct Whitepaper 2021- Percentage proportioning taken from Welsh Public Sector Net Zero Reporting Guide-2021 Modified WG Tier 1 using 885 staff, 94% homeworking in this year*
Travel - car passenger	Staff commuting	31,166.00	vehicle km	+/-25%	0.00	*Data unavailable in the timescales*	*as above*
Travel - cycle	Staff commuting	6,611.00	vehicle km	+/-25%	0.00	*Data unavailable in the timescales*	*as above*
Travel - motorcycle	Staff commuting	2,833.00	vehicle km	+/-25%	0.41	*Data unavailable in the timescales*	*as above*
Travel - private car	Staff commuting	302,215.00	vehicle km	+/-25%	65.45	*Data unavailable in the timescales*	*as above*
Travel - private car	Business mileage - all employees	48,403.27	vehicle km	+/-5%	10.48	*Data complete and easy to collect and process*	
Travel - rail	Staff commuting	8,972.00	passenger km	+/-25%	0.38	*Data unavailable in the timescales*	*as above*
Travel - taxi	Staff commuting	1,889.00	passenger km	+/-25%	0.35	*Data unavailable in the timescales*	*as above*
Travel - walk	Staff commuting	44,860.00	vehicle km	+/-25%	0.00	*Data unavailable in the timescales*	*as above*
Waste - incineration	TGA and Mold WtE	10.71	tonnes	+/-2%	0.23	*Data complete and easy to collect and process*	*WtE used at these sites - no waste sent to landfill*

Waste - incineration	Castlebridge, Mamhilad and Swansea WtE, all calculated using floor area	3.47	tonnes	+/-15%	0.07	*Availability of data unknown*	*Estimated tonnage based on floor area - waste disposed of via WtE, no waste is sent to landfill by our landlord as part of lease agreement.*
Waste - landfill	**No sites**	0.00	tonnes	+/-15%	0.00	*Availability of data unknown*	*Estimated tonnage based on floor area - watse sent to landfill by our landlords as part of lease agreement.*
Waste - landfill	Bocam	0.14	tonnes	+/-2%	0.07	*Data complete and easy to collect and process*	*Estimated tonnage based on collection contract.*
Waste - recycling	All Sites	6.82	tonnes	+/-2%	0.15	*Data complete but requires effort to collect and process*	*DHCW provide and dispose of IT kit from across NHW Wales*
Waste - recycling	All Sites Confidential Waste Data and TGA and Bocam recycling	12.41	tonnes	+/-2%	0.26	*Data complete but requires effort to collect and process*	*These figures include our confidential and dry mixed recycling i.e plastic, cans, glass and cardboard.*
Waste - recycling	Castlebridge, Mamhilad, and Swansea recycling are all calculated using floor area	4.85	tonnes	+/-15%	0.10	*Availability of data unknown*	*These figures include our confidential and dry mixed recycling i.e plastic, cans, glass and cardboard. Estimated tonnage based on floor area.*
Water supply	TGA, Bocam and Mamhilad	1,567.31	m^3	+/-2%	0.23	*Data complete and easy to collect and process*	*Invoiced water supply*

Water supply	Castlebridge, Swansea and Mold are all calculated using floor area	393.79	m^3	+/-15%	0.06	*Data complete but requires effort to collect and process*	*Water is included within lease agreement. In the absence of invoice data, usage is calculated using floor area*
Water treatment	TGA, Bocam and Mamhilad	1,490.64	m^3	+/-2%	0.41	*Data complete and easy to collect and process*	*Invoiced water supply*
Water treatment	Castlebridge, Swansea and Mold are all calculated using floor area	374.63	m^3	+/-15%	0.10	*Data complete but requires effort to collect and process*	*Water is included within lease agreement. In the absence of invoice data, usage is calculated using floor area*
		6,741,963			**1,719**		

Indirect emissions from the supply chain

This table is taken directly from the Defra source 'Table 13 - Indirect emissions from the supply chain'.
www.gov.uk/government/statistics/uks-carbon-footprint
This table only covers indirect emissions from the supply chain and is an estimate of the indirect GHG emissions resulting from expenditure on procuring goods and services. The emission factors were calculated by the Centre for Sustainability Accounting and were last updated for the year 2011. Currently there are no more recent factors available for expenditure by SIC code.
This table also includes a number of activities that are likely to be covered in your operational emissions, such as fuel use and transmission and distribution, travel and water. If you have captured that expenditure in the Operational emissions tab, you should remove the expenditure from this table as otherwise you will be double counting your emissions. However, the information in this table may still be useful for a rough initial calculation of the relative importance of these activities in the first instance.

Instructions for users:

1) Identify the amount spent on different product groups (in actual prices in £s, including VAT).
2) Multiply the amount of spending by the conversion factor to get total emissions in kilograms of carbon dioxide equivalent (kg CO_2e). This excel spreadsheet does this automatically following your entry of the amount of spending into the appropriate box.

Table 13 Indirect emissions from the supply chain

SIC code (SIC 2007)	Product category	Amount spent by product category (£)	Emission factor (kgCO2e per £ spent)	Total kg CO_2e	RSD estimate (+/-%)	Notes on data source and exclusions
10.8	*Other food products*	£0.00	*0.96*	0	+/-25%	
11.07	*Soft drinks*	£0.00	*0.60*	0	+/-25%	
14	*Wearing apparel*	£1,137.75	*0.68*	769	+/-25%	

17	*Paper and paper products*	£466.03	*1.18*	552	+/-25%	
18	*Printing and recording services*	£0.00	*0.58*	0	+/-25%	
20.4	*Soap and detergents, cleaning and polishing preparations, perfumes and toilet preparations*	£5,129.96	*1.44*	7398	+/-25%	
22	*Rubber and plastic products*	£2,986.50	*0.96*	2868	+/-25%	
26	*Computer, electronic and optical products*	£2,568,926.09	*0.41*	1055117	+/-25%	
27	*Electrical equipment*	£42,752.66	*0.62*	26514	+/-25%	
28	*Machinery and equipment n.e.c.*	£0.00	*0.56*	0	+/-25%	
31	*Furniture*	£24,409.22	*0.64*	15539	+/-25%	
32	*Other manufactured goods*	£0.00	*0.45*	0	+/-25%	
38	*Waste collection, treatment and disposal services; materials recovery services*	£0.00	*1.36*	0	+/-25%	
41-43	*Construction*[4]	£0.00	*0.37*	0	+/-25%	
52	*Warehousing and support services for transportation*	£0.00	*0.28*	0	+/-25%	
53	*Postal and courier services*	£1,451.27	*0.35*	508	+/-25%	

55	*Accommodation services*	£0.00	*0.45*	0	+/-25%	
56	*Food and beverage serving services*	£17,939.22	*0.40*	7236	+/-25%	
58	*Publishing services*	£20,199.50	*0.23*	4558	+/-25%	
61	*Telecommunications services*	£1,760,237.69	*0.32*	560862	+/-25%	
62	*Computer programming, consultancy and related services*	£53,281,493.02	*0.18*	9401503	+/-25%	
65.1-3	*Insurance, reinsurance and pension funding services, except compulsory social security & Pensions*	£0.00	*0.18*	0	+/-25%	
68.1-2	*Real estate services, excluding on a fee or contract basis and imputed rent*	£0.00	*0.13*	0	+/-25%	
69.1	*Legal services*	£27,342.86	*0.10*	2629	+/-25%	
69.2	*Accounting, bookkeeping and auditing services; tax consulting services*	£0.00	*0.12*	0	+/-25%	
70	*Services of head offices; management consulting services*	£0.00	*0.17*	0	+/-25%	
71	*Architectural and engineering services; technical testing and analysis services*	£74,587.67	*0.18*	13379		
73	*Advertising and market research services*	£0.00	*0.20*	0	+/-25%	
74	*Other professional, scientific and technical services*	£0.00	*0.16*	0	+/-25%	

77	*Rental and leasing services*	£1,068,552.61	*0.23*	251059	+/-25%	
78	*Employment services*	£1,624,346.01	*0.14*	223606	+/-25%	
80	*Security and investigation services*	£0.00	*0.24*	0	+/-25%	
81	*Services to buildings and landscape*	£239,196.43	*0.25*	58741	+/-25%	
82	*Office administrative, office support and other business support services*	£4,270,021.14	*0.18*	765820	+/-25%	
84	*Public administration and defence services; compulsory social security services*	£0.00	*0.27*	0	+/-25%	
85	*Education services*	£0.00	*0.17*	0	+/-25%	
95	*Repair services of computers and personal and household goods*	£0.00	*0.22*	0	+/-25%	
Not confirmed	*Spending categories with less than £10Kpa spend*	£0.00	*0.25*	0	+/-25%	*Data complete but requires effort to collect and process - conservative EF assigned*
Unknown	*37470-Miscellaneous Expenditure*	£0.00	*0.25*	0	+/-25%	*Metadata unavailable in the timescales - conservative EF assigned.*
Unknown	*37400-Other General Provisions*	£0.00	*0.25*	0	+/-25%	*Metadata unavailable in the timescales - conservative EF assigned.*

Unknown	*32810-Other General Supplies & Services*	£0.00	*0.25*	0	+/-25%	*Metadata unavailable in the timescales - conservative EF assigned.*
Unknown	*37710-Recharge : Miscellaneous*	£0.00	*0.25*	0	+/-25%	*Metadata unavailable in the timescales - conservative EF assigned.*
	Total	**£65,031,175.63**		**12,398,656**		