# Hywel Dda University Health Board

# Accountability Report 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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# Hywel Dda University Health Board

# Corporate Governance Report 2018/2019

GIG CYMRU NHS WALES

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# Hywel Dda University Health Board

# Annual Governance Statement 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Annual Governance Statement 2018-2019

## Scope of Responsibility

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

Effective governance is derived from more than systems and processes; it is built on strong and enduring relationships which engender trust and cooperation between the Board, Executive Team, staff, partners and stakeholders. The seamless alignment of process and people creates a collegiate governance culture that:

- Provides a foundation for ensuring that the Hywel Dda University Health Board (HB) is operating effectively and delivering safe, high quality care;
- Delivers assurance to the Welsh Government (WG), key stakeholders and the public regarding organisational probity and sustainability; and
- Demonstrates leadership that enables the HB to respond to the significant challenges it continues to face.

The HB recognises that the function of governance is to ensure that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens and service users and operates in an effective, efficient and ethical manner. In recognising that governance is a wide-ranging term encompassing concepts such as leadership, stewardship, accountability, scrutiny, challenge, ethical behaviours, values and controls, the essence of Hywel Dda is reflected in its Values and Behaviours Framework, which represents how we do things and the behaviours expected of those working for the HB.

The Board is responsible for maintaining appropriate governance arrangements to ensure that it is operating effectively and delivering safe, high quality care. It also recognises the need to govern the organisation effectively and in doing so build public and stakeholder confidence. This is of particular relevance in light of the challenges we face as an organisation and the decisions that were taken when approving the Health and Care Strategy based upon the outcomes from the Transforming Clinical Services programme of work. It has, therefore, been imperative that a robust governance structure has been enacted around the delivery of such major pieces of work during this year, in order to ensure openness and transparency regarding our future plans.

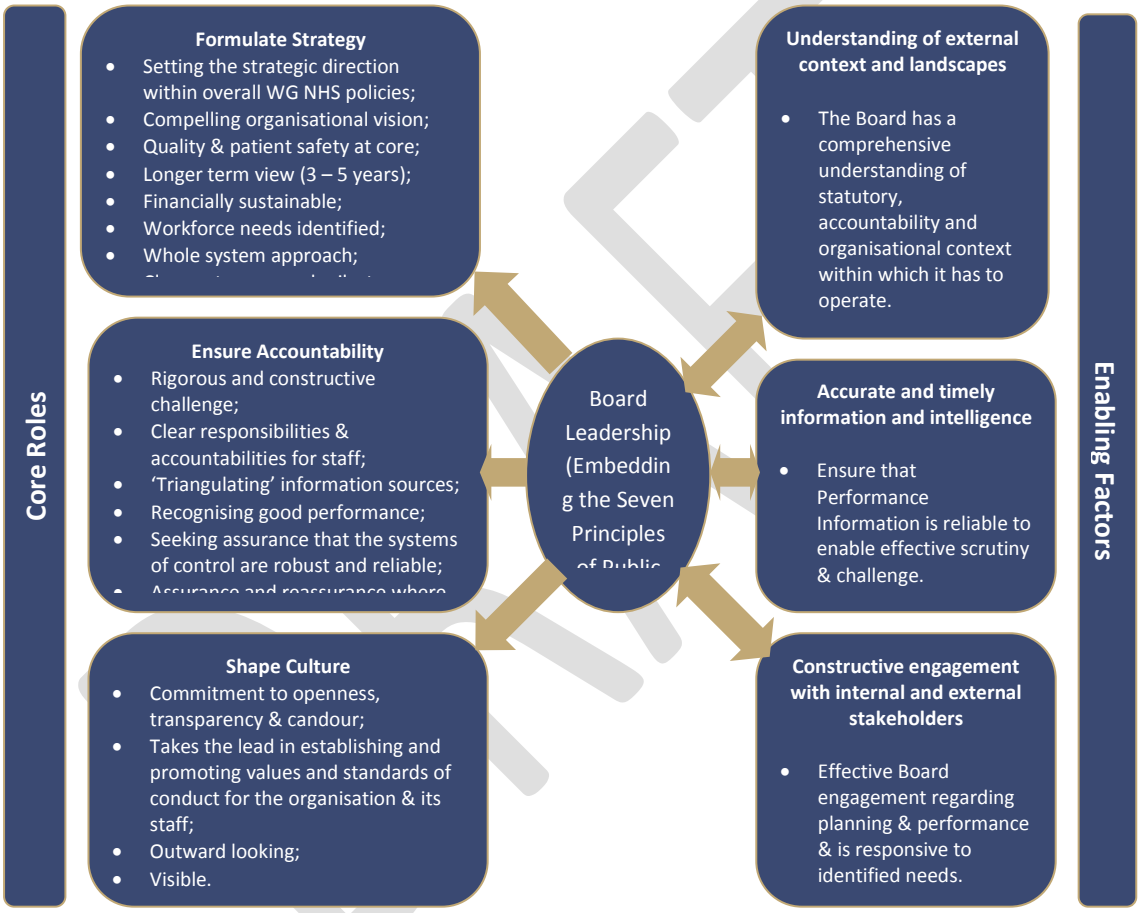
The HB has remained at the “Targeted Intervention” level of the NHS Wales Escalation and Intervention arrangements throughout the year, with no further escalation. The rationale for the HB remaining at Targeted Intervention level is reported regularly to both The Board and the Audit and Risk Assurance Committee. The main focus of the discussions has been in relation to the HB’s financial position as the NHS Finance (Wales) Act 2014 requires each HB to prepare a plan which sets out the Board’s strategy for complying with the three year financial duty to breakeven. As it has failed in its duty to have an approved three year IMTP in place for each submission in the period 2014/2015 to 2018/2019, the HB has been in breach of this statutory duty throughout this time.

During the year the HB has, with the support provided from the WG, continued to make progress, particularly in respect of the continuous engagement with our population in respect of the development of the Health and Care Strategy and much improved performance in particularly in relating to the significant reduction in referral to treatment times. Whilst the HB

has delivered on a wide range of challenging areas during some particularly pressured operational periods with some areas of progress identified and made, the HB's financial position has remained a dominant factor throughout the year as has the Board's ability to deliver an approved annual plan for the forthcoming year.

All Board members share corporate responsibility for formulating strategy, ensuring accountability, monitoring performance and shaping culture, together with ensuring that the Board operates as effectively as possible. The Board, which comprises individuals from a range of backgrounds, disciplines and areas of expertise, has during the year provided leadership and direction, ensuring that sound governance arrangements are in place.

Taking the above principles into account, the principal role of the Board during the year has been to exercise leadership, direction and control as shown in the following figure:




The Board has an open culture, with its meetings held in public and the meeting papers, as well as those of its committees, available on the HB's website. The Board has a strong and independent non-executive element and no individual or group dominates its decision making process. The Board considers that each of its non-executive members are independent of management and free from any business or other relationship which could materially interfere with the exercise of their independent judgement. There is a clear division of responsibility in that the roles of the Chair and Chief Executive Officer (CEO) are separate.

**Board and Committee Membership**

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in the terms and conditions of appointment, Board members also fulfil a number of Champion roles where they act as ambassadors for these matters. With the exception of the position of Chair, this year has seen stability in membership from both an Independent Member and Executive Team perspective. Sadly, due to ill health, Bernardine Rees retired from her role as Chair at the end of February 2019 (this role is being undertaken on an interim basis by the HB's Vice-Chair). The recruitment process is underway, with the new Chair due to commence in post in June 2019.

The Board and Committee Membership and Champion roles during 2018/2019 is included as Appendix 1 to this statement.

At a local level, NHS organisations in Wales must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegation to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the HB and define - its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework. The following table outlines dates of Board and Committee meetings held during 2018/2019, with all meetings being quorate:

**Table 1**

| Dates of Meeting | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Meeting** | **April 2018** | **May 2018** | **June 2018** | **July 2018** | **Aug 2018** | **Sep 2018** | **Oct 2018** | **Nov 2018** | **Dec 2018** | **Jan 2019** | **Feb 2019** | **March 2019** |
| Board | 19.04.18 | 30.05.18<br>31.05.18 | | 26.07.18 | | 26.09.18<br>27.09.18 | | 29.11.18 | | 31.01.19 | | 28.03.19 |
| Audit & Risk Assurance Committee | 17.04.18 | 02.05.18<br>30.05.18 | 19.06.18 | | 21.08.18 | | 25.10.18 | | 11.12.18 | | 19.02.19 | |
| Charitable Funds Committee | | | 21.06.18 | | | | 03.10.18 | | 20.12.18 | | | 14.03.19 |
| Quality, Safety & Experience Assurance Committee | 10.04.18 | | 12.06.18 | | 14.08.18 | | 16.10.18 | | 04.12.18 | | 05.02.19 | |
| Finance Committee | | | | | | 28.09.18 | 25.10.18 | 22.11.18 | 20.12.18 | 24.01.19 | 25.02.19 | 25.03.19 |
| Mental Health Legislation Assurance Committee | | | 07.06.18 | | | 20.09.18 | | | | 15.01.19 | | 21.03.19 |
| Business Planning & Performance Assurance Committee | 24.04.18 | | 26.06.18 | | 28.08.18 | | 30.10.18 | | 18.12.18 | | 26.02.19 | |
| Primary Care Applications Committee | 30.04.18 | 10.05.18 | | 04.07.18 | | 04.09.18 | | | 06.12.18 | | 21.02.19 | |
| University Partnership Board | | 16.05.18 | | | 02.08.18 | | | 21.11.18 | | | 12.02.19 | |
| Remuneration & Terms of Service Committee | | 30.05.19 | | | 23.08.18 | | | | | | 25.02.19 | |

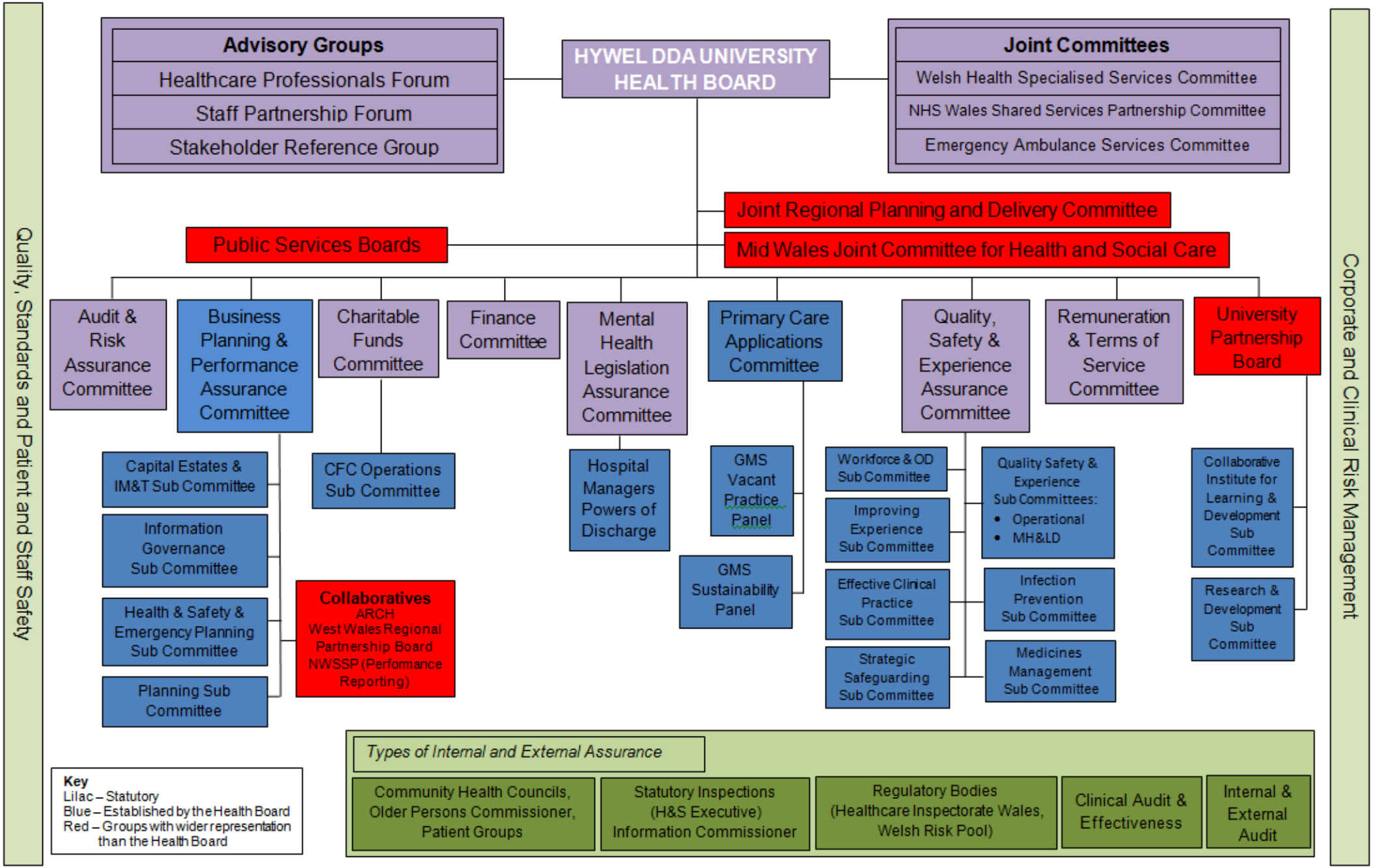
**The Board and its Committees**

The Committees of the Board, chaired by Independent Members, have key roles in relation to the Governance and Assurance Framework. On behalf of the Board, they provide scrutiny, development discussions, assessment of current risks and performance monitoring in relation to a wide spectrum of the HB's functions and its roles and responsibilities. Each of the main Committees of the Board is supported by an underpinning sub-committee structure reflecting the remit of its roles and responsibilities.

The HB regularly seeks assurance through its Committee reporting structure that the following disciplines are in place:

- High quality services are delivered efficiently and effectively;
- Risk management and internal control activities are proportionate to the level of risk within the organisation, aligned to other business activities, comprehensive, systematic and structured, embedded within business procedures and protocols and dynamic, iterative and responsive to change;
- Equality Impact Assessment is carried out in accordance with legislation and the HB's Equality Impact Assessment Policy;
- Performance is regularly and rigorously monitored, with effective measures implemented to tackle poor performance;
- Compliance with laws and regulations;
- Information used by the HB is relevant, accurate, reliable and timely;
- Financial resources are safeguarded by being managed efficiently and effectively;
- Human and other resources are appropriately managed and safeguarded.

The Committees have met regularly during the year, with update reports outlining key risks and highlighting areas which need to be brought to the Board's attention to contribute to its assessment of assurance and provide scrutiny against the delivery of objectives. The Committees, as well as reporting to the Board, also work together on behalf of the Board to ensure, where required, that cross reporting and consideration takes place and assurance and advice is provided to the Board and the wider organisation. The Wales Audit Office (WAO) Structured Assessment 2018 acknowledged that the Board continues to be generally well-run, providing a good level of scrutiny and challenge. The Board recognises, however, that further work is required improve its quality and safety governance arrangements and is committed to addressing these issues in the forthcoming financial year. Our system of Governance and Accountability (the assurance arm of the organisation) during the year is therefore demonstrated in the following diagram:


Quality, Standards and Patient and Staff Safety
Corporate and Clinical Risk Management
Advisory Groups
Healthcare Professionals Forum
Staff Partnership Forum
Stakeholder Reference Group
HYWEL DDA UNIVERSITY HEALTH BOARD
Joint Committees
Welsh Health Specialised Services Committee
NHS Wales Shared Services Partnership Committee
Emergency Ambulance Services Committee
Joint Regional Planning and Delivery Committee
Public Services Boards
Mid Wales Joint Committee for Health and Social Care
Audit & Risk Assurance Committee
Business Planning & Performance Assurance Committee
Charitable Funds Committee
Finance Committee
Mental Health Legislation Assurance Committee
Primary Care Applications Committee
Quality, Safety & Experience Assurance Committee
Remuneration & Terms of Service Committee
University Partnership Board
Capital Estates & IM&T Sub Committee
Information Governance Sub Committee
Health & Safety & Emergency Planning Sub Committee
Planning Sub Committee
CFC Operations Sub Committee
Collaboratives
ARCH
West Wales Regional Partnership Board
NWSSP (Performance Reporting)
Hospital Managers Powers of Discharge
GMS Vacant Practice Panel
GMS Sustainability Panel
Workforce & OD Sub Committee
Improving Experience Sub Committee
Effective Clinical Practice Sub Committee
Strategic Safeguarding Sub Committee
Quality Safety & Experience Sub Committees:
Operational
MH&LD
Infection Prevention Sub Committee
Medicines Management Sub Committee
Collaborative Institute for Learning & Development Sub Committee
Research & Development Sub Committee
Key
Lilac – Statutory
Blue – Established by the Health Board
Red – Groups with wider representation than the Health Board
Types of Internal and External Assurance
Community Health Councils, Older Persons Commissioner, Patient Groups
Statutory Inspections (H&S Executive) Information Commissioner
Regulatory Bodies (Healthcare Inspectorate Wales, Welsh Risk Pool)
Clinical Audit & Effectiveness
Internal & External Audit

**The Board**

In governing the business of the organisation, all Executive Directors and Independent Members are collectively and corporately accountable for the HB's performance. This is fundamental to the Board's role in pursuing performance and ensuring that the interests of patients are central, and creates a culture which supports open dialogue. The Board strives to ensure that ethical standards are integral to its governance arrangements and form part of its culture and behaviour and recognises that governance is not a static concept. The HB is committed to being honest and improving values and behaviours, as demonstrated by its Values and Behaviours Framework. The Board continues to hold its meetings across its catchment area of the three Counties, with a focus on local as well as strategic and wider HB issues, enabling wider engagement with the public. There is a Public Forum section of the meeting at which the Chair takes questions submitted in advance. The presentation of patient and staff stories at the start of each Board meeting demonstrates that there is a clear patient and staff centred focus by the Board. This is further strengthened through a programme of scheduled patient safety walkabouts with which all Board members are engaged, acknowledging that leadership is fundamental in the creation of a culture that supports and promotes safety and wellbeing for patients and colleagues. In order to increase the reach of the work of the Board, webcasting of its meetings commenced in April 2018, enabling its discussions to be accessible to members of the public who are unable to attend. The WAO's 2018 Structured Assessment concluded that the Board continues to be generally well-run with the quality of board level scrutiny and challenge being good.

The Board, whilst complying with a planned programme of work, adapted as necessary to respond to emerging events and circumstances has, during the year, discussed and considered, amongst other items, the following areas of HB activity:

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| HB Wide Issues<br><br>(Approval) | • Approved the Draft Operational Plan for 2018/2019.<br>• Approved the savings element of the interim Financial Plan 2018/2019 as the basis for delivery in year.<br>• Approved the Committees' Annual Reports and the Governance, Leadership and Accountability Report.<br>• Approved the Annual Quality Statement, Accountability Report, Annual Governance Statement, Annual Accounts, Letter of Representation and WAO ISA 260 for submission to WG.<br>• Approved the Annual Report for 2017/2018.<br>• Approved the revised Performance Management & Assurance Framework.<br>• Approved the establishment of the Transforming Clinical Services Design Steering Group, its supporting governance structure and the Terms of Reference for the Group.<br>• Approved the HB's Well-being Objectives Annual Report reporting on the period 1 April 2017-31 March 2018, for publication in order to fulfil the HB's statutory obligations under the Well-being of Future Generations (Wales) Act 2015.<br>• Approved the recommendation from Welsh Health Specialised Services Committee (WHSSC) to undertake a formal public consultation in line with the proposals outlined in the 'draft' public consultation plan and 'draft' core consultation on the Review of Adult Thoracic Surgery and subsequently approved the recommendations that thoracic surgery services for the population of south east Wales, west Wales and south Powys are delivered from a single site with this being Morriston Hospital, Swansea.<br>• Approved the Seasonal Influenza Plan 2018/2019.<br>• Approved the updated Major Incident Plan 2018/2019.<br>• Approved the HB's Risk Appetite Statement.<br>• Approved the contents of the Board Assurance Framework based on the |

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| | HB's strategic objectives and approved updates to existing risks and new principal risks for inclusion.<br>• Approved completion of Stage 2 of the consultation process (public consultation) aligned with Transforming Clinical Services and a number of clinical recommendations as follows –<br>- Approved the integration of health and social care to deliver an integrated community model, based on an integrated social model for health and wellbeing (the model), at pace. Working with social care and other partners, this will be a long term commitment focused on prevention, wellbeing, early intervention and help build resilience to enable people to live well within their own communities.<br>- Approved the development of a plan for the existing Community Hospitals, working with local communities. This plan will be focussed on the provision of ambulatory care including out-patient services, diagnostics, treatment, observation, rehabilitation and end of life care.<br>- Approved a modification of the remaining proposals for delivering hospital services.<br>- Approved the progression of a proposed new Planned and Urgent Care hospital on a single site through the business case process (Five Case Model).<br>- Approved development of a plan to redesign the remaining main hospital sites, working with local people, to maximise the range of services and support available aligned to the proposed model, and a new Urgent and Planned Care Hospital.<br>- Approved the development of a detailed plan to address the significant concern heard during the consultation regarding access, travel, transport and infrastructure, ensuring a focus on exploring innovative approaches to accessing care and support.<br>- Approved the development of a plan to maximise the use of technology as a key enabler to the delivery of the proposed model underpinned by secure IT infrastructure with sufficient back-ups, so that patient data is safe, timely and secure.<br>- Approved the development of a workforce redesign and transformation plan – starting now and forward planning – to enable delivery and sustainability of the future model.<br>- Reaffirmed its commitment to continuously engage in innovative ways, and support co-production between staff, and local people, partner organisations and other interested parties with a particular focus on engagement and co-design with those most vulnerable in our population, and those with Protected Characteristics, as set out in the Equalities Act (2010). This includes the co-design of integrated local care and support, clinical pathways and innovative ways of working together.<br>- Approved the further development of all recommendations into the draft Health Strategy for consideration at the Public Board meeting on 29 November 2018.<br>• Approved the revised Scheme of Delegation and Reservation of Powers.<br>• Approved the establishment of the Finance Committee as a Committee of the Board.<br>• Approved the HB's Health and Care Strategy and the underpinning updated Integrated Impact Assessment.<br>• Approved the HB's 3 re-framed strategic goals to replace the existing 8 |

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| | health-related strategic objectives.<br>• Approved the Strategic Equality Plan Annual Report 2017/2018.<br>• Approved the Organ Donation Annual Plan for submission to NHS Blood & Transplant (NHSBT) and WG.<br>• Approved the HB's Health and Wellbeing Framework.<br>• Approved the Hywel Dda Community Health Council and Hywel Dda University Health Board Framework for Continuous Engagement and Consultation.<br>• Approved the preferred option regarding Laundry Services outlined within the Outline Business Case.<br>• Approved the revised version of the HB's Standing Orders and Standing Financial Instructions.<br>• Approved the Scoping, Governance and Delivery document (and the appended Programme Delivery Plans and Check and Challenge process) aligned with the Programme Plan for "A Healthier Mid & West Wales".<br>• Approved the proposed portfolio governance (aligned to the Regional Partnership Board governance), with the view to bringing together the portfolio programme outlined in the Scoping, Governance and Delivery document and the RPB priority groups and Transformation Fund groups in order that there is one key mechanism reporting into shared governance.<br>• Approved the Terms of Reference of the Health and Care Strategy Delivery Group subject to clarification regarding frequency of reporting to Board.<br>• Approved the development of a Transformation Programme Office team to drive forward delivery of the health and care strategy.<br>• Approved the Terms of Reference and endorsed the establishment of, a new Regional Leadership Group (RLG) comprising the four statutory Chief Executives, Chair and or Vice Chair of the HB and Cabinet Members for Social Services from the three local authorities.<br>• Approved the creation of a new Integrated Executive Group (IEG) across the 4 agencies to support joint working and integration at an operational level and oversee delivery of the regional strategies.<br>• Agreed the onward submission to WG of the draft interim 2019/2020 Annual Plan including the draft interim financial plan.<br>• Approved the Policy Statement on the use of the Welsh Language internally. |
| HB Wide Issues<br><br>(Endorsement) | • Supported the approach being taken to ensure that the requirements of the Nurse Staffing Levels (Wales) Act 2016 are embedded into the HB's governance infrastructures.<br>• Accepted the Health & Care Standards/Fundamentals of Care (2017) audit findings as an assurance that the care delivered within the HB continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.<br>• Received for information the Annual Report from Healthcare Inspectorate Wales (HIW) 2017/2018.<br>• Received for information the Medical Revalidation and Appraisal Annual Report 2017/2018.<br>• Acknowledged the risk in delivering the HB's financial forecast position.<br>• Noted the extent of preparations and planning undertaken ahead of winter 2018/2019 and the content of the winter resilience plan and was assured by the measures the service had designed into its plan to tackle the pressures expected to impact through the period.<br>• Endorsed the Llanelli Wellness and Life Science Village as a Health and Wellbeing Centre in line with the principles set out in the report and the Transforming Clinical Services Strategy. |

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| | • Supported the content of the Annual Audit Report and Structured Assessment 2018 Report and was assured that it presented a fair and balanced view of the organisation recognising both the positive aspects identified and those areas where further progress is required.<br>• Assured that principal risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been fully reviewed by its Board level Committees.<br>• Endorsed the Register of Sealings as appropriate.<br>• Received the progress update for each Public Service Board and the key areas of discussion highlighted in the report. |
| Focus on Pembrokeshire Issues | • Noted the focus on an integrated and united approach to health and social care provision, with focus on how teams work together collectively for the needs of the population, rather than the individual sovereignty of any one organisation.<br>• Received an update on the Tenby Walk-in Service, with it being noted that demand on this service had increased significantly and had recently celebrated its one year anniversary, having seen 1 patient short of 5,000 patients.<br>• Supported the plans and initiatives identified which will strengthen services and provide integration on all levels, across organisations and between individual services in improving the health and wellbeing of the population of Pembrokeshire. |
| Focus on Ceredigion issues | • Acknowledged the multi-professional, multi-agency approach to addressing falls in Ceredigion and the example this gives of how services can deliver comprehensive care to allow patients/clients to be as close to home as possible.<br>• Noted the significant progress on delivering a community health and wellbeing model in Ceredigion to support the future sustainable delivery of care and the important links being built with neighbouring statutory organisations to deliver a consistent model of care across mid-Wales.<br>• Noted the Healthcare Services in Ceredigion: Into the Future report, written from the standpoint of patient pathways. The report demonstrated the complexity and number of people involved in healthcare systems in Ceredigion, including integration and co-dependencies. |
| Focus on Carmarthenshire Issues | • Acknowledged the contribution of the strategic partners, agencies, third sector organisations, staff and unpaid carers that support people in Carmarthenshire. The need for integration between health and social care services was acknowledged with the work of Improving Outcomes for Frail Older Adults and the Integrated Pathway for Older People (IPOP) which the HB was fortunate to be piloting.<br>• Acknowledged assurances that Carmarthenshire community district nursing service provides an accessible, effective, safe and quality service for people living in the county. |

**Board Development Programme**

As the scope of corporate governance has increased in recent years, Boards now play an essential role in implementing high performance organisation principles and practices as part of their corporate governance responsibilities. An effective Board Development Programme is therefore critical in enabling the Board to move towards the wider model of corporate governance which incorporates:

- Monitoring the performance of the organisation and the senior management team;
- Setting organisational goals and developing strategies for their achievement;
- Being responsive to changing demands, including the prediction and management of risk.

The HB has a comprehensive, Board-approved Board Development Programme designed to provide ongoing developmental support. The programme has involved separate sessions held initially for Independent Members and Executive Directors based on facilitated discussions to provide a foundation for continued learning and development. The programme is delivered in-house with support from Academi Wales and focuses on key development areas that, once completed, will provide members with the enhanced knowledge, skills and behaviours required to improve individual and collective performance.

Throughout 2018/2019, the Independent Members and Executive Directors took part in both separate and joint Board organisational development programmes. A comprehensive programme of development for Independent Members is in place, making good use of both internal and external resources, and there are effective arrangements to support handover for Independent Members. This programme develops the Independent Members personally, as well as strengthening the Board as a whole and is supported by regular six-monthly reviews on an individual basis. There have been regular joint sessions conducted for Independent Members and Executives on a range of issues. In addition, on an individual basis, Independent Members have been able to access the All Wales Governance and Board Leadership Programme of events delivered by Academi Wales, choosing those sessions that best meet their requirements.

A new Executive Director Performance Framework was introduced in 2018/2019 to provide clarity on performance expectations and role requirements. In addition, Academi Wales have assisted with specific leadership diagnostics and 360 degree feedback tools. These have been taken up by each Executive with the results analysed and discussed in detail, both individually and collectively. Executive coaching provision is also in place.

The above programme has been supplemented by Board Member participation in the HB's Board Seminars which have been held on a regular basis during the year. Board Seminars have provided the Board with an opportunity to receive and discuss subjects/topics which provide additional sources of information and intelligence as part of its assurance framework. This in turn assists with the Board's ability in adequately assessing organisational performance and the quality and safety of services, with sessions held over the year having featured:

- The implications of the Nurse Staffing Level (Wales Act 2016);
- The All Wales HIW summary of activity 2017/2018;
- Performance Management Assurance Framework 2018/2019;
- Adding Value Through Partnership from NHS Wales Shared Services Partnership;
- The Board Assurance Framework, Corporate Risk Register, Risk Appetite & Tolerance;
- Transforming Clinical Services, including Consultation Findings;
- Sustainability of General Medical Services;
- Medical & Dental Education at the HB;

- Health Care Support Worker Framework including the “grow your own nurses” programme;
- An introduction to the work of Health Education & Improvement Wales;
- The Integrated Medium Term Plan/Annual Operating Plan;
- The Board’s future approach to Patient Experience;
- Update on Paediatric Services;
- The HB’s Strategy “A Healthier Mid & West Wales”;
- Violence Against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015.

**Audit & Risk Assurance Committee (ARAC)**
The ARAC is an important Committee of the Board in relation to this Annual Governance Statement. On behalf of the Board, it keeps under review the design and adequacy of the HB’s governance and assurance arrangements and its system of internal control, including risk management. The Committee keeps under review the risk approach of the HB and utilises information gathered from the work of the Board, its own work, the work of other Committees and other activity in the organisation in order to advise the Board regarding its conclusions in relation to the effectiveness of the system of governance and control.

In enacting its responsibilities, the ARAC is very clear on its role in seeking assurances, with the assurance function being defined as:
- Reviewing reliable sources of assurance and being satisfied with the course of action;
- An evaluated opinion, based on evidence gained from review – tends to be based on independent validation, both internal and external.

The Committee is therefore a key source of assurance to the Board that the organisation has effective controls in place to manage the significant risks to achieving its strategic objectives and that controls are operating effectively.

The Committee, through its in-year reporting, has regularly kept the Board informed in respect of the results of its reviews of assurances, together with any exceptional issues. In supporting the Board by critically reviewing governance and assurance processes on which reliance is placed during 2018/2019, a summary of the work of, and key issues considered by, the Committee, on which it has specifically commented in relation to the overall governance of the organisation during the year, is included at Appendix 2 to this statement. Each of the issues highlighted below have been monitored by both ARAC and the Board with clear action taken as a result. Full details are contained within the Committee update reports and the ARAC annual report. The specific concerns included the following issues highlighted to the Board:
- Compliance with agreed timescales in response to recommendations from external organisations resulting in a formalised escalation process and concern regarding the standard of audit management responses;
- Concerns around Consultant and Specialty and Associate Specialist (SAS) job planning compliance;
- Continued concern in relation to the governance regarding private practice;
- Concerns regarding the potential resource impacts (both financial and staff) on Hywel Dda’s Public Health Wales resources arising from the WAO report on Collaborative Arrangements for Managing Local Public Health Resources;
- Continuing concerns regarding the findings of the Physical Verification of Fixed Assets & Personally Identifiable Information (PII) Internal Audit report and the steps being taken to address these;
- Continued concerns regarding the current Single Tender Actions process, in terms of lack of compliance with proper procedures and failure to conduct tender processes when possible;

- Concerns with regard to the Theatres Directorate Internal Audit report, specifically the extended period of time between completion of fieldwork and publication of the final report with recommendations, and the findings around payroll and on-call arrangements;
- In recognition of the significant work undertaken to achieve a Reasonable Assurance rating on the Fire Precautions Follow-up audit, consideration of the requirement for additional investment in this area to maintain and improve compliance;
- Continued concerns regarding clinical audit and governance regarding non-participation, with it noted that this is an area where decisions would be raised to Board level;
- Concerns regarding a lack of patient feedback and patient experience strategy, both specifically in terms of hospital catering & patient nutrition, and that more generally, a clear timeline should be agreed for progress;
- Concerns due to the seriousness of both WAO & Internal Audit reports regarding operating theatres that highlighted significant issues;
- Concerns regarding delays in implementing the RADIS radiology IT system due to losing the slot for implementation;
- Disquiet regarding delays in payments to suppliers, particularly in the case of smaller companies where this can result in a significant impact;
- The need for the HB to strengthen its governance and reporting around maternity services, due to the inherent risks and potential cost, both in human terms and in clinical negligence claims;
- Concerns regarding the lack of assurance provided by management responses to the Internal Audit reports on the Procurement and Disposal of IT Assets and the IM&T Directorate;
- The need for a cultural shift in terms of the way in which the organisation approaches concerns and complaints, and to ensure a continuous improvement programme is established for learning from events/timeliness of responses;
- The Committee's rejection of management responses to Internal Audit Reports on the Radiology Directorate and Glangwili Hospital's Women & Children's Development Phase 2, due to a lack of assurance;
- Concern regarding the pace of progress against the WAO Consultant Contract report on consultant job plans;
- Concerns around adherence to the Internal Audit Charter, resulting in new escalation protocols, timescales, processes and rules;
- Concerns regarding issues relating to Radiology, particularly on-call working practices and payments;
- Concerns around the reduction in Public Health resources proposed in the Public Health Wales Review Closure Report;
- Risks in dealing with private sector companies for capital projects;
- Concerns regarding the HB's financial position, and the risks to delivery of the planned deficit position;
- Concerns regarding ongoing WG questions relating to the organisation's underlying deficit, and suggestions that the reasons for this are not sufficiently understood;
- Concerns regarding European Working Time Directive (EWTD) non-compliance amongst switchboard lone-workers, identified within the IM&T Directorate report;
- Concerns regarding the findings of the Records Management report, particularly a lack of progress and a need for ownership and leadership in this area;
- Continued concerns regarding the implications of HMRC requirements in relation to the GP Out of Hours service and the process to be employed in this regard;
- Concerns regarding the Water Safety and the National Standards for Cleaning Internal Audit reviews, both awarded Limited Assurance ratings.

Throughout the course of the year the ARAC has also made recommendations/undertaken the following actions which have in turn led to improvements in the HB's governance and assurance systems:

- Recommendation by the Committee of the Hywel Dda University Health Board's Annual Report 2017/2018 to the Board for approval;
- Revisions made to the Internal Audit Charter, including new escalation protocols, timescales, processes and rules;
- Development of the new Audit Tracker holding to account process;
- Recommendation by the Committee of the Scheme of Delegation & Reservation of Powers to the Board for approval;
- Monitoring of the Joint Escalation & Intervention Arrangements;
- Recommendation by the Committee of the ARAC's revised Terms of Reference for ratification by the Board.

In keeping with the HB's commitment to openness and transparency, the ARAC papers continue to be available on our public facing website. A detailed update report, presented by the Chair of ARAC, is provided to each Board meeting alongside an independent report of progress against the Committee's work programme and associated business. Link for further information Audit and Risk Assurance Committee.

**Business Planning and Performance Assurance Committee (BPPAC)**

Working to Board approved Terms of Reference, amended during the year to avoid duplication with the work of the Finance Committee, the Committee has provided one of the internal control mechanisms for providing assurance and where appropriate, highlighting risks to the Board. The purpose of the BPPAC is therefore to assure the Board on the following:

- That the planning cycle is being taken forward and implemented in accordance with HB and WG requirements, guidance and timescales;
- That all plans put forward for the approval of the HB for improving the local population's health and developing and delivering high-quality, safe and sustainable services to patients, and the implementation of change, are consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;
- That wherever possible, HB plans are aligned with partnership plans developed with Local Authorities, Universities, Collaboratives, Alliances and other key partners;
- That the data on which performance is assessed is reliable and of high quality and that any issues relating to data accuracy are addressed;
- To provide support to the Board in its role of scrutinising performance and assurance on overall performance and delivery against HB plans and objectives, including delivery of Tier 1 targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required, focus in detail on specific issues where performance is showing deterioration or there are issues of concern;
- To seek assurance on the management of principle risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and its Sub-Committees and provide assurance to the Board that risks are being managed effectively, reporting any areas of significant concern and recommending acceptance of risks that cannot be brought within the HB's risk appetite/tolerance to the Board through the Committee Update Report.

A summary of those matters on which the Committee made specific comment is included in Appendix 2 of this statement; the following however are some of the key matters which were brought to the Board's attention:

- Fishguard Health Centre Refurbishment and Extension BJC – approval of the Fishguard Health Centre Refurbishment and Extension BJC via Chair's Action for submission to WG;
- Recommending Board approval of the Major Incident Plan 2018/2019;
- Approval of BPPAC Revised Terms of Reference and the Committee Annual Report 2018/2019.

The detail of those matters on which BPPAC has briefed the Board regarding internal control matters during the year are included in the regular update reports, the minutes of the meetings and the Annual Report to the Board, all of which can be accessed through the following link on the HB's website: Business Planning and Performance Assurance Committee.

**Quality, Safety and Experience Assurance Committee (QSEAC)**
The Committee is responsible for providing evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care and services provided and secured by the HB. It also has the role of providing assurance to the Board in relation to the HB's arrangements for safeguarding vulnerable people, children & young people and improving the quality and safety of health care to meet the requirement and standards determined for the NHS in Wales. In discharging its role, the Committee has overseen and monitored activities in accordance with its Terms of Reference with the following three matters requiring Board approval:

- Approval of the Quality Improvement Framework Document;
- Approval of the Annual Quality Statement;
- Approval of QSEAC Revised Terms of Reference.

As highlighted by WAO in the 2018 Structured Assessment, there are weaknesses in the HB's quality and safety governance arrangements, this factor being recognised by the Board, with action already being taken to address the situation. Work has already taken place to revisit and refine the QSEAC supporting structures, however these may need to be further refined once the WAO report of the review of operational quality and safety arrangements has been published.

A summary of those matters on which the Committee has raised to the Board's attention is included in Appendix 2 of this statement. The detail of those matters on which QSEAC has briefed the Board regarding internal control matters during the year are included in the regular update reports and Annual Committee Report to the Board, all of which can be accessed on the HB's website. Further information on the detailed work undertaken by QSEAC focusing on patient care and outcomes can also be found in the Annual Quality Statement and/or by accessing the following link in the HB's website: www.wales.nhs.uk/sitesplus/862/page/72049.

**Finance Committee (FC)**
The introduction of the Committee during 2018/2019 has been a welcome addition to the HB's governance structures. Agreement has also been reached with the Minister for Health and Social Services to appoint an additional Associate Member of the Board with significant financial experience with this individual chairing the FC. The purpose of the FC is to provide scrutiny and oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability), review (and report to the Board) financial performance and any areas of financial concern, conduct detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects, and proposed investment decisions on behalf of the Board; regularly review contracts with key delivery partners, and provide assurance on financial performance and delivery against HB

financial plans and objectives and, on financial control, give early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern. The Committee has consistently highlighted the risks and concerns regarding the HB's ability to deliver the forecast deficit of £35.5m, however through the work of the Committee assurance have been provided to the Board that the HB was on track to achieve this forecast deficit position.

**Mental Health Legislation Assurance Committee (MHLAC)**
Working to its remit in respect of its provision of assurance to the Board, the following represent some of the key issues which the Committee highlighted during the year:

- Monitoring of issues relating to medical staffing levels within Mental Health and Learning Disabilities Directorate – issues included pressures on current medical workforce and the number of locums being used across the service, as well as recruitment issues having an impact on the timeliness of tribunal and hospital managers' reports.

Other areas of concerns were also brought to the Board's attention:

- Monitoring of specific issues relating to mental health legislation highlighted from HIW inspections and reviews;
- Attendance of local authority representatives.

**Primary Care Applications Committee (PCAC)**
The purpose of this Committee is to determine the Primary Care contractual matters on behalf of the Board, and in accordance with the appropriate NHS regulations. During 2018/2019 the Committee has met bi-monthly and has discussed matters relating to GP branch closures, opening hours and border change applications, Community Pharmacy opening hours and ownership applications and dental contractual changes and the issuing of remedial and breech notices. Furthermore, it has been a useful forum for discussing primary care estates developments and priorities as well as broader GP sustainability issues. During the year, the Board was consistently advised of the following key concerns:

- Sustainability issues within GMS;
- Challenges within HB's Managed Practices and its impact on the primary care team.

**Charitable Funds Committee (CFC)**
The Committee is charged with providing assurance to the Board in its role as corporate trustees of the charitable funds held and administered by the HB. It makes and monitors arrangements for the control and management of the Board's Charitable Funds within the budget, priorities and spending criteria determined by the Board and consistent with the legislative framework. In discharging its duties, matters highlighted to the Board included the following:

- Concerns in respect of donations to Just Giving and My Donate had decreased by 57%; the rationale may be negative publicity towards the fees charged by some online giving platforms.

**University Partnership Board (UPB)**
The UBP is a formal partnership arrangement between the HB and its University partners. It is a creative hub that drives and monitors developments in the three domains of Research and Innovation, Workforce and Organisational Development and Collaborative Partnerships, and provides assurance to the Board. Matters considered and reported to the Board during the year have included:

- The continuing concern of a lack of regular attendance from all University partners at UPB meetings. Direct dialogue was undertaken with partner universities to resolve this issue;

- A key risk relating to the lack of research space. Discussions are on-going in terms of utilising space at Aberystwyth University.

**Health Strategy Committee (HSC)**
The Committee was established as part of the strategy development arm of the organisation and therefore due to the nature of this committee this was not incorporated within the assurance arm of the organisation as depicted on page 10. The purpose of the HSC was to provide a forum for meaningful and purposeful engagement and discussion between the Executive Team and Clinical Leaders within the HB and bringing together the Clinical Strategy and the Prevention and Health Inequalities agenda into an overarching Health Strategy with clear linkages with the HB's key stakeholders and partners programmes of work i.e. Local Authority, NHS bodies, etc. Matters brought to the attention of the Board during the year have included:

- Recommending approval of Transforming Clinical Services "Our Big NHS Change" Consultation – Mid Point Review and resulting actions;
- Consideration and approval of the *A Healthier Mid and West Wales: Our Future Generations Living Well* strategy document;
- Consideration of the Integrated Impact Assessment of the above strategy document.

Other areas of concerns were also brought to the Board's attention:

- Further discussions were required in relation to the governance arrangements of the Strategic Objective Groups, which were reflected within the Terms of Reference report to the Health Strategy Committee and the Planning Sub-Committee;
- The finance department were to be made fully aware of the detail of the Transformation Fund bid, for financial planning purposes;
- Risks associated with staff and public perception of the *A Healthier Mid and West Wales: Our Future Generations Living Well* strategy document.

**Stakeholder Reference Group (SRG)**
The Group is formed from a range of partner organisations from across the HB's area and engages with and has involvement in the HB's strategic direction, advises on service improvement proposals and provides feedback to the Board on the impact of its operations on the communities it serves. Members, having previously recognised the importance of being able to work in co-production, to engage and to convey messages to the public agreed to continue with the themed workshops to alternate with meetings, which had been introduced the previous year. Matters brought to the attention of the Board during the year have included:

- To extend the role of SRG to act as a reference group to the Regional Partnership Board as well as to the HB, and to review the terms of reference in light of this in conjunction with governance colleagues, for approval by a subsequent Board.

**Local Partnership Forum (LPF)**
The Forum is responsible for engaging with staff organisations on key issues facing the HB and met regularly during the year. It provides the formal mechanism through which the HB works together with Trade Unions and professional bodies to improve health services for the population it serves. It is the Forum where key stakeholders engage with each other to inform debate and seek to agree local priorities on workforce and health service issues.

**Healthcare Professionals' Forum (HPF)**
In accordance with its Terms of Reference, the Forum should comprise of representatives from a range of clinical and healthcare professions within the HB and across primary care practitioners with the remit to provide advice to the Board on all professional and clinical issues it considers appropriate. It is one of the key Forums used to share early service change plans, providing an opportunity to shape the way the HB delivers its services.

It was also acknowledged that through its breadth of different professions within its membership, the Forum were invaluable during the development of the Health and Care Strategy. Not unexpectedly, therefore, the main crux of the Forum's attention during this year has been on these two issues, with detailed progress reports being received at each of its meetings. Matters brought to the attention of the Board during the year have included:

- The importance of HPF having early sight of plans and potential developments, in their infancy, in order to facilitate the HPF's role in providing clinical and professional advice to Board;
- The Forum recommended that a distinction is made between 'prolonging life' and 'prolonging healthy life' in terms of the impact on quality of the prolonged last stage of life;
- IT solutions need to be given priority within transformation and new ways of integrated working.

Other areas of concerns were also brought to the Board's attention:

- A concern that caps on visas affect all departments within the HB, with a joint letter from the Nuffield Trust, Kings Fund and Health Foundation sent to the Prime Minister on this issue;
- In respect of the development of the Health and Care Strategy, the following risks were highlighted:
    - The challenge for the HB to keep everyday services running safely during planning and implementation of the Health and Care Strategy;
    - The challenges of targets within dashboards and the future of Integrated Care Fund (ICF) funding which may impact on capacity and investment to pump prime primary and community care;
    - The capacity of clinicians to contribute to informing the clinical design of the new model, given the current pressure with performance targets and Turnaround;
    - Specific issues relating to GMS Primary Care may be lost, due to this work being merged with the workstream for the community model;
    - Consideration of a separate workstream for GMS Primary Care was requested;
    - The work of the current, individual, workstreams may result in a non-integrated system;
    - Community independent contractors may be planning service development outside the context of the Health and Care Strategy;
- In respect of workforce role design, the following risks were highlighted:
    - The new Band 4 Assistant Practitioners may not have the same level of competency and the appropriate regulation of currently established Band 4 regulated roles in some professions (e.g. pharmacy), posing the risk of appropriate delegation to these new roles;
    - These roles will be internal to the organisation and not externally regulated, there will not be safeguards for other organisations in the case of malpractice or incompetency of a practitioner;
    - The new workforce roles could become a substitute for formal professional training, or become a rationalisation for funding cuts for formal training places at universities, impacting on quality and professional standards in the workplace.
- The risk to services and quality of care whilst services are undergoing change and transition;
- The risk to staff wellbeing during times of change. However, it was noted that there had been an improvement in staff acceptance and engagement with change in recent months, and that staff morale had improved;
- There is a risk of clinical and professional advice being presented by the Forum to Board, without reference to paramedic opinion. In order to resolve this, the Forum agreed to invite Paramedics as 'Members in Attendance' (under the Forum's Terms of Reference);

- There is a risk to the efficiency of integrated working, freeing up GPs through appropriate skills delegation, as some primary care referrals are not being progressed unless issued by a Doctor.

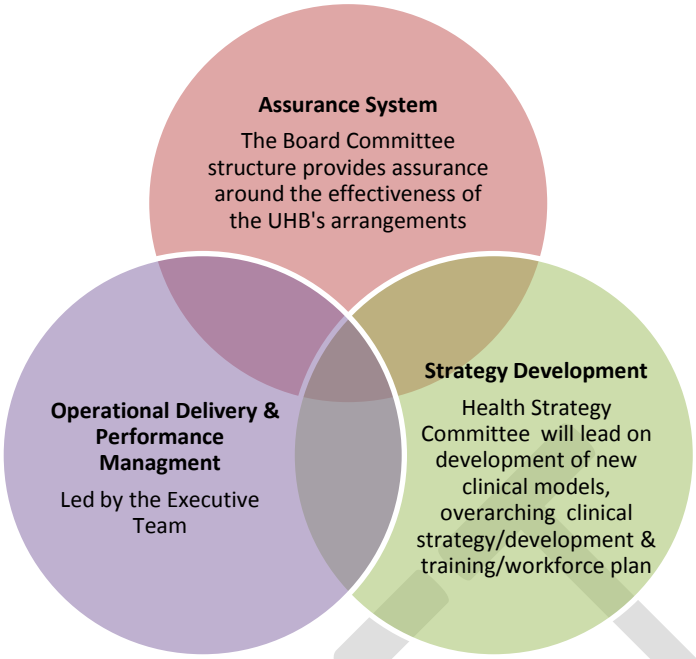
**Other Committees of the Board**

In addition to the above, the WHSCC (Wales) Regulations 2009 (SI 2009 No. 3097) made provision for the constitution of a 'Joint Committee'. This Committee comprises all the Welsh Local Health Boards and is a Committee of each Board, with the HB being represented by the Chief Executive. The HB also has representation on the NHS Wales Shared Services Partnership Committee which is considered as a Sub-Committee of the Board, at which the HB is represented by the Director of Finance. The Emergency Ambulances Services Committee at which the HB is represented by the Chief Executive is also a Committee of the Board. The Lead Officers and/or Chairs from these Committees, have all attended a public Board meeting or a Board Seminar meeting to discuss progress made and to assure the Board the governance arrangements are being discharged. An additional Committee of the Board, established to support and clarify clinical service decisions across the region, is the Joint Regional Planning & Delivery Committee (JRPDC) formed between Swansea Bay University Health Board (formerly Abertawe Bro Morgannwg University Health Board) and the HB. The Committee has a key role to drive forward a range of projects that have been jointly identified as priorities for joint working to deliver Ministerial objectives, especially those relating to the NHS Outcomes Framework as well as alignment to the more strategic A Regional Collaboration for Health (ARCH) Programme Board and that of the Service Transformation Programme. A further role for the JRPDC is to consider and prioritise the regional projects included within the agreed programme, approving Project Initiation Documents (PIDs) and Business Cases, and identifying and agreeing any further projects to be included in the work programme. The JRPDC will ensure projects deliver against their outcomes, timescales, quality measures and programme benefits, as identified in PIDs and or Business Cases.

Reflecting in year changes which saw the disestablishment of the previous Mid Wales Healthcare Collaborative (MWHC) at the end of its term, the Mid Wales Joint Committee for Health & Social Care (MWJC) was formed as a Committee of the Board. Extensive work was undertaken with partner organisations to consult on the successor arrangements for the MWHC, cumulating in a transition process and handover arrangements to transition into the Mid Wales Joint Committee for Health & Social Care. Terms of Reference and an Operating Framework which sought to both reflect the changes in the requirements of NHS bodies for collaborative and regional working and build upon the strengths and successes of the MWHC arrangements, have been agreed.

**Governance & Accountability**

In accordance with good governance practice, the HB's Standing Orders and Standing Financial Instructions were reviewed and updated during the year to account for any local amendments before being presented to the ARAC for comment prior to onward submission for approval to the Board. The Terms of Reference for the HB's Committees (including the Advisory Committees) were also reviewed as part of this process. In recognising that the function of governance is to ensure that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens and service users, operating in an effective, efficient and ethical manner, the Board's governance arrangements are focused on the following three elements:




Although as Chief Executive I retain accountability, the Interactive Scheme of Delegation, which is recognised as good practice by WAO, reflects the responsibilities and accountabilities delegated to Executive Directors for the delivery of the HB's objectives, whilst ensuring that high standards of public accountability, probity and performance are maintained. The Executive Team has been at full complement during the year, with the respective individual portfolios providing clarity whilst also ensuring that focus remains on capacity, balance and appropriateness.

However, this does not preclude Executive Directors from working collaboratively together as a collective leadership team. This provides the stability and expertise required in order for the Board to execute its duties effectively and ensures each member is clear about what their role is and the role of the other members. The Board's Committee structure, the roles of the Committees and Advisory Groups, their relationship with the Board and a clear scheme of delegation means that we can demonstrate "Knowing Who Does What and Why", in that we have clarity and unanimity about everyone's role and how it fits into the bigger picture.

This principle is not limited to operating within the boundaries of the HB, as it also means being clear about how it relates to its partners and stakeholders, how it fits into the wider picture and being clear about how the various arms of WG fit into the picture. To reflect these principles the Board works to a Partnership Governance Framework & Toolkit which assists the organisation in identifying and understanding the risks associated with partnerships, and provides the evidence required should the HB wish to end its relationship with a partner. The HB is required to adhere to a wide range of legislation but there are two specific pieces of partnership legislation, i) The Wellbeing of Future Generations (Wales) Act 2015 and ii) The Social Services and Wellbeing (Wales) Act 2014, which have a statutory requirement for collaboration in the development and implementation of a joint strategic plans.

One of the underpinning principles recognised by the Board is that governance is about vision, strategy, leadership, probity and ethics as well as assurance and transparency, and should provide confidence to all stakeholders, not only to the regulators, in the delivery of objectives. The HB regularly circulates its Stakeholder Briefing which informs both the organisation and the wider community, in particular partner organisations, of current

developments and progress made across a range of subjects. These can be found on the HB's website on the following link: http://www.wales.nhs.uk/sitesplus/862/page/67271. This sharing of information is further enhanced by the HB's use of a range of social media channels.

The governance structure of the HB accords with the WG's Governance E-Manual and Citizen Centred Governance Principles in that the seven principles together with their key objectives, provide the regulatory framework for the business conduct of the HB and define its 'ways of working'. These arrangements support the principles included in HM Treasury's "Corporate Governance in Central Government Departments: Code of good practice 2011".

**Governance in Primary Care**

The main medium for governance and contractual issues in Primary Care is the Primary Care Applications Committee, as referred to earlier in this statement. Performance and planning issues are monitored through BPPAC with Quality and Safety issues monitored and reported through the HB wide Operational Quality, Safety and Experience Committee and where required directly to QSEAC. The Operational Quality, Safety & Experience Sub-Committee focuses on both acute, primary and community services quality and safety governance arrangements at an operational level, bringing together accountability and ownership for those quality and safety issues to be resolved operationally.

Other elements of governance are enacted through a number of groups within the Primary & Community Care governance framework, (without being formal committees/sub-committees of the Board) with some of the main channels being as follows:

The Primary Care Risk Register, performance exception reports, Inspection reports and action plans at its bi-monthly meetings with these being signed off by the primary care group. It is recognised within Primary Care that effective risk management is integral to the achievement of all the HB's objectives. The Primary Care risk register highlights the current and ongoing risks in Primary Care and mitigation, actions and progress are monitored and updated bi-monthly. A monthly Primary Care Concerns meeting is also held where open concerns and incidents are discussed, as well as timescales and lessons learned or any further action to be taken. GP Practices and community pharmacies are encouraged to use Datix – the HB's incident reporting system – to report incidents, some of which may occur in Primary Care, however Practices will often also identify incidents that have occurred with patients during their care within community or secondary care and will also use this mechanism for their reporting. The Complaints and Incidents Management 'Putting Things Right' (PTR) Facilitator liaises with GP Practices on Putting Things Right Regulations and where it has been identified in an Ombudsman report that a Practice may need further support in adhering to the PTR guidance. All Primary Care contractors follow this guidance when dealing with complaints and incidents and all have their own documented complaints procedures which mirror this guidance. All complaints concerning Primary Care received into the central hub are screened by the Quality Manager to ascertain whether it is a matter for the Practice to investigate the concern or whether the HB needs to investigate. Case studies, action plans and lessons learned are also fed into the Improving Experience Sub-Committee and, in some cases the Primary Care Performers Issues Group.

There is a robust system of prescribing monitoring in the HB and issues are discussed at the GP Prescribing Leads Group where peer review also takes place. Medicines Management Technicians work with Practices across the three counties to address certain areas of work and ensure that equity and quality is maintained across the whole of the HB with representatives from each practice attending this meeting. Medicines Management are also linked in to cluster work with some clusters appointing Cluster Pharmacists. For full details relating to Primary Care Governance please see Appendix 5.

**Future Vision**
The strategic direction for the delivery of primary care services across the contractor professions is core to the strategic direction of the HB in delivering the Health and Care Strategy. Through the development and implementation of an integrated model for health and wellbeing (inclusive of social care), the HB has defined the ambition of a long term commitment focussed on prevention, wellbeing, early intervention and to help build resilience to enable people to live well in their own communities. The development of seven integrated localities aligned to the current cluster configuration will establish the platform for service development and modernisation. In considering clusters it is important to recognise the variation between the contractual levers for engagement of GP practices and the associated financial incentive to develop services as well as the need for wider engagement with multi-professional groups and agencies to ensure that the strategic agenda for change is embedded and championed across the geographical area. In line with A Healthier Wales the HB will continue to support the strategic direction of clusters as a key component of the future health and wellbeing service delivery model.

Recognising that recruitment and retention across the contractor professions is a challenge in the more rural areas, the need for a stable primary care footprint is paramount to the modernisation and development of service provision that is aligned to national strategic direction and also that of the HB.

Consideration of how Pacesetter funding is utilised to support both sustainability and the implementation of the Primary Care Model for Wales will be a key action for the HB . Existing schemes will be reviewed and evaluated with the purpose of identifying those that need to be mainstreamed and those that need to be reviewed, refined or terminated. Similarly, potential new schemes will be considered, where innovation in service models to support the national aims of the Pacesetter programme are demonstrated.

It is also important to recognise the current contractual negotiations for both General Medical (GMS) and General Dental Services (GDS) and the challenges and opportunities that these both bring in improving the overall health and wellbeing of the resident population.

The key priorities for 2019/2020 are:
- Implementation of the Primary Care Model for Wales;
- Return managed practices to independent contractor status;
- Modernisation and delivery of accessible NHS dental services.

**The purpose of the system of internal control**
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

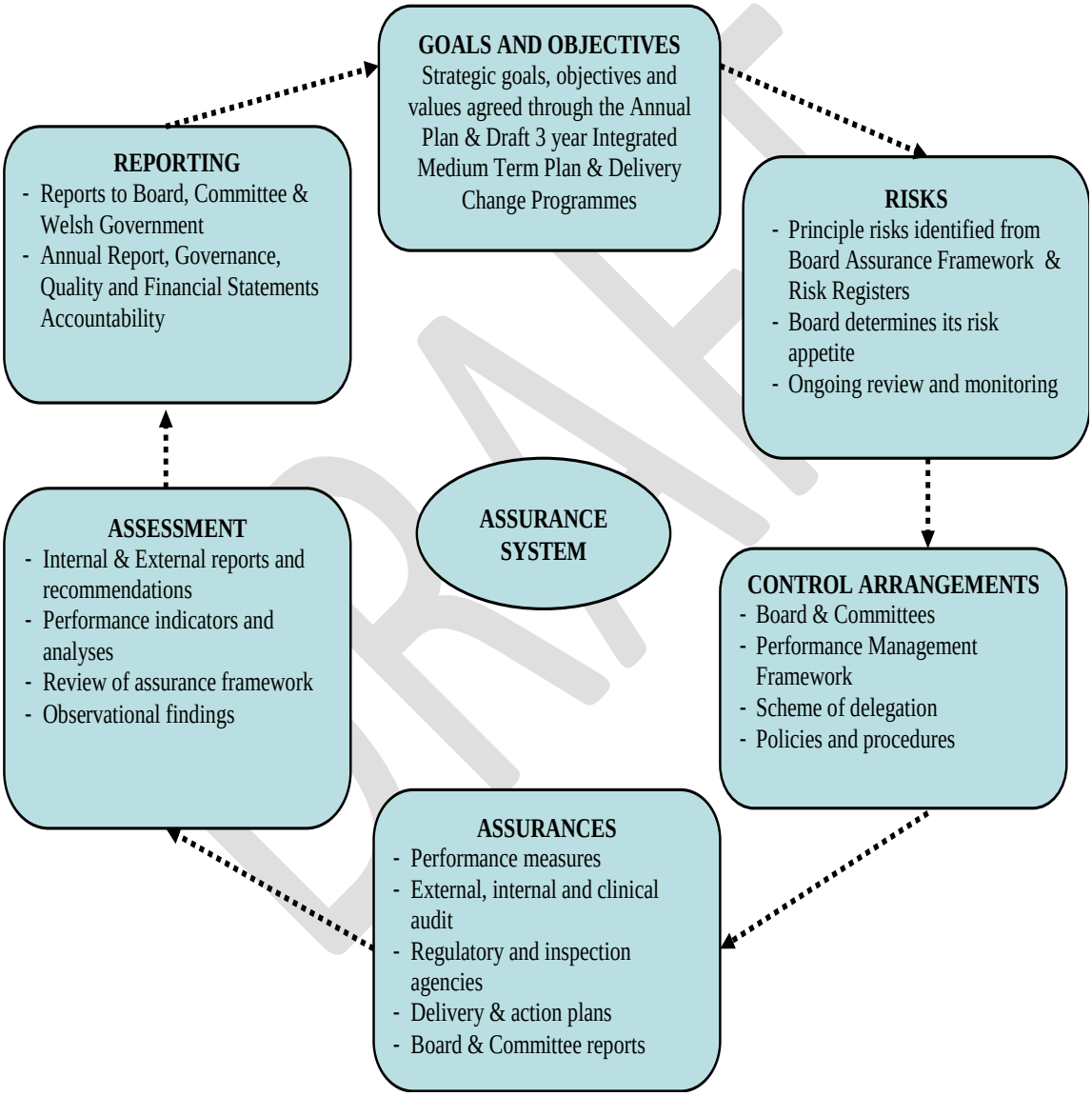
The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

The Board is accountable for maintaining a sound system of internal control which supports the achievement of the organisation's objectives. It has been supported in this role by the work of the main Committees, each of which provides regular reports to the Board, underpinned by a Sub-Committee structure, as shown on page 6 of this statement. The system of internal control is based on a framework of regular management information,

administrative procedures including the segregation of duties and a system of delegation and accountability.

The HB recognises that scrutiny has a pivotal role in promoting improvement, efficiency and collaboration across the whole range of its activities and in holding those responsible for delivering services to account. The role of scrutiny remains important at this time when the HB is continuing to respond to the challenge of its targeted intervention status whilst also forging ahead with its long term Health and Care Strategy. The responsibility for maintaining internal control and risk management systems rests with management.

The Board therefore draws on assurances from a number of different sources in order to demonstrate that the system of internal control has been in place, as shown below:



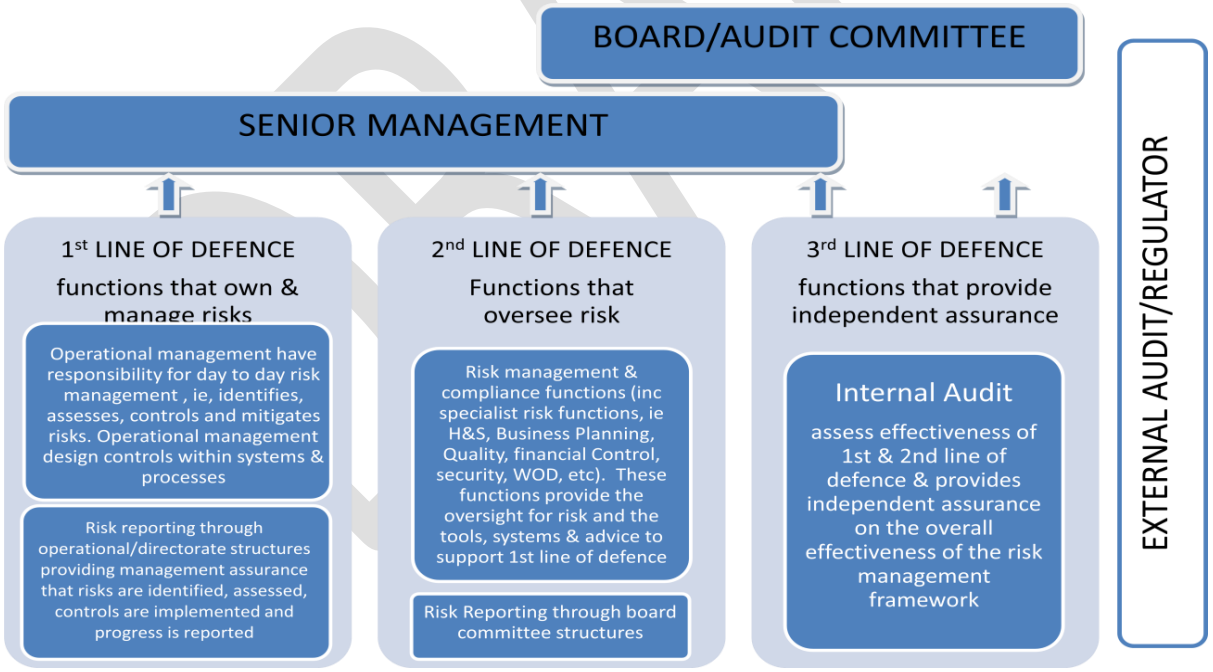

Combined, these provide the body of evidence required to support the continuous assessment of the effectiveness of the management of risk and internal control and that internal control has been in place for the year ended 31 March 2019.

**Capacity to handle risk**
The HB acknowledges that delivery of healthcare services carries inherent risk. This is compounded by delivering healthcare across the large geographical area of Hywel Dda, meeting the needs of its demographic profile and staying within its financial allocation. Over the last year, the HB has continued to develop and strengthen its risk management framework to enable it to make better decisions to provide improved quality and safer care for patients and residents, achieve its strategic objectives, as well as fulfilling its statutory obligations.

Risk management is important to the successful delivery of the HB's services. We operate an effective risk management system that identifies and assesses risks, decides on appropriate responses and then provides assurance that the responses are effective. At the HB we understand the implications of risks taken by management in pursuit of improved outcomes in addition to the potential impact of risk-taking on and by its local communities, partner organisations and other stakeholders.

**Risk Management Framework**
Our Risk Management Framework clearly sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in the HB. It clarifies roles and responsibilities and reduces duplication, particularly in respect of reviewing and monitoring risks by setting out the individual responsibilities and communication lines whilst also outlining the other components, risk strategy and risk protocols which make up the Risk Management Framework.

The HB operates a 'Three Lines of Defence' model that outlines the principles for the roles, responsibilities and accountabilities for risk management throughout the organisation as shown below:




The 'Three Lines of Defence model' advocates that management control is the first line of defence in risk management. The various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three "lines" plays a distinct role within the HB's wider governance framework; however all three lines need to work interdependently to be effective.

We recognise that an effective Risk Management Framework, including our Risk Management Strategy & Policy, is an essential component of successful clinical and corporate governance. We believe that by approaching the control of risk in a strategic and organised manner, risk factors can be reduced to an acceptable and manageable level. This should result in better quality and safer care for patients and residents, and a reduction in unnecessary expenditure. By adopting a risk management approach, statutory obligations can be identified and fulfilled in a positive way, rather than as a means of avoiding litigation and prosecution.

**Risk Management Strategy and Policy**

The Board recognise that risk management is an integral part of good management practice and to be most effective should become part of the HB's culture. The Board is therefore committed to ensuring that risk management forms an integral part of its philosophy, practice and planning rather than viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation. The HB recognises that success will depend upon the commitment of staff at all levels, and the development of a culture of openness within a learning environment will be an important factor. We work to a Board approved Risk Management Strategy and Policy which:

- Provides a Framework for managing risk both across the organisation and in working with partners/stakeholders, consistent with best practice and WG guidelines;
- Outlines the HB's risk management objectives, our approach to and appetite for risk and approach to risk management;
- Clearly defines risk management roles and responsibilities at each level of the organisation;
- Details the risk management processes and tools in place, including reference to the risk register, risk reporting arrangements, frequency of risk activities and available guidelines;
- Is underpinned by a Risk Assessment Procedure;
- Includes a clear policy statement.

**Policy Statement**

Hywel Dda University Health Board Hospital (HB) is committed to delivering the highest level of safety for all of its patients, staff and visitors. The complexity of healthcare and the ever-growing demands to meet health care needs, means, that there will always be an element of risk in providing high quality, safe health care services.

The management of risks is a key factor in achieving the provision of the highest quality care to our patients; of equal importance is the legal duty to control any potential risk to staff and the general public as well as safeguarding the assets of the organisation.

The HB recognises effective risk management is a key component of corporate and clinical governance and is integral to the delivery of its objectives in service provision to the citizens of the health community. There will be a holistic approach to risk management across the HB which embraces financial, clinical and non-clinical risks in which all parts of the organisation are involved through the integrated governance framework.

The mission of the HB supports the effective management of risk and the role of the individual. This requires all staff to recognise that there is a responsibility to be involved in the identification and reduction of risks. The HB will seek to ensure that risks, untoward incidents and mistakes are identified quickly and acted upon in a positive and constructive manner so that any lessons learnt can be shared. This will ensure the continued improvement in the quality of care and the achievement of the HB objectives.

The commitment of the HB is therefore to:
Minimise harm to patients, colleagues or visitors to a level as low as reasonably practicable;
Protect everything of value to the HB (such as high standards of patient care, reputation, community relations, assets and resources);
Maximise opportunity by adapting and remaining resilient to changing circumstances or events;
Assist with managing and prioritising the business/activities of the HB through using risk information to underpin strategy, decision-making and the allocation of resources;
To ensure that there is no unlawful or undesirable discrimination, whether direct, indirect or by way of victimisation, against its service users, carers, visitors, existing employees contractors and partners or those wishing to seek employment, or other association with the organisation.

The risk management strategy will be reviewed in 2019/2020, following an assessment of risk maturity and to align with our strategic objectives.

**Risk Appetite**

The Risk Appetite Statement provides staff with guidance as to the boundaries on risk that are acceptable and how risk and reward are to be balanced, and provides clarification on the level of risk the HB is prepared to accept. It is integrated with the control culture of the organisation to encourage more informed risk taking at strategic level with more exercise of control at operational level, as well as recognition of the nature of the regulatory environment the organisation operates within.

During 2018/2019, the Board reviewed its risk appetite through detailed Board Seminar discussions and considered it in line with its capability to manage risk, and formally agreed the following at a Board Meeting in Public.

> *"Hywel Dda's approach is to minimise its exposure to safety, quality, compliance and financial risk, whilst being open and willing to consider taking on risk in the pursuit of delivery of its objective to become a population health based organisation which focuses on keeping people well, developing services in local communities and ensuring hospital services are safe, sustainable, accessible and kind, as well as efficient in their running.*
>
> *The HB recognises that its appetite for risk will differ depending on the activity undertaken, and that its acceptance of risk will be based on ensuring that potential*

*benefits and risks are fully understood before decisions on funding are made, and that appropriate actions are taken.*

*The HB's risk appetite takes into account its capacity for risk, which is the amount of risk it is able to bear (or loss we can endure) having regard to its financial and other resources, before a breach in statutory obligations and duties occurs."*

The Board also agreed levels of tolerance for risk across its activities, aligned to its risk scoring matrix, to provide management with clear lines of the level to risk it will accept. These can be accessed via the following link: http://www.wales.nhs.uk/sitesplus/documents/862/Item%205.4%20Board%20Assurance%20Framework%2C%20Corporate%20Risk%20Register%20and%20Risk%20Appetite.pdf

The Risk Appetite will be reviewed during 2019/2020, to ensure it remains aligned to the HB's strategic objectives as they are further developed this year.

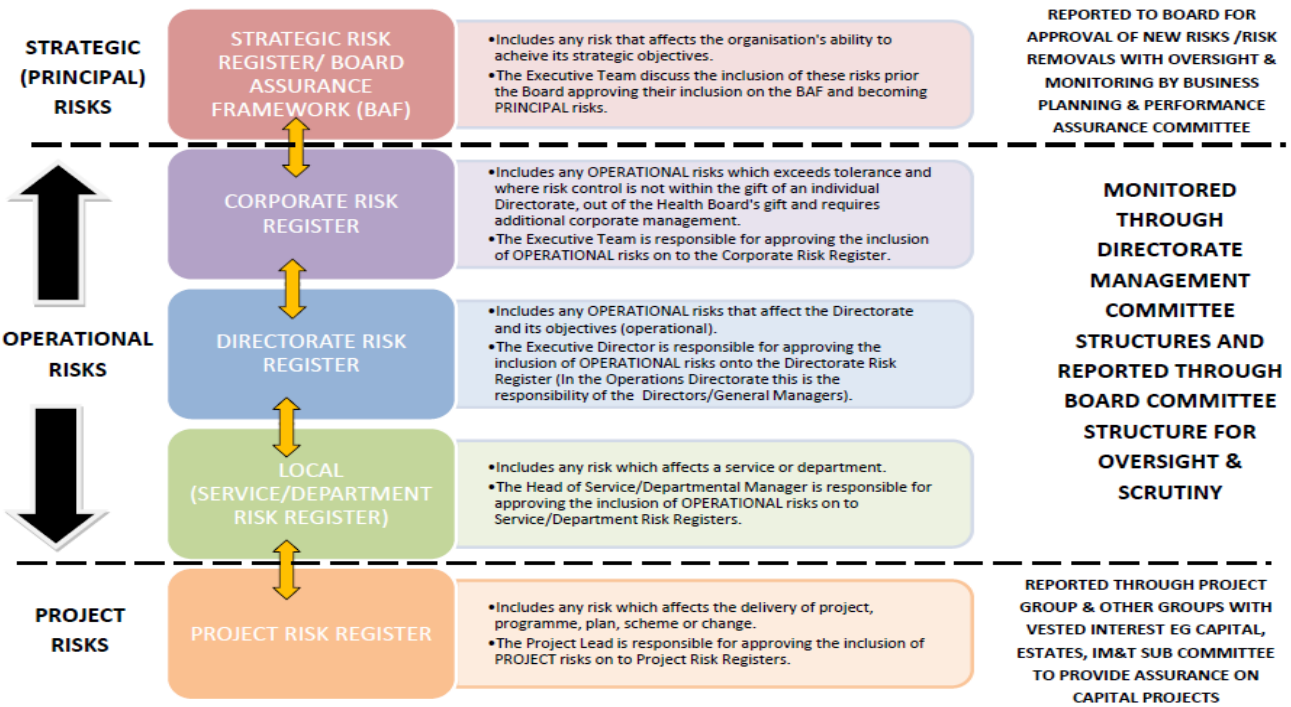
**Risk Management Procedure & Protocols**

During 2018/2019, the HB has further developed procedures, guidance, systems and tools to assist operational management to identify, assess and manage risks on a day to day basis. This is supported with training and advice from the HB's assurance and risk team, whose role it is to embed the HB's risk management framework and process, and facilitate a risk aware culture across the organisation.

**Risk Register & Oversight of Risk**

In following the Three Lines of Defence Model (above), the HB ensures that operational management are supported in their role of day to day risk management by specialist functions who have expertise and knowledge to help them control risk.

Management are held to account on the effective and efficient management of operational risks through our Performance Management Assurance Framework. Risks are also aligned to the HB's assurance committee structure whose role it is to provide assurance to the Board that risks are being managed appropriately. This process is outlined below:



Members of the Board recognise that risk management is an integral part of good management practice and to be most effective should become part of the HB's culture. The Board is therefore committed to ensuring that risk management forms an integral part of its philosophy, practice and planning, rather than viewed or practiced as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation. The HB recognises that success will depend upon the commitment of staff at all levels, and the development of a culture of openness within a learning environment will be an important factor.

The HB is committed to the principle that risk must be managed, and to ensure:

- Compliance with statutory legislation;
- All sources and consequences of risk are identified;
- Risks are assessed and either eliminated or minimised;
- Information concerning risk is shared with staff across the HB;
- Damage and injuries are reduced, and people's health and wellbeing is optimised;
- Resources diverted away from patient care to fund risk reduction are minimised;
- Lessons are learnt from incidents, complaints and claims in order to share best practice and prevent reoccurrence;
- Assurance is provided to the Board that risk management and internal control activities are proportionate, aligned, comprehensive embedded and dynamic;
- That it supports decision-making through risk-based information.

**Corporate Risk Register (CRR) and Board Assurance Framework (BAF)**
During 2018/2019, the Board refreshed its approach to the management of the Board's principal risks to enable it to take full account of risks of non-compliance with statutory obligations, disruption and inefficiency within operations; late delivery of projects, or failure to deliver promised strategy.

The BAF is a key source of evidence that links strategic objectives to risks and assurances, and is one of the main tools that the Board should use in discharging its overall responsibility for internal control. This year was a transitional year for the HB in terms of redefining its strategic direction, therefore it was challenging to develop a robust and meaningful BAF, as its purpose is to provide the Board with a confidence statement on whether it will be able to achieve its strategic objectives. However, the HB did outline a number of key deliverables within its Annual Plan 2018/2019, and risks to these were identified by Executive Directors. In addition, the Board is advised of any significant new/emerging risks, which it considers is outside of the influence of an individual directorate or the HB to manage.

The CRR contains risks that have been identified in a top down and bottom up approach and are:

- Associated with the delivery of the objectives set out in the Annual Plan 2018/2019 (identified on the BAF).
- Significant operational risks escalated by individual Directors and agreed by the Executive Team as they are of significant concern and need corporate oversight and management.

The Executive Team plays a pivotal role in the management of the Corporate Risk Register and is responsible for agreeing the content through the identification of principal risks and the escalation/de-escalation of operational risks that have been identified on directorate risk registers and/or through discussions from the new Performance Reviews which could have a significant impact on the HB. Whilst each Director is responsible for the ownership of risk(s) and the identification of controls and action to address gaps, it is the role of Executive Team, at its formal monthly Executive Team Meeting, to review the effectiveness of the controls and ensure appropriate action plans are in place, which might include the development of

corporate risk management strategies to manage risk(s). The Executive Team also use risk information, including that from discussions at performance reviews, to help inform prioritisation of resources and decision-making, i.e. by ensuring risk information is fed into different business processes within the HB such as capital planning, budget planning, etc.

The risk profile of the HB is constantly changing, with the key risks that emerge and which can impact on the achievement of objectives including strategic, operational, and financial and compliance risks. The Board has reviewed the key risks to which the organisation is exposed, together with the operating, financial and compliance controls that have been implemented to mitigate those risks. The Board is of the view that there is a formal on-going process for identifying, evaluating and managing its significant risks that have been in place during the year ended 31 March 2019 and up to the date of approval of the Annual Report and financial statements.

The Board receives the CRR/BAF twice a year, however each risk has been mapped to a Board level committee to ensure that principal risks are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board, through their update report, on the management of these risks. Each risk on the CRR/BAF is presented to the Board and its Committees as a risk on a page, which includes a visual representation of the level of risk over a defined reporting period.

The WAO Structured Assessment in 2018 looked at the HB's approach to assuring itself that risks to achieving priorities are well managed and reported that the HB had a well-developed BAF in place which is being refreshed as new strategic objectives are developed. The HB will continue to develop its BAF to ensure the Board has timely and reliable information as to achievement of its strategy.

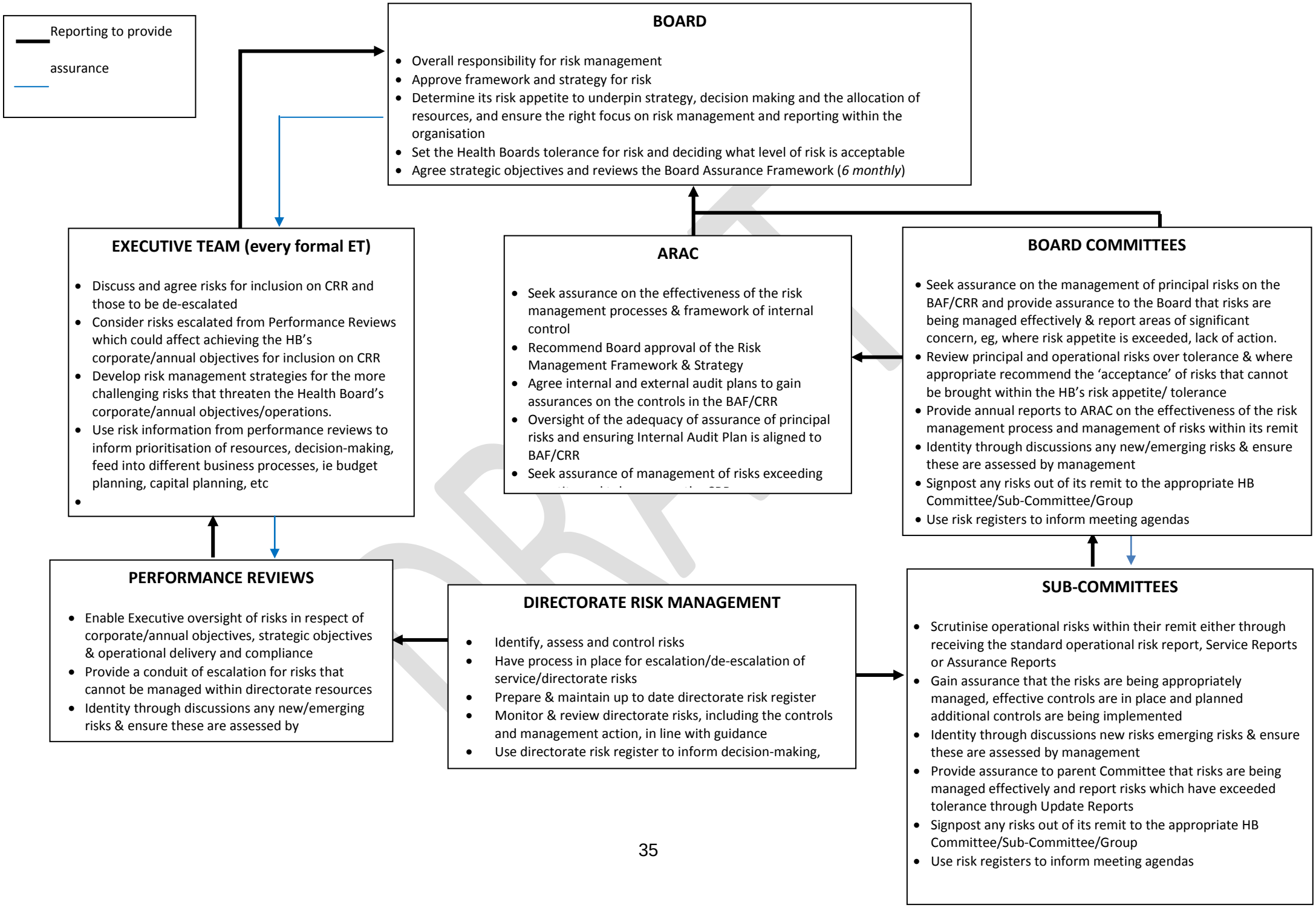
There were 29 principal risks on the CRR which will be presented to the Board in May 2019. The paper details the movement of risk since its last presentation to the Board in January 2019. Both these reports can be viewed via the following links:
January 2019 Corporate Risk Report
May 2019 Corporate Risk Report
As at the end of March 2019, the profile of the 29 principal risks in terms of their current level of risk is outlined on the matrix below and further detail is included in Appendix 3.

| RISK MATRIX | | | | | |
|---|---|---|---|---|---|
| | LIKELIHOOD → | | | | |
| **IMPACT ↓** | **RARE 1** | **UNLIKELY 2** | **POSSIBLE 3** | **LIKELY 4** | **ALMOST CERTAIN 5** |
| **CATASTROPHIC 5** | | 117 | 508<br>634 | 626<br>627 | |
| **MAJOR 4** | | 630<br>648 | 295 384 291 43<br>44 631 636 646<br>647 652 | 624 625 628<br>629 632 686 | 451<br>245 |
| **MODERATE 3** | | | 635<br>650 | 633<br>129 | |
| **MINOR 2** | | | | | |
| **NEGLIGIBLE 1** | | | | | |

These 29 risks were in the following impact domains:

| Domain | No of Risks as at March 2019 |
|---|---|
| Safety – Patients, Staff or Public | 7 |
| Quality/Complaints/Audit | 6 |
| Service/Business interruption/disruption | 6 |
| Statutory duty/inspections | 4 |
| Finance inc. claims | 2 |
| Business objectives/projects | 4 |

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place. The HB has a clear pathway for ensuring that all identified risks are monitored through Board & Committee Structure, with an overview demonstrated in the figure below:


Reporting to provide assurance
BOARD
Overall responsibility for risk management
Approve framework and strategy for risk
Determine its risk appetite to underpin strategy, decision making and the allocation of resources, and ensure the right focus on risk management and reporting within the organisation
Set the Health Boards tolerance for risk and deciding what level of risk is acceptable
Agree strategic objectives and reviews the Board Assurance Framework (6 monthly)
EXECUTIVE TEAM (every formal ET)
Discuss and agree risks for inclusion on CRR and those to be de-escalated
Consider risks escalated from Performance Reviews which could affect achieving the HB's corporate/annual objectives for inclusion on CRR
Develop risk management strategies for the more challenging risks that threaten the Health Board's corporate/annual objectives/operations.
Use risk information from performance reviews to inform prioritisation of resources, decision-making, feed into different business processes, ie budget planning, capital planning, etc
ARAC
Seek assurance on the effectiveness of the risk management processes & framework of internal control
Recommend Board approval of the Risk Management Framework & Strategy
Agree internal and external audit plans to gain assurances on the controls in the BAF/CRR
Oversight of the adequacy of assurance of principal risks and ensuring Internal Audit Plan is aligned to BAF/CRR
Seek assurance of management of risks exceeding
BOARD COMMITTEES
Seek assurance on the management of principal risks on the BAF/CRR and provide assurance to the Board that risks are being managed effectively & report areas of significant concern, eg, where risk appetite is exceeded, lack of action.
Review principal and operational risks over tolerance & where appropriate recommend the 'acceptance' of risks that cannot be brought within the HB's risk appetite/ tolerance
Provide annual reports to ARAC on the effectiveness of the risk management process and management of risks within its remit
Identity through discussions any new/emerging risks & ensure these are assessed by management
Signpost any risks out of its remit to the appropriate HB Committee/Sub-Committee/Group
Use risk registers to inform meeting agendas
PERFORMANCE REVIEWS
Enable Executive oversight of risks in respect of corporate/annual objectives, strategic objectives & operational delivery and compliance
Provide a conduit of escalation for risks that cannot be managed within directorate resources
Identity through discussions any new/emerging risks & ensure these are assessed by
DIRECTORATE RISK MANAGEMENT
Identify, assess and control risks
Have process in place for escalation/de-escalation of service/directorate risks
Prepare & maintain up to date directorate risk register
Monitor & review directorate risks, including the controls and management action, in line with guidance
Use directorate risk register to inform decision-making,
SUB-COMMITTEES
Scrutinise operational risks within their remit either through receiving the standard operational risk report, Service Reports or Assurance Reports
Gain assurance that the risks are being appropriately managed, effective controls are in place and planned additional controls are being implemented
Identity through discussions new risks emerging risks & ensure these are assessed by management
Provide assurance to parent Committee that risks are being managed effectively and report risks which have exceeded tolerance through Update Reports
Signpost any risks out of its remit to the appropriate HB Committee/Sub-Committee/Group
Use risk registers to inform meeting agendas

A leading role in providing assurance over the adequacy of controls across a range of risks is played by Internal Audit. The relationship between risk management and Internal Audit is an important one, with Internal Audit's role being to evaluate the controls and test their efficiency and effectiveness, which is undertaken through the Internal Audit programme of work. Assurance can also be obtained from management or from other assurance functions in place. The systems in place and activities undertaken during the year have ensured our capacity to handle risk and achievement of our main aims of risk management which are:


**Working with Partners/Stakeholders**

As an organisation, we recognise that although delivering services through partners can bring significant benefits and innovation, there is less direct control than if delivering them alone. An environment where services and projects are increasingly being delivered through partner organisations puts a premium on successful risk management. It is essential that partnership agreements are underpinned by robust governance arrangements including appropriate reporting mechanisms and that the HB has a clear approach, including its associated risk appetite, to partnership working.

Unclear governance arrangements in public services can create risk. Increasingly, public services are delivered through subsidiaries, partners or contractors, and the sheer diversity of governance arrangements that exist within and between bodies that operate at arm's length increases the inherent risks associated with them. If differences in perception and understanding are not recognised, then associated risks are often not properly assessed and are not well managed. Whilst recognising the diversity and dynamism of service delivery, it is essential that governance expectations are clearly and consistently understood by the HB and those who provide services on its behalf.

As the HB continues to work increasingly in partnership to deliver its strategic aims, objectives and priorities, it is essential that partnership arrangements are underpinned by robust governance arrangements, including appropriate reporting mechanisms, in order that the Board has a clear approach to its partnership work. It is recognised that whilst partnerships can deliver benefits, they can also involve risks. Given that the HB will remain accountable for the care for which it is responsible, it is essential that such partnerships are underpinned by robust governance arrangements which link back into partner organisations. If such arrangements are not in place, governance arrangements can become diluted, and the Board will not receive the assurances it requires regarding the quality, safety and efficacy of services delivered. This is particularly important where partnerships are focused on some of our most vulnerable patient groups, and where there needs to be both a trust and confidence in the arrangements in place.

The Board approved its Partnership Governance Framework and Toolkit in September 2017. This set out key principles such as how to capture the costs and benefits of engaging in different forms of partnerships, how to monitor and mitigate the risks associated with working across a wide variety of partners, and how to measure their performance. The Partnership Governance Framework, based on a Toolkit approach, provides guidance and support to all those involved in partnership working in conjunction with key stakeholders, in adopting a consistent approach for the governance of partnerships, and in ensuring on-going consideration of each partnership's effectiveness. The Framework was reviewed in September 2018, which has resulted in the ongoing evaluation of the governance supporting the HB's strategic partnerships.

Where possible, all existing partnerships and collaborations of which the HB is aware, continue to be mapped to the HB's internal governance structure in terms of its assurance, operational and strategic arms, as identified on the Governance Wiring Diagram. This ensures that any decisions or directions of travel that are being proposed in partnership can be tracked and agreed through the HB's existing governance arrangements.

It is recognised that effective risk management is essential for successful partnerships and the framework ensures that the HB's existing risk management arrangements will be used both when reviewing an existing partnership or when seeking to establish a new partnership, in managing the risks of working within the partnership. Regular review of partnership risks will enable an understanding of both the risks to the Partnership objectives, their impact on the HB's objectives and its reputation, feeding the partnership risk registers and inclusion on the HB's risk register as appropriate.

Building upon the value of the Partnership Governance Framework, significant progress has been made in the development of an International Partnership Framework. This will maximise the development of robust governance regarding current and future international health partnerships, and the subsequent engagement in initiatives, demonstrating the HB's commitment to the Charter for International Health Partnerships in Wales, and enhancing opportunities and benefits for staff, the wider population and wider organisations, as well as for our international partners and their beneficiaries.

The Wellbeing Plans of the Public Services Boards (PSBs) represent the additional value that can be delivered through working innovatively and collaboratively as partners. Their development has created a significant opportunity to reframe the focus and understanding of health and wellbeing not just on the absence of disease or the treatment of illness; the PSB Wellbeing Plans will help to re-orientate the focus on the wider determinants of health. Each PSB has established a governance structure to drive forward the delivery of the PSB Wellbeing Plans and a number of new sub-groups established in order to progress this work.

As we move from strategic development of individual organisations towards delivery of a shared model, aligning governance across statutory organisations requires strengthening in

order to ensure appropriate accountability and facilitated joint decision making. The Board, at its meeting in March 2019, approved a number of recommendations which strengthens the West Wales Regional Partnership Board (RPB) governance arrangements.

Leading on from the Inspiring Research and Innovative Practice Conference in 2017, The West Wales Academic Health Collaborative (WWAHC) along with UPB, has continued its work to identify creative solutions and development opportunities to drive research, education and innovation in health improvement. Following appointment of a new WWAHC coordinator, 3 follow-up workshops on 'Getting into Research' have been run through 2018 at both University and HB Sites, attended by representatives from all 4 partners. They have provided a platform for collaboration and to share activities. Additionally, funding was secured in 2018 for 50 HB staff and those University Researchers engaged with the WWAHC to undertake the BMJ Research to Publication Course. This course provides education in research and evaluation skills and supports continued professional development.

**Projects and Strategic Policy Decisions**
It is explicit within the Risk Management Strategy and Policy that all discrete/significant projects or strategic policy decisions within the HB must be risk assessed using the agreed Risk Management Procedure. This requirement is re-iterated in the Risk Management Framework. Each Project Manager within the HB must undertake risk assessments of their designated projects at the beginning of the project with each project required to have a separate risk register. The management of the project's risk register must be a standing agenda item at all Project Board (or equivalent) meetings, where risks must be reviewed and updated as appropriate.

Where the HB is involved in projects which are managed through third parties who utilise a different project methodology, a clear protocol will be established which identifies how risks held in the project format or system will be escalated to the risk register. There may be projects that require formal project methodology which is fully documented within a Project Initiation Document, detailing all project risks which are known and are included in any associated Business Case. A formal project approach using or based upon a recognised project methodology will reduce the associated risks within a project.

**Emergency Preparedness**
The HB has a well-established Major Incident Plan which is reviewed and ratified by the Board on an annual basis. The Major Incident Plan meets the requirements of all relevant guidance and has been consulted upon by partner agencies and assurance reviewed by the WG's Health Resilience Branch. This Plan, together with our other associated emergency plans, detail our response to a variety of situations and how we meet the statutory duties and compliance with the Civil Contingencies Act 2004.

Within the Act, the HB is classified as a Category One responder to emergencies. This means that in partnership with the Local Authorities, Emergency Services, Natural Resources Wales and other NHS Bodies, including Public Health Wales, we are the first line of response in any emergency affecting our population. In order to prepare for such events, local risks are assessed and used to inform emergency planning.

We currently have 10 Executive/Senior Level Staff who have completed Exercise Wales Gold Command Training and/or Tactical Command Training together with 59 Hospital Managers/Senior Nurses who have completed Silver Level Major Incident Training for Health.

The HB is also represented on the multi-agency Dyfed Powys Local Resilience Forum, (LRF), which includes a Severe Weather Group as part of its structure. The Severe Weather

Group has undertaken a robust risk assessment process based on the National Risk Assessment which identifies risks across our community and rates them according to a number of factors to give a risk score (low, medium, high, very high) and a preparedness rating. The Severe Weather Group focuses on responses to Flooding, Severe Winter Weather, Heat Wave and Drought events and the effects of climate change underpins this work. The Dyfed Powys LRF Severe Weather Arrangements Plan was first developed in 2011 and is now reviewed on a biennial basis. The group also publishes a Community Risk Register – https://www.dyfed-powys.police.uk/media/1159/dplrfcrrv10en.pdf - which highlights the effects of climate change and informs the public about the potential risks we face and encourages them to be better prepared. We discharge our roles in terms of the management of any prospective issues which could arise through climate change, working with partners from all agencies through this group. As part of the LRF we also work as a core partner to train and exercise staff to ensure preparedness for emergency situations.
During 2018/2019, key achievements include:

- Annual major review of our Major Incident response arrangements, referencing the Mass Casualty Incident Arrangements for NHS Wales;
- Ongoing progress on Business Continuity development and review across the HB, including significant planning for the consequences of Brexit;
- Planning for, and delivering, as part of an All Wales NHS Training Group
- Health Prepared Wales 2018 - Symposium exploring health resilience at mass gatherings – considering whether we are prepared for the unexpected;
- Further development and facilitation of trained Medical Emergency Response Incident Team capability. The HB currently has 40 trained MERIT Nurses with another 12 scheduled to participate this year.

**Brexit**
Maintaining high-quality and safe services is our top priority in preparing for Brexit. We are working with the UK and WG, as well as through the LRFs and with other health and social care organisations across Wales to ensure services are protected, as much as possible, from any disruption. Our business continuity plans have been reviewed in light of our forthcoming exit from the EU and we have a HB Brexit Steering Group to manage and respond to the situation. Areas of work include medicines management, procurement and workforce, amongst others. I am very grateful to our workforce for their vigilance and commitment in preparing our organisation.

We have a tremendously talented and dedicated workforce, many of whom are from the EU and are personally affected by Brexit, as well as other international and home-grown NHS staff. The HB is committed to supporting these staff to remain working for us, and this is a key priority in our preparation for Brexit. We have a closed Facebook group for our EU staff where they can receive updates and find peer support. We also have a website for staff and the public where they can obtain local information and signposting to national updates such as the WG Preparing Wales website.

**The control framework**
We are committed to putting quality at the heart of our services, providing the right care, in the right place at the right time and in the right way. The implementation of our Health and Care Strategy is a critical programme of work in making sure that we are able to deliver services that are Safe, Sustainable, Accessible and Kind. Redesigning the healthcare system to reflect current need and future sustainability requires strong leadership and empowerment of front line staff in order to constantly deliver the highest standards of care. We recognise that we are working through a complex system of interwoven parts covering many different aspects which are not limited to health and care services however include those that encompass the wider determinants of health, including housing, education, transport and other important public services. Our strategy is to strengthen the resilience and

quality of these services, grow the integration between health, social care and other key statutory and third sector organisations.

In order to strengthen the assurance provided to the Board, the Integrated Performance Assurance Report (IPAR), examines and considers the latest performance data, achievements, challenges and needs. Supplementary Dashboards have also been developed for a number of performance indicators, including referral to treatment targets, unscheduled care, cancer, stroke and diagnostics and therapies. A quality Dashboard has also been developed to support the QSEAC, which includes data for healthcare acquired infections, concerns, incidents, delayed follow-ups, hand hygiene and patient satisfaction.

Following its introduction towards the end of the previous financial year, we now have a formalised programme for the patient safety walkabouts, which are being well evaluated by both staff and the Executive/Independent members. The purpose of these is twofold; firstly it allows front line colleagues the opportunity to "say how it is", to raise patient safety/quality issues and to share ideas for improvement. Secondly, a walkabout is a way for leaders to stay in touch and be connected with all corners of acute, community, mental health and primary care services. A report is provided to the area visited and feedback is delivered at each Board meeting.

To accord with the core values for the NHS in Wales, designed to support good governance and the achievement of high standards of care (as included in the NHS e-governance manual), the HB places significant emphasis on:

- Prioritising quality and safety;
- Improvement being integrated with everyday working;
- Focusing on prevention, health improvement and inequality;
- Partnership working;
- Investing in our staff.

During March 2019, we launched the HB's first Quality Improvement Strategic Framework. The Framework, approved by Board in July 2018, describes a new approach to creating a culture of continuous improvement. The launch started the process to deliver the first collaborative training programme to take forward quality improvement projects across the HB, linked to our quality goals and strategic objectives.

As a Board, we recognise that failure to deliver the fundamentals of care can have a significant impact and that the Board has a key role in safeguarding quality. In order to give appropriate scrutiny to the key facets of quality, i.e. effectiveness, patient safety, timeliness of care and patient experience, towards the end of the year we again undertook a Health and Care Standards Fundamentals of Care Audit in a selection of areas across the HB to highlight the findings in relation to key areas of practice. There were three elements to the audit: patient survey, staff survey and operational questions referring to patients' records, medication charts, food charts and fluid charts. A report is to be taken to a forthcoming meeting of the Board which will focus on the development work which was undertaken, where there are continued and sustained outcomes and recognition of any areas of concern and action plans to address these in the coming period. The report will provide assurance to the Board that the care delivered within the HB continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas for improvement. Detailed information on what we do to ensure that all our services are meeting local needs and reaching high standards is included in our Annual Quality Statement. The HB recognises that further work needs to be undertaken in strengthening our approach to patient experience and developing a patient charter. These will be priority areas for 2019/2020.

As referred to above, the report on the results of the Health & Care Standards Fundamentals of Care Annual Audit exercise will be based on the themes and standards integral to the

Standards. The HB uses the Health & Care Standards for Wales as its Framework for gaining assurance on its ability to fulfil its aims and objectives for the delivery of safe, high quality health services. To be consistent with WG guidance that the focus should be on the embedding of the standards throughout the work of the HB in the delivery of services, the following processes are in place, with assurance reports being provided to the Board or its Sub-Committees as appropriate:

- Self-assessment, tested through mechanism such as internal and clinical audit;
- Participation in peer review exercises;
- Consideration of and responding to external reviews from inspection and regulatory bodies such as Healthcare Inspectorate Wales;
- Acting on feedback from bodies such as Community Health Councils.

Further evidence of embedding the standards is that all Board and Committee papers have to demonstrate alignment with the relevant standard/s.

At the HB, corporate governance is regarded as the way in which we are governed and controlled to achieve our objectives, and the effectiveness of these arrangements can impact on how well these are met. The control environment provides the Framework for ensuring effective scrutiny of the organisation's progress towards achieving these objectives within a tolerable degree of risk, whilst risk management provides the resilience.

In accordance with current guidelines appertaining to the Corporate Governance Code and its application to public bodies in Wales, the HB has undertaken an assessment of its compliance with the Code. During the year, the HB has strengthened its practices for conducting business in an open and transparent manner. The HB is satisfied that it is complying with the main principles of, and is conducting its business in an open and transparent manner in line with, the Code. The outcome of the assessment has been reported to the Board via the ARAC. Although the HB, through its scrutiny and review processes, continues to identify areas for improvement, the assessment against the Corporate Governance Code was clear in that the organisation has complied with and has not identified any departures from the Code during the year.

We have again undertaken a self-assessment against the Governance, Leadership and Accountability Standard (GLA), which was presented to the Board for discussion and subsequent approval. The standard sets out expectations for working within a legal and regulatory framework for health bodies and asks a series of questions to assess the organisation's current position in terms of the following areas:

- Having a defined structure in which accountabilities, roles, responsibilities and values are clear and which upholds the standards of behaviour expected of its staff;
- Having a system of governance which supports successful delivery of its objectives and partnership working. The organisation will provide leadership and direction so that it delivers effective, high quality and evidenced based services, meets patient needs at pace, with staff that are effective and appropriately trained to meet the needs of patients and carers;
- Ensuring that effective systems and processes are in place to assure the organisation, service, patients, service users, carers, regulators and other stakeholders, that the organisation is providing high quality, evidenced based treatment and care through the principles of prudent healthcare and services that are patient and citizen focused.

The HB's self-assessment considered all the questions as set out in the WG's supporting guidance in relation to the standard criteria and the entire assessment can be found within the May 2019 Extraordinary Public Board meeting by clicking on the following link - Hywel Dda Board Papers.

The Governance Leadership and Accountability Standard has been completed in terms of the HB's current position. The self-assessment both identifies areas where progress continues to be made with some areas of good practice highlighted, and any other spheres where it is felt that further development is required.

**Other control framework elements**

Within the HB, the following control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The HB practices a person-centred approach to service delivery with co-production and prudent health care at the forefront of the way in which we plan, develop and deliver services. During 2018/2019 this has been further enhanced by our work towards meeting the duties of the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015. In particular, we have completed a self-assessment in relation to the Wellbeing of Future Generations Act, which has assisted us to identify both good practice and where further work may be needed to progress towards each goal and demonstrate the five ways of working. We have also contributed to the Future Generations Commissioner's Journey Checker project which seeks to highlight examples of good and best practice that can be implemented more broadly throughout Wales.

The principles of equality, diversity and human rights are embedded in the guidance to the Board on our approach to service planning and reporting mechanisms, enabling robust scrutiny of proposals, performance and actions. We use an Integrated Impact Assessment Tool in conjunction with our Equality Impact Assessment Tool, enabling equality considerations to be embedded into the core mechanisms of the HB. Integrated Impact Assessment (IIA) (including equality considerations) forms part of the gateway process for service design, strategies, plans and policies. The IIA has been further developed to support the new 'check and challenge' process approved by the Board in March 2019.

Our Written Controls Document Policy includes an explanatory section around Equality Impact Assessment and further information and guidance is available on our intranet and internet websites for staff and public consumption. Equality Impact Assessments for policies are published on our website and Board papers are published for public scrutiny. This ensures that due regard is given to equality, diversity and human rights considerations during the development and review of all HB policies and the scrutiny of policies in relation to local impact on the adoption of policies developed and reviewed on an All Wales basis.

Equality and Diversity training is mandatory for all staff – 'Treat me Fairly' the Equality e-learning package is available to all staff as part of the Core Skills Framework, uptake is monitored and is increasing incrementally. We have also refreshed the existing Equality and Diversity Induction session. Now entitled, "Person Centred Care", it brings together information on key legislation including the Wellbeing of Future Generations (Wales) Act 2015 and the Equality Act 2010, identifying the links across all protected characteristics and considerations in relation to the needs of particular vulnerable groups, e.g. carers', refugees and asylum seekers, veterans and homeless people. This approach supports staff prior to their completion of the mandatory e-learning module. In addition, we have responded to requests for bespoke training to meet the needs identified by individual departments or teams. This has included bespoke training on "trans awareness" and "unconscious bias".

Comprehensive information on equality, diversity and human rights (including links to external advisory bodies/organisations) is available to staff and the public on our dedicated intranet and internet web pages which have been reviewed and updated during the year. Progress on the HB's stated Equality Objectives is reported to and scrutinised by a number of sub-committees and committees prior to presentation at Board and subsequent publication in our Annual Equality Report.

These groups/committees constitute wide representation across all functions, facilitating action directly targeted at improving staff and patient experience. The HB has completed its second year of its refreshed Strategic Equality Plan and Objectives 2016/2020 and the Strategic Equality Plan Annual Report (reporting on the year April 2017 – March 2018) was presented to Board prior to publication in December 2018. This year, we aim to publish our 2018/2019 Strategic Equality Plan Annual Report at the same time as our 2018/2019 HB Annual Report in order to provide a more contemporaneous overview of our progress towards meeting our Equality Objectives.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. The HB would confirm that it acts strictly in compliance with the regulations and instructions laid down by the NHS Pensions Scheme and that control measures are in place with regard to all employer obligations. This includes the deduction from salary for employees, employer contributions and the payment of monies. Records are accurately updated both by local submission (Pensions On-Line) and also from the interface with the Electronic Staff Record (ESR). Any error records reported by the NHS Pension Scheme which arise are dealt with in a timely manner in accordance with Data Cleanse requirements.

In terms of Carbon reduction, the HB has included on the organisation's risk register a risk which captures the scale of action needed to meet reduction targets. The development of feasibilities and delivery of smaller scale efficiencies has continued within this context. Best practice initiatives, such as the energy efficiency improvements to the new Minaeron Health and Wellbeing Centre are nearing completion which achieves BREEAM requirements around energy and carbon performance. The HB's Health and Care Strategy and future plans for estate and service delivery which are now underway provide an excellent opportunity to align and deliver significant carbon benefits and reductions. To support this aim, the HB will work closely with the WG's Energy Service to develop an energy and carbon strategy to signpost the opportunities moving forward with the new service strategy.

**Integrated Medium Term Plans (IMTP)**

The NHS Finance (Wales) Act 2014 requires each HB to prepare a plan which sets out the Board's strategy for complying with the three year financial duty to breakeven. The HB acknowledges that it is not in a position to submit a three year IMTP given the current inability to evidence financial balance together with the current status of the Turnaround Programme. Therefore, the HB was unable to meet the requirement to submit a financially balanced three year IMTP for the period 2018/2021 to WG in accordance with the Act. Instead the HB submitted an Annual Plan for 2018/2019 concentrating on Finance, Performance and Turnaround; whilst also meeting the requirements of the NHS Planning Framework 2019/2022 (WHC/2018/040). To this end a formal accountability letter was submitted to WG supporting this position.

At its meeting in March 2018, the In-Committee Board was asked to note a revised draft of the 2018/2019 Annual Plan for submission to WG, noting that the Plan was not financially balanced and therefore could not be formally approved by the Board. At its meeting on 29 March 2018 the Board considered the Financial Plan for 2018/2019 and, whilst the interim plan was agreed, the Board requested further detail on the savings target delivery. A subsequent paper providing further detail was considered at the Board meeting on 19 April 2018, at which the Board approved the savings element of the interim Financial Plan 2018/2019 as the basis for delivery in year.

The Annual Plan 2018/2019 set out our intentions for the year including a focus on financial improvement, progressing our Turnaround delivery, performance improvement and progressing the Transforming Clinical Services programme. This in turn was a precursor to the intention to develop a three year IMTP for the 2019/2022 three year planning period. The deliverables and actions for 2018/2019 were agreed with WG, as well as clear milestones for how critical planning components were to be developed or strengthened during the year.

In terms of Performance and Finances against the plan, in 2018/2019 we made substantial improvements in patient waiting times for planned care, such that by the end of the year we had no patients waiting over 36 weeks for treatment and no patients waiting over 8 weeks for access to diagnostics. Our deficit has reduced to £35.4m which is slightly better than the control total agreed at the start of the financial year. We recognise, however, that we still have much more to do to stabilise our services, and address in particular our workforce challenges, and thereby stabilise and improve our finances.

Detailed information can be obtained within the BPPAC papers http://www.wales.nhs.uk/sitesplus/862/page/83830 and in the performance section of the Annual Report. Throughout, quarterly updates on the 2018/2019 Annual Plan, focused on actions to improve the HB's position and complement our performance whilst improving quality and safety, were scrutinised by both the BPPAC and the QSEAC. As part of the report each plan was RAG (risk) rated for the quarter, as well as detailing the change from the previous quarter, to provide the BPPAC with a level of assurance that actions were being met and that plans were being delivered. The Planning Department also developed an Integrated Planning Assurance Report during 2018/2019 to help deliver the Plan for 2019/2020 and ensure the planning cycle is a stronger process.

The WHC for the Planning Framework also states that "WG will work closely with those organisations that do not currently have an approved plan, to identify clear key deliverables and work towards the ambition of achieving an approved IMTP". We can confirm that we have continued to work closely with WG through targeted intervention meetings and quality and delivery and planning meetings. This has been further informed by the outcome of the Health and Care Strategy and the HB is aiming for an approvable IMTP in due course, subject to discussion with WG regarding the transitional plans and the zero-based review which show the journey we will need to take in the bridging years.

In developing the Plan for 2019/2020, the HB continued to be unable to meet compliance with the NHS Finance (Wales) Act 2014, and therefore an Annual Plan for 2019/2020 was submitted to WG. The Annual Plan submitted for 2019/2020 concentrates on Finance, Performance, Turnaround and alignment to the Health and Care Strategy, whilst also meeting the requirements of the NHS Planning Framework 2018/2021 (WHC/2017/047 NHS Planning Framework 2018/2021). To this end, a formal accountability letter was submitted to WG supporting this understanding.

***Ministerial Directions***

A number of Ministerial Directions were issued during 2018/2019, this information being available by accessing the following links:
Welsh Government | National Health Service non-statutory instruments 2018

A schedule of the directions, outlining the actions required and the HB's response to implementing these was presented to the ARAC as an integral element of the suite of documents evidencing governance of the organisation for the year. From this work it was evidenced that the HB was not impeded by any significant issues in implementing the actions required as has been the situation in previous years.

**Information Governance**

The HB has a range of responsibilities in relation to the appropriate use and access to the information it holds including confidential patient and staff information. These responsibilities are guided by legislation with the Medical Director acting as the designated Caldicott Guardian and the Director of Planning, Performance and Commissioning as the Senior Information Risk Owner (SIRO). Information Asset Owners (IAOs) are in place for all service areas and information assets held by the HB and a programme of compiling a full asset register for the HB is underway and due to be completed by November 2019.

The HB has responsibilities in relation to Freedom of Information, Data Protection, Subject Access Requests and the appropriate processing and sharing of personal identifiable information. The HB is currently working towards compliance with the General Data Protection Regulations (GDPR) which came into force on 25 May 2018, together with the Data Protection Act 2018. This work continues to strengthen the arrangements in place to ensure that information is protected and managed in line with relevant legislation and the HB's duty of care to staff and patients. A recent audit on the HB's compliance with GDPR and the level of the effectiveness of the internal control systems to manage the risks associated with GDPR compliance was rated as providing the Board with substantial assurance that these controls are in place.

The HB has adopted and implemented a robust procedure for managing Information Governance Incidents across the organisation that ensures incidents are reported in line with statutory requirements and lessons are learnt to improve future practice. The HB has had contact with the Information Commissioner's Office (the ICO) in relation to eight incidents during the year. The incidents fell into four broad categories:

- Breach of patient confidentiality/S.170 offence by an individual under the Data Protection Act 2018;
- Loss of information sent by post or information sent to another individual in error;
- Subject Access Request – not all information has been released;
- Health records accessed by unauthorised individual.

For seven of those cases closed by the ICO, the ICO have been satisfied with the preventative and follow up action taken by the HB and no fines or enforcement notices have been issued. One case still remains open and the HB is awaiting the response from ICO.

The National Intelligent Integrated Audit Solution (NIIAS) which audits access to patient records has been fully implemented within the HB with an associated training programme for staff and procedures for managing any inappropriate access to records. Training sessions are scheduled regularly (2 sessions per month) and staff receive training from the Information Governance Team through the NIIAS programme. In addition to the above training, global e-mail, group training sessions and Information Governance 'Drop In' sessions were in place. Posters, leaflets and staff briefings have all been used to disseminate information to staff around the importance of confidentiality, appropriate access to patient records and ensuring information is shared in an appropriate way. This is in addition to the mandatory Information Governance training module that all staff are required to complete every two years. The HB has worked hard to increase the level of completed Information Governance mandatory training across the organisation which is 78.2% (as recorded in the Annual Report 2018/2019). The continuance of this work will form a key part of the Information Governance Team's work for 2019/2020.

The HB has refreshed its Information Governance Framework in light of the GDPR and its strengthened governance arrangements. The HB has undertaken a full review of its position against the Caldicott Principles into Practice Assessment with an updated action plan ready for 2019/2020 to target areas that require improvement.

The Information Governance Sub-Committee (IGSC) and its reporting groups provide oversight, advice and assurance to both the BPPAC and the Board with regard to Information Governance.

**Data Quality and Information**
The HB has continued with improving the quality of our data which informs our decisions, performance assessments and reporting and which also informs some of the internal/ external reviews undertaken. The HB however does recognise there is further work required in this area following both internal and external audit reviews.

The HB has improved the quality of the data within a number of key clinical systems, and is continuing work to target other systems. The established group of information asset owners are key in the data quality assurance process, and we are therefore concentrating during 2019/2020 in further developing our network of Information Asset Owners. The role of the Information Asset Owners will be pivotal in improving the data quality within the HB.

**Review of effectiveness**
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the Internal Auditors, and the Executive Officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

**Internal Audit**
Internal Audit provide me, as Accountable Officer, and the Board through the ARAC, with a flow of assurance on the system of internal control. The programme of audit work which has been delivered in accordance with Public Sector Internal Audit Standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the ARAC and is focussed on significant risk areas and local improvement priorities.

The ARAC has received progress reports against delivery of the NHS Wales Shared Services Partnership Internal Audit and Capital (Specialised Services) plans at each meeting, with individual assignment reports also being received. The findings of their work are reported to management, and action plans are agreed to address any identified weaknesses. The assessment on adequacy and application of internal control measures can range from 'No Assurance' through to 'Substantial Assurance'. Where appropriate, Executive Directors or other Officers of the HB have been requested to attend in order to be held to account and to provide assurance that remedial action is being taken. A schedule tracking the implementation of all agreed audit recommendations is also provided to the Committee.

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

The Head of Internal Audit has concluded for 2018/2019:

| | | |
|---|---|---|
| Reasonable assurance |  <br>- +<br>Yellow | The Board can take **reasonable** assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. |

The All Wales Framework for expressing the overall audit opinion identifies that there are eight assurance domains all of equal standing. The rating of each assurance domain is based on the audit work performed in that area and takes account of the relative significance of the issues identified.

In reaching this opinion the Head of Internal Audit has identified that the Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

In reaching this opinion the Head of Internal Audit has considered all the domains, with these being rated for assurance as follows:

| **Domain** | **Assurance** |
|---|---|
| Corporate governance, risk and regulatory compliance | Reasonable |
| Strategic planning, performance management and reporting | Reasonable |
| Financial governance and management | Reasonable |
| Clinical governance, quality and safety | Reasonable |
| Information governance and IT security | Reasonable |
| Operational service and functional management | Reasonable |
| Workforce management | Limited |
| Capital and estates management | Reasonable |

Thus overall a reasonable assurance rating is given to the HB.

Internal Audit is aware of the plans and actions put in place by the HB in response to their recommendations, and will follow these up in the 2019/2020 year to ensure they have been enacted.

The role of Internal Audit is to provide the Board with an objective assessment of the extent to which the systems and controls to manage our risks are adequate and are operating effectively, based on the work undertaken. The work of the Internal Audit service is informed by an analysis of the risks to which the HB is exposed with an annual plan based on this analysis. It should be recognised that many of the reviews were directed at high risk areas, and the overarching opinion therefore needs to be read in that context. Whilst acknowledging the Head of Internal Audit Opinion, it should be noted that 79% of the Internal Audit reports achieved a rating of substantial or reasonable with 12% of the reports receiving a limited or no assurance rating, with 9% of reports where a rating was not applicable. See table below:

| Internal Audit Assurance Rating | 2018/2019 | |
|---|---|---|
| | No. | % |
| Substantial | 8 | 23 |
| Reasonable | 19 | 56 |
| Limited | 4 | 12 |
| No assurance | 0 | 0 |
| Rating Not Applicable | 3 | 9 |
| Total | 34 | 100 |

*34 includes 3 draft reports to be finalised. .

Similarly for Capital and PFI it should be noted that 70% of the audit reports achieved a rating of substantial or reasonable assurance, with 10% of reports in receipt of a limited rating. A rating was not applicable for 20% of reports. See table below:

| Capital and PFI Audit Assurance Rating | 2018/2019 | |
|---|---|---|
| | No. | % |
| Substantial | 1 | 10 |
| Reasonable | 6 | 60 |
| Limited | 1 | 10 |
| No Assurance | 0 | 0 |
| Rating Not Applicable | 2 | 20 |
| Total | 10 | 100 |

During the year internal audit issued the following audit reports with a conclusion of limited assurance:

| Subject | Issue | Action |
|---|---|---|
| **Information Governance & Security Domain** | | |
| PC and laptop Security (Follow Up)<br><br>February 2019 | Whilst some aspects of the recommendations from the previous report that were attributable to ICT were addressed and a schedule of concerns has been passed to the Security Manager for the HB, work to address the recommendation has not been completed in full. This should have been identified in the original management response with additional responsible officers listed at the time. Site visits conducted as part of the Internal Audit follow up confirmed that the situation in relation to ICT related issues observed in three of the six sites visited in the original review remained unchanged. The new recommendations will enable the ADI to identify individuals with jurisdiction to implement the recommendation fully and draw on their expertise and services to coordinate and carry forward a programme of work to improve the security arrangements surrounding the HB's IT assets. | The following recommendations are outstanding:<br><br>R1 – Should consider a wider security awareness programme.<br><br>R2, R3 & R4 – Work with leads at South Pembrokeshire Hospital, Bro Cerwyn and Amman Valley Hospital to coordinate the resolution of weaknesses identified in the security assessment, where necessary drawing on assistance from specialist departments such as Estates and Facilities.<br><br>ARAC requested that the Management Response was reviewed and strengthened, and clear timescales were provided for outstanding recommendations which should be implemented by February 2020. |
| **Operational Service and Functional Management Domain** | | |
| Records Management<br><br>February 2019 | • The extant Corporate Records Management Strategy document does not reflect new legislative arrangements.<br>• Lack of health records inventory in place by Service and Departmental Managers;<br>• Current storage arrangements are impacting on the HB capacity-wise and financially.<br>• Patient information continues to be held beyond the required retention period set by the WG, which increases the risk of storage breaching its capacity.<br>• The *Access to Health Records Policy* does not reference the introduction of new legislation. | The following actions are outstanding:<br>• R1 – Update the Corporate Records Management Strategy<br>• R2 - Information Asset Owners questionnaire to be circulated<br>• R5 - Access to Health Records Policy to be reviewed and updated<br>• R7- possibility of introducing joint IG/Health Records training sessions<br>• R9 - ensure that the Health Records Committee regularly meet as per the frequency detailed in their terms of |

| Subject | Issue | Action |
|---|---|---|
| | • Lack of appropriate arrangements for the storage of health records and patient information agreed between third party providers and the HB.<br>• Lack of registers or logs noting the records and patient information currently in storage.<br>• Some staffing groups continue not to have received training for the management of health records.<br>• Policies and terms of reference do not reflect the requirements set out by the WG in the revised Health & Care Standards 2015.<br>• The lack of regular Health Records Committee meetings, as per the terms of reference, could lead to a lack of scrutiny. | reference).<br><br>Whilst some timescales have slipped, recommendations should be delivered by September 2019. |
| National Standards for Cleaning Follow-Up<br><br>April 2019 | • Cleaning and Estates issues, although being reported upon are not actually being resolved.<br>• Standards of cleanliness will not be monitored and areas that fall short of the expected standards will be not be identified and corrected if Internal Technical Audits (Cleaning for Credits) are not undertaken.<br>• C4C audits are not always uploaded to the PMS website on the same day as the checks are undertaken.<br>• iPads are not always used to complete audits at WGH and they are never used at GGH during an area visit increasing the likelihood of a delay between carrying out the checks and getting the information onto C4C.<br>• Audits at peripheral sites to ensure that standards of cleanliness are monitored and areas that fall short of the expected standards will be identified and corrected. | ARAC have requested the management response to be reviewed to ensure a robust plan is in place to address the findings in the report with this reported back to the next meeting. |
| **Capital and Estates Management** | | |
| Water | • Staff may not be appropriately trained to identify potential | All the recommendations have been agreed by management |

| Subject | Issue | Action |
|---|---|---|
| Management<br><br>April 2019 | hazards or issues.<br>• The HB's implemented policy and procedures may not sufficiently address legislative compliance requirements.<br>• Plans may not be appropriate to effectively manage an outbreak.<br>• Water Safety Plan in place, the document was out of date (last updated in 2015) and did not therefore reflect the latest guidance (published in 2016).<br>• A review should be undertaken of all outstanding high priority actions arising from NWSSP: SES audits, including assessment of the risk to the HB of these not being completed.<br>• The legionella risk may not be effectively prioritised and managed within Estates.<br>• Potential non-compliance with ACOP/WHTM 04-01.<br>• Staff may not be appropriately trained to identify potential hazards or issues, or to undertake testing/monitoring in accordance with the Water Safety Plan. | and are being implemented in accordance with the timescales agreed in the management action plan.<br><br>A follow up has been included in the internal audit plan for 2019/2020. |
| **Workforce management** | | |
| PADRs<br><br>May 2019 | • Issued May 2019. | Despite the improvement in PADR compliance, the limited rating was issued in respect of the quality of PADRs undertaken in the HB. |
| Internal Audit will undertake follow up reviews of all limited audits within 2019/2020. Implementation of recommendations is being monitored by the relevant Executive Performance Review or HB committee and tracked via the HB's audit tracking mechanisms. | | |

In addition to the above, the ARAC has also received for assurance, a number of Internal Audit Reports appertaining to those functions delivered on its behalf by the NWSSP and which have been approved by the Velindre NHS Trust's Audit Committee, as the host authority for the service.

**Wales Audit Office (WAO)**
As the HB's appointed external auditor, WAO is responsible for scrutinising the HB's financial systems and processes, performance management, key risk areas and the Internal Audit function. The WAO undertake financial and performance audit work specific to the HB with all individual audit reviews being considered by the ARAC with additional assurances

sought from Executive Directors and Senior Managers as appropriate. The WAO also provides information on the Auditor General's programme of national value for money examinations which impact on the HB, with best practice being shared.

During the year, WAO undertook its annual Structured Assessment review of the HB which examined the arrangements to support good governance and the efficient, effective and economical use of resources. In addition to reviewing the HB's financial management arrangements, the progress made in addressing key issues identified in previous year's structured assessment was also scrutinised, with the overall conclusions being as follows:

- Although the HB has generally good governance arrangements in place, the Board has recognised that quality and safety governance arrangements need to improve and that the current organisational structure needs to be revisited to support delivery of its new strategy;
- The HB is to be commended for its engagement and ambitious approach to longer-term strategic planning but needs to develop joined up and streamlined planning and delivery arrangements and ensure there is sufficient capacity to drive through the necessary change;
- Whilst the Board is strengthening arrangements for financial management and accountability, there remain significant financial challenges and it needs to address asset management risks and increase its focus on improving the efficiency of services. The management of workforce, is however, improving.

The work undertaken as part of Structured Assessment contributed towards the WAO Annual Audit Report 2018. The key findings and conclusions emanating from both the assessment and the report are summarised as follows:

- While there are generally good arrangements to support Board and Committee effectiveness, there are weaknesses in its quality and safety governance arrangements which the HB recognises and is addressing. The Board continues to be generally well-run with the quality of Board-level scrutiny and challenge good. There is a full complement of Independent Members with a comprehensive programme of development in place. Board agendas are well structured, with a clear focus on governance items, strategic issues and performance, although more work is needed to get the right level of information within the papers. The Board's Committees generally work well although there is recognition that the QSEAC needs to further improve;
- There is a well-developed BAF in place which is being refreshed as new strategic objectives are developed. In refreshing its BAF, the HB has also developed a comprehensive Regulatory and Review Body Assurance Framework, and over time has increased the level of information included in the BAF, including the Board's risk appetite. A well-documented Corporate Risk Register is also in place, and the HB has been working to further embed its revised risk management framework;
- The review of primary care services, maternity services, district nursing, operating theatres and a range of information governance aspects, as well as regional partnership working has found some positive aspects of securing efficient, effective and economical use of resources, but challenges remain, and several previous recommendations are outstanding;
- The HB has made good progress in addressing recommendations from previous audit work but a number remain outstanding, some of which are reliant on national guidance and improvements in IT systems;
- An unqualified opinion was issued on the preparation and accuracy of the accounts for 2017/2018; however due to the HB not achieving financial balance for the three year period ending 31 March 2018, a qualified opinion was issued on the regularity of the financial transactions within the 2017/2018 accounts. This was accompanied with a substantive report highlighting the HB's failure to achieve financial balance and its failure to have an approved three year plan in place.

The Board did not disagree with any of the content of the WAO Annual Report and I can confirm that progress has already been made in a number of the areas outlined above. A detailed management response was prepared in response to the recommendations made in the Structured Assessment report by WAO, with implementation of these being tracked through the ARAC. The management response can be viewed on the HB's website and can be found on the following link: http://www.wales.nhs.uk/sitesplus/862/page/95468

**Other sources of External/Independent Assurance**

**Healthcare Inspectorate Wales (HIW)**

The Board is provided with independent and objective assurance on the quality, safety and effectiveness of the services it delivers through reviews undertaken by and reported on by HIW. Any unannounced hospital inspections and any special themed reviews undertaken during the year would have been reported to the QSEAC and any matters for concern escalated accordingly. The outcomes of any such reviews and any emanating improvement plans are discussed with any lessons learnt shared throughout the HB.

All HIW reports, including the improvement plans, are presented to QSEAC, with an update on progress to date on the implementation of the recommendations within the reports. This includes any inspections of acute hospitals and mental health and learning disabilities facilities, GP and Dental practices and any incidents involving Ionising radiation (IR(ME)R). Services are held to account on the implementation of the recommendations through the Executive Performance Reviews. The Committee is also informed of any immediate assurance letters received by the HB.

During the year, HIW had undertaken eight inspections across acute, mental health and community and primary care (managed practices) services within the HB, as well as a number of thematic reviews the details of which are shown in Appendix 4. The key messages emanating from the inspections were that, overall, patients reported they were happy with the care they received with it being evidenced that patients were treated with dignity and respect. The work also highlighted some issues requiring further action and where issues had been identified, the HB had generally responded soundly with improvement plans being completed and submitted in a timely manner. It was also stated by HIW that generally, themes identified in the previous inspections were being addressed in follow up work and the HB had been open and responsive to any matters raised.

**Audit & Review Tracker**

Audits and reviews play an important independent role in providing the Board with assurance on internal controls and that systems and processes are sufficiently comprehensive and operating effectively. Therefore it is essential that recommendations from audits and reviews, both internal and external, are implemented in a timely way.

The HB continues to develop its Audit and Review Tracker which logs and tracks the progress of all external audits, reviews and inspections undertaken by an external organisation on the services that are provided by the HB. The tracker is intended to ensure that:

- All external reports received by the HB are received and logged in a central repository;
- It details where reports have been formally received by the HB;
- Clarity is provided by the lead Executive Director and lead officer for each report;
- Updates on progress are provided and reported periodically to the ARAC;
- Services are held to account in executive performance reviews.

Throughout 2018/2019, escalation processes were developed for late and non-delivery of recommendations, with progress being monitored quarterly through the executive

performance reviews, and which culminates in ARAC inviting lead Executives and Officers to explain reasons behind delays in implementation and the impact to patients.

A strategic log was also developed to ensure that where the HB does not currently have the resources to implement recommendations, these are logged and agreed by the Executive Team to take forward and implement through it strategic and capital plans.

WAO reported in the Structured Assessment 2018 that the HB has a robust process for tracking recommendations from all regulators, not just those identified by Internal and External Audit, and identified it as an area of good practice.

**Performance Management Assurance Framework (PMAF)**

The HB's Performance Assurance Framework complements other key elements of the Board's governance and assurance arrangements, particularly risk management, and provides a method for triangulation of data from different sources to give assurance that risks reported are escalated consistently and appropriately. The HB developed and implemented its PMAF in 2018/2019 to enable the Executive Team to enhance its understanding, monitoring and assessment of the HB's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. The PMAF also incorporates delivery against the service and directorate plans set out in the Annual Plan 2018/2019. The PMAF will be strengthened further in 2019/2020 following feedback from WAO SA18.

The performance dashboards are updated monthly, with new dashboards available for Mental Health & Learning Disabilities and Theatre cancellations. Also, the Stroke Dashboard has been updated to include a summary by hospital site for the new quality improvement measures. Following a request from the BPPAC, future reports will include the number of patients who are waiting to start an Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD) neurodevelopment assessment.

Work is underway to make the performance dashboards available via a business intelligence tool, to allow easier access across different devices, including iPads. The first dashboards to be migrated are Referral to Treatment Time (RTT) and Cancer.

The Board is presented at each of its meetings with an Integrated Performance Assurance Report (IPAR) that provides it with assurance on the most recent outturn position for key deliverable areas with these reports clearly highlighting where improvements are needed.

**Legislative Assurance Framework (LAF)**

The legal obligations of the HB are wide ranging and complex. In order to provide the Board with a level of assurance of compliance, the Legislative Assurance Framework has been reviewed focusing on those matters that present the highest risk in terms of likelihood and impact of non-compliance. A critical element of compliance is demonstrating the type and level of assurance that is relied upon. The type of assurance relates to the three lines of defence, where first line of assurance is provided by management systems, the second line is provided from oversight and the third line relates to independent and more objective assurance and focuses on the role of internal audit and other external auditors/regulators. The level of assurance follows the internal audit gradings of substantial, reasonable, limited or no assurance.

The framework has been further developed, and now captures:-

- Primary legislation requirement as set out in European law, UK Public Acts or WG measures;
- Relevant Statutory Instruments issued as Regulations and Orders;
- Licences issued by Regulatory Authorities as part of statutory arrangements;

- Summary of requirement;
- Regulatory/monitoring body, where applicable;
- Powers that can be enacted by the Inspectorate/regulatory body;
- Executive and Operational lead arrangements;
- Type of assurance (linked to three lines of defence model);
- Assurance level (this is determined by the appropriate operational lead) and Datix risk score, if there is limited or no assurance;
- Key controls in place to assist the HB in complying with the legislation;
- Date of last inspection and outcome (including actions, where identified);
- Link to Health and Care Standards in Wales;
- This framework does not extend to healthcare professional regulation and certification; neither does it extend to compliance with Alert Notices, which are subject to a separate process.

During 2018/2019, services from across the HB were asked to undertake a baseline assessment of the relevant key laws/legislation (not all legal requirements are included as such a development would require considerable resource) which come under their remit. Where an assurance rating of 'limited' or 'no assurance' has been given, these have been extracted and reported to the ARAC. Services have also undertaken a risk assessment for these areas (if not already in place) to ensure that the impacts are understood and the planned actions detail how risks of limited compliance will be managed/mitigated. Documenting and understanding the level of risk will help to inform HB's annual prioritisation process going forward. These will also be included in the performance management reviews undertaken with services. The LAF enables the HB to understand where there are areas of concern and provides a source of information which can be used to triangulate with other sources of information and assurance.

**Review of economy, efficiency and effectiveness on the use of resources**

It was recognised in the WAO structured assessment that the HB faces significant and on-going challenges in respect of the organisation's financial position, its ability to meet the requirements of an approvable Integrated Medium Term Plan and concerns around specific aspects of its performance, most notably in relation to unscheduled care and referral to treatment times. The efficient, effective and economical use of resources largely depends on the arrangements the HB has for managing its workforce, its finances and other physical assets.

The structured assessment found that the HB is managing its workforce effectively, however vacancies continue to present challenges. It is recognised that the HB has generated several innovative initiatives to attract candidates or to develop its own workforce. The assessment highlighted that financial management and accountability had improved, but that the HB's financial position remains a significant and long-term challenge. During the year WG awarded the HB additional recurrent funding of £27million, to reflect the unique set of challenges it faces in relation to its demography and scale that contribute to the continuing financial position. The HB's year-end financial position is a deficit of £35.4million (2016/2017: £69.4million deficit) which is marginally ahead of that agreed with WG at the beginning of the financial year. The savings delivery in year was £26.6million which exceeds that delivered in 2016/2017 (£25.1million). During the year the Turnaround programme has strengthened the internal processes with fortnightly holding to account meetings with directorates, 60-day cycle meetings to identify new areas of efficiencies and a new escalation process with the Chief Executive for Directorates that are failing to deliver.

The structured assessment stressed that the HB's estate and physical assets are deteriorating and that these need to be risk assessed to prioritise actions for replacement. The HB has an Infrastructure Enabling plan which supports its current one-year operational

plan. This sets out the estates requirements needed in the short-term and how these will be funded.

In order for the HB to achieve it statutory breakeven duty going forward the pace of change needs to accelerate and it needs to demonstrate a clearer trajectory of improvement and financial sustainability as part of the implementation of the health and care strategy.

**Targeted Intervention (TI)**
The HB's status remains at TI which is the third level in the NHS Wales Escalation and Intervention Framework. This means the WG and external review bodies continue to review whether to take and co-ordinate action in liaison with the HB to strengthen its capability and capacity in order to drive improvement. When originally escalated to TI, we acknowledged the change as one intended to support us and as an opportunity to accelerate our improvement trajectory. This is still our view and since that time we have welcomed the support that we have been receiving.

The progress we have continued to make over the last year has been acknowledged, particularly in respect of the continuous engagement with our population in the development of our Health and Care strategy, the continued improved performance with the significant achievement of no patients waiting over 36 weeks for treatment, no patient waiting over 36 weeks for treatment and no one waiting over 8 weeks for access to diagnostics and, for the first time in a number of years, reducing the financial deficit of the organisation. The growing effectiveness of the Executive Team and their contribution to progress was also recognised. Whilst the escalation level remains unchanged, some concerns and issues were raised at the last review and these are being addressed by the HB.

The Turnaround programme which we introduced last year provides a robust process for the delivery of savings schemes. The total value of savings achieved was £26million which was our highest performance in a number of years and was also in the higher end of delivery across NHS Wales. Work to further improve our position continues to progress. Under the management of the Turnaround Director the team continues to work with Directorates on a range of areas. The new Performance Management Framework which was introduced during the year, integrates the Turnaround accountability process into it and has generally strengthened the rounded performance management approach by the Executive Team towards the Directorates, this will be developed further in the new financial year.

In response to the findings of the zero based review of the HB healthcare services, the Minister for Health and Social Services approved the release of £27million additional recurrent funding. This was to reflect that the review confirmed the view of the HB that we face a unique set of healthcare challenges that have contributed to the consistent deficits incurred since the inception of the HB and also carried forward from its predecessor organisations. The review findings were that two factors, demographics and scale, generated excess costs that were unavoidable to the Board, however that the other two factors, remoteness and efficiency, did not generate excess costs for the organisation. The intention of the additional recurring funding is to place the HB on a fair funding basis by funding the excess costs identified in the review and provides a sound footing for the Board to develop and transform services. At the same time WG made it very clear that there is an expectation that as a Board we will focus on the costs that are within our control to manage and deliver on the efficiencies identified in the review. The Board therefore supports and is grateful to WG for the commissioning of external support to work alongside the organisation to help reduce the deficit and reach a balanced plan position.

Members of the Executive Team and I continue to meet with the Chief Executive NHS Wales and members of his Senior Team in WG, on a monthly basis. These meetings continue to review progress against the issues raised regarding our TI escalation level with the most

recent meeting taking place in April 2019. The Board, in recognising the significance of this level of escalation and its implications, is continuing to work with WG colleagues to address the long standing challenges we have been facing and see the escalation process as a helpful support mechanism to make progress. As in previous years, our financial position has constantly dominated the conversation at the TI meetings over the last year, with workforce issues also being a cause for concern. All agreed actions are subject to tracking for monitoring purposes and we will be working hard this year to reduce our escalation status.

**Conclusion**

This has been a momentous year for the HB which has seen the Board approve its first ever Health and Care Strategy and its enabling strategies for health and wellbeing and continuous engagement, which describes the long term vision for the population health outcomes for current and future generations and the HB's 10 year Health and Care Strategy. This year has also been about hard choices and continuing on the journey to build sustainable services; the authority and accountability for delivery has been with the Directorates and Triumvirate teams, with the Executive Team driving delivery and holding to account.

As detailed above during 2018/2019 we have made substantial improvements in patient waiting times for planned care, such that by the end of the year we had no patients waiting over 36 weeks for treatment and no one waiting over 8 weeks for access to diagnostics. Our deficit has reduced for the first time in a number of years to £35.4million, although we recognise that we still have much more to do to stabilise our services, and address in particular our workforce challenges and thereby, stabilise and improve our finances. Our Integrated Performance Assurance Report evidences how we track our performance across a range of quality and waiting times targets and our financial performance. However, we recognise we need to significantly improve upon waiting times performance, in particular relating to follow ups, and improve our financial performance even further.

Whilst there have been improvements in our performance this year we must also acknowledge the challenges we have faced and continue to face, particularly in relation to operational challenges both in provided and commissioned services, staffing levels, recruitment and with our estate. There have been occasions when the services we have provided have not been of the standard or quality we would aspire to achieve.

The winter period is without doubt one of the most challenging periods for the NHS. During the year, we have worked very closely with our partners to ensure everything runs as smoothly as possible and to ensure everyone can access the right services when they need them. We want to acknowledge and say thank you to our dedicated staff and volunteers who have shown great commitment and gone above and beyond to rise to these challenges and continue to deliver compassionate and patient centred care.

In the 2019/2020 Annual Plan we will be looking to scope out how many of our services, through Quality and Pathway improvements, could work towards 26 week waits, and for access to therapy services below 14 weeks and for diagnostics waits to become even shorter, so moving the organisation even further forward in the delivery of our Mission Statement. The introduction of the single cancer pathway during 2019/2020 will make us strive for this, and will bring a step change in the improvement of cancer treatment. Delivery of our year end improvement has been acknowledged as a key milestone and momentum needs to continue for 2019/2020.

We acknowledge that because of the significant financial challenges within our current clinical model, we cannot pay as much attention to the prevention agenda as we should. However, in our planning for 2019/2020 we have signalled a step change in the way in which

we do business and to that end we have approved our Health and Wellbeing Framework - Our Future Generations: Living Well. This builds upon and supplements our Health and Care Strategy and is designed to help us focus on our long-term ambitions to deliver better health and wellbeing for all. The implementation of the framework will be fundamental to the success of the strategy, as it signals the shift in mind-set and culture needed in order to put prevention and early intervention at the heart of everything we do, to secure a sustainable future and better health and wellbeing for all. This framework will help drive and align our short and medium term planning to deliver our vision for the future. It is equally important for all of our services to get involved in the first step, 'help me to choose and age well', and our 2019/2020 Annual Plan describes the key actions we need to take to do this.

Whilst the last twelve months have continued to be difficult and challenging for the organisation, stability has been obtained in some areas, with progress continuing in a number of other areas. However, the organisation recognises that this is not good enough and that there is a need to take further steps in 2019/2020 to continue in driving down the deficit year on year. This is consistent with messaging from WG in both the TI and Annual Plan feedback meetings. We continue to meet regularly with WG colleagues to review progress against the issues which raised our escalation level to TI.

It is with some regret that the Board has had to approve a deficit budget for the coming financial year, a decision which was not taken lightly. The level of deficit which has been approved by the Board at its meeting on 29th March 2019 is that of £29.8million for the year, reducing from the final 2018/2019 out-turn deficit of £35.4million. However, in light of the control total for 2019/2020 recently having been confirmed as £25million, and accepting the deficit position is a disappointment, a further, more detailed discussion of the challenges and efficiencies needed was held in a subsequent discussion at the In Committee Board on 11 April 2019 and is planned for our Board meeting scheduled to be held in public on 30 May 2019.

Despite our forecast deficit we are committed to exhibiting best practice in all aspects of corporate governance and recognises that as a body entrusted with public funds, we have a particular duty to observe the highest standards of corporate governance at all times. The Board is provided with regular and timely information on the overall financial performance of the organisation, together with other information on performance, workforce and quality and safety. Formal agendas, papers and reports are supplied to members in a timely manner, prior to Board meetings. The Board's agenda includes regular items for consideration of risk and control and receives reports thereon from the Executive and the ARAC. The emphasis is on obtaining the relevant degree of assurance and not merely reporting by exception.

As detailed above the approval of our Health and Care Strategy at the November 2018 Board meeting was a significant strategic milestone in respect of local services and the exemplary way in which this process was taken forward has been recognised by WG. In moving forward with the delivery of the strategy, we are confident as a Board, that we can manage both the delivery of our existing commitments as well as taking forward our future plans.

The behaviour and culture of the Board are key determinants of the Board's performance. The Board should have it in mind that it is the first line regulator on behalf of the public, and should be confident at all times that they understand and are alerted to any significant failures in controls or gaps in assurance. The Board is focussed on its statutory duties, quality of services, corporate and service risks and organisational needs, while acting responsibly towards its stakeholders, employees, partners and society as a whole. The Board is also simultaneously driving the organisation forward while keeping it under prudent control and is knowledgeable about local issues whilst also aware of wider influences.

In moving forward, achieving a sustainable funding model for the delivery of health care at the HB will not be a quick task to complete and discussions with WG to find the right approach will continue. It is for this reason that the Board supports the WG approach of commissioning external support to work alongside the organisation towards achieving a balanced plan position.

As Accountable Officer and based on the review process outlined above I have reviewed the relevant evidence and assurances in respect of internal control enacted during 2018/2019. The Board and its Executive Directors are fully accountable in respect of the system of internal control. The Board has had in place during the year a system of providing assurance aligned to support delivery of both the policy aims and corporate objectives of the organisation. As highlighted earlier in this statement overall Board and Committee effectiveness is generally sound contributing to an effective internal control system. My review confirms that although there have been some internal control issues which have been identified during the year with remedial action taken to address these, the Board has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that no significant internal control or governance issues have been identified.

Signed by

Steve Moore
Chief Executive:

Date: 29th May 2019

## Appendix 1 – Board and Committee Membership & Champion Roles

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| Bernardine Rees | Chair | | • Board (Chair)<br>• Remuneration & Terms of Service Committee (Chair)<br>• University Partnership Board | 8/8<br>2/3<br>1/4 | • Unscheduled Care |
| Judith Hardisty | Vice Chair | Mental Health Primary Care & Community Services | • Board (Vice Chair)<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee (Vice Chair)<br>• Finance Committee<br>• Mental Health Legislation Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• Primary Care Applications Committee | 8/8<br>7/8<br>6/6<br>4/6<br>2/3<br>4/6<br>6/6 | • Carers |
| Judith Hardisty | Interim Chair | | • Board (Chair) | 1/1 | • Unscheduled Care |
| Julie James until April 2018 | Independent Member | Third Sector | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• (Vice-Chair) Audit & Risk Assurance Committee<br>• (Vice-Chair) Primary Care Applications Committee | 0/1<br>0/1<br>0/1<br>0/1<br>1/1 | • NHS (Concerns; Complaints and Redress Arrangements (Wales) |
| Anna Lewis | Independent Member | Community | • Board<br>• Charitable Funds Committee<br>• Quality, Safety & Experience Assurance Committee<br>• Primary Care Applications Committee | 8/9<br>2/4<br>5/5<br>4/5 | • Public and Patient involvement |
| Professor John Gammon | Independent Member | University | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & | 8/9<br>4/6 | |

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| | | | Experience Assurance Committee (Chair)<br>• Remuneration & Terms of Service Committee<br>• University Partnership Board (Chair) | 6/6<br>3/3<br>4/4 | |
| Owen Burt | Independent Member | Third Sector | • Board<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Primary Care Applications Committee | 8/9<br>6/7<br>4/5<br>4/4<br>5/5 | Design |
| David Powell | Independent Member | Information Technology | • Board<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee (Chair)<br>• Finance Committee<br>• Primary Care Applications Committee ( Vice-Chair)<br>• Remuneration & Terms of Service Committee<br>• Quality, Safety & Experience Assurance Committee | 9/9<br>8/8<br>6/6<br>7/7<br>6/6<br>3/3<br>6/6 | |
| Simon Hancock | Independent Member | Local Government | • Board<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee (Chair)<br>• Mental Health Legislation Assurance Committee<br>• University Partnership Board (Vice-Chair) | 8/9<br>7/8<br>6/6<br>4/4<br>2/4<br>3/4 | • Older People<br>• Equalities & Diversity<br>• Flu<br>• Emergency Planning<br>• Armed Forces & Veterans |
| Adam Morgan | Independent Member | Trade Union | • Board<br>• Charitable Funds Committee<br>• Quality, Safety & Experience Assurance Committee (Vice-Chair)<br>• Mental Health Legislation Assurance Committee | 7/9<br>2/4<br>5/6<br>3/4 | |

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| | | | • University Partnership Board | 3/4 | |
| Delyth Raynsford | Independent Member | Community | • Board<br>• Charitable Funds (Vice-Chair)<br>• Mental Health Legislation Assurance Committee (Vice-Chair)<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 8/9<br>3/4<br>3/4<br>6/6<br>3/4 | • Welsh Language<br>• Cleaning, Hygiene and Infection Management<br>• Children, Young People & Maternity Services<br>• Nutrition & Hydration<br>• NHS Concerns complaints and redress arrangements |
| Mike Lewis | Independent Member | Finance | • Board<br>• Audit & Risk Assurance Committee (Vice-Chair)<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Finance Committee (Vice-Chair)<br>• Mental Health Legislation Assurance Committee | 9/9<br>8/8<br>6/6<br>4/4<br>5/7<br>2/4 | |
| Paul Newman | Independent Member | Community | • Board<br>• Audit & Risk Assurance Committee (Chair)<br>• Remuneration & Terms of Service Committee<br>• Mental Health Legislation Assurance Committee | 7/9<br>7/8<br>3/3<br>3/4 | |
| Steve Moore | Chief Executive Officer | | • Board<br>• Finance Committee<br>• Remuneration & Terms of Service Committee | 9/9<br>6/7<br>3/3 | • Time to Change Wales Mental Health |
| Joe Teape | Deputy Chief Executive Officer/ Director of Operations | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Finance Committee<br>• Quality, Safety & Experience Assurance Committee | 9/9<br>6/6<br>4/7<br>6/6 | • Delayed Transfers of Care<br>• Sustainable Development<br>• Security<br>• Fire Safety |

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| | | | • Mental Health Legislation Assurance Committee | 3/4 | |
| Karen Miles | Executive Director of Planning, Performance & Commissioning | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 9/9<br>6/6<br>6/6<br>2/4 | |
| Stephen Forster (until September 2018) | Executive Director of Finance | | • Board<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Quality, Safety & Experience Assurance Committee<br>• Finance Committee | 4/4<br>5/5<br>3/3<br>1/1<br>0/3<br>1/2 | |
| Huw Thomas | Interim Director of Finance until September 2018 & Executive Director of Finance | | • Board<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Finance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 5/5<br>4/4<br>3/3<br>3/3<br>7/7<br>2/3<br>1/2 | |
| Mandy Rayani | Executive Director of Nursing, Quality & Patient Experience | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 9/9<br>5/6<br>6/6<br>3/4 | • Violence & Aggression<br>• Children's Act 2004<br>• Children Young People and maternity services |
| Jill Paterson | Director of Primary Care, Community and Long Term Care | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance | 9/9<br>3/6<br>5/6 | |

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| | | | Committee<br>• Primary Care Applications Committee | 5/6 | |
| Alison Shakeshaft | Executive Director of Therapies and Health Science | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 9/9<br>5/5<br>6/6<br>3/4 | |
| Lisa Gostling | Executive Director of Workforce & Organisational Development | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Finance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• Remuneration & Terms of Service Committee<br>• University Partnership Board | 9/9<br>5/6<br>7/7<br>6/6<br>3/3<br>4/4 | |
| Ros Jervis | Executive Director of Public Health | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 9/9<br>3/6<br>6/6<br>1/4 | • Emergency Planning |
| Sarah Jennings | Director of Partnerships & Corporate Services | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 7/9<br>3/6<br>4/4<br>3/6<br>4/4 | • Public Patient Involvement |
| Joanne Wilson | Board Secretary | | • Board<br>• Audit & Risk Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• Remuneration & Terms of Service Committee | 9/9<br>8/8<br>6/6<br>3/3 | |

| NAME | POSITION | AREA OF EXPERTISE REPRESENTATION ROLE | BOARD COMMITTEE MEMBERSHIP/ATTENDANCE | ATTENDANCE AT MEETINGS | CHAMPION ROLES |
|---|---|---|---|---|---|
| Phil Kloer | Executive Medical Director & Director of Clinical Strategy | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | 9/9<br>5/6<br>5/6<br>4/4 | • Patient Information |
| Andrew Carruthers | Turnaround Director | | • Board<br>• Business Planning & Performance Assurance Committee<br>• Finance Committee | 9/9<br>3/6<br>6/7 | |
| Libby Ryan-Davies | Transformation Director | | • Board<br>• University Partnership Board | 5/9<br>1/4 | |
| In line with Standing Orders and approved Terms of Reference, on some occasions appropriately briefed deputies (for Executive Directors) have counted towards quorum and attendance at Board and its Committees. | | | | | |

## Appendix 2 – Summary of the work of Board Committees

### 2.1 Audit & Risk Assurance Committee (ARAC)

The ARAC continues to receive progress updates directly as and when requested, including any reports relating to clinical governance issues, having previously been referred for further consideration to the Quality, Safety & Experience Assurance Committee (QSEAC). In addition, each of the Board Committee Chairs and Lead Executives are requested to attend the ARAC on a cyclical basis, at least annually, to provide assurance that the Committee is fully discharging its duty and complying with the requirements of its Terms of Reference.

Acting on the outcomes of effectiveness reviews is as important as undertaking them and it is desirable that outcomes and associated actions are reported appropriately. Where reports received a less than reasonable assurance audit rating or where there are specific areas of concern, the appropriate Executive Directors were requested to attend Committee meetings. This process provided opportunities to discuss the reports more fully, and for the Committee to satisfy itself that the findings raised in the reports were being addressed and recommendations implemented to address control weaknesses or compliance issues.

All audit recommendations are tracked in one place with a detailed audit tracker being periodically considered by the ARAC. In its Annual Audit Report 2018 WAO recognised that the HB is making steady progress in addressing previous issues identified and that it has effective arrangements in place to track audit recommendations. The ARAC has a key role to play in supporting the application of good governance principles in decision making and is well placed to understand the risks to good governance faced by HB, such as risks arising from external factors, e.g. legislative changes or risks arising from changes or initiatives within the organisation.

The Committee is responsible for overseeing risk management processes across the organisation and has a particular focus on seeking assurance that effective systems are in place to manage risk and that the HB has an effective framework of internal controls that addresses principal risks. The Committee is responsible for monitoring the assurance environment and challenging the build-up of assurance on the management of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied on and reviewing the internal audit plan in year as the risk profiles change. The ARAC has received bi-annual reports from Board level committees, providing assurance that risks are being managed appropriately and that the risk management framework and process is effective.

In line with Standing Orders, and in the interest of probity and transparency, the Committee received reports relating to all Single Tender Actions during the course of the year. Although some concern was expressed at the beginning of the year regarding the continuing trend of increasing volume and value of single tender actions being received by the Committee, the most recent internal audit report indicates a reduction in both volume and value.

In accordance with the ARAC Handbook, the Committee reviewed the adequacy of arrangements for declaring, registering and handling gifts, hospitality and sponsorship currently enacted by the Board.

The HB must effectively seek to promote the counter fraud agenda and ensure that the appropriate action is taken when an allegation of fraud is received. The role of the ARAC is to ensure the promotion and implementation of the policy and compliance is monitored by the Committee through the reports of counter fraud activity received and the Annual Counter Fraud Work Plan. The Committee received the 2018/2019 Annual Work Plan of the Local Counter Fraud Officer, ensuring that it had an appropriate level of coverage and received regular reports to monitor progress against the plan. These reports provided an overview of current cases, details of concluded fraud investigations, policy and procedure reviews, actions

being taken to deter and prevent fraud and to raise fraud awareness throughout the HB. The Counter Fraud Service is taking various approaches to achieve this, including the use of tools such as the new Twitter account.

Regular Financial Assurance Reports have been presented to the ARAC. This is consistent with the Committee's role of maintaining an appropriate financial focus by demonstrating robust financial reporting and that the maintenance of sound systems of financial control are enacted. The HB's position has remained as that of "Targeted Intervention" status during the year, primarily as a result of the underlying financial position and performance challenges that the HB faces. The Committee has closely monitored the enhanced escalation status of the HB during the year with the Joint Escalation & Intervention Arrangements being a standing agenda item for its meetings.

Reports from the following Committees were received which provided assurances that the respective Committee's Terms of Reference, as set by the Board, are being adequately discharged:

- University Partnership Board;
- Primary Care Applications Committee;
- Business Planning & Performance Assurance Committee (BPPAC);
- Quality, Safety & Experience Assurance Committee (QSEAC);
- Mental Health Legislation Assurance Committee (MHLAC);
- Finance Committee;
- Charitable Funds Committee.

Whilst it is recognised that Committees are discharging their Terms of Reference adequately, there are still improvements to be made to strengthen the assurance and risk focus of the Sub-Committees. It was highlighted in particular that the QSEAC has been on a development journey with this work continuing.

The ARAC, in accordance with best governance practice, has undertaken a self-assessment and evaluation of its own performance and operation. In response to the requirement for continual improvement of the self-assessment process, the questionnaire answered by members included enhancements regarding the work of Internal Audit, External Audit and Counter Fraud, with members also being asked to consider their individual understanding, role and contribution to the Committee. Members were constructive in their responses, commenting on processes and procedures, with areas for development being identified.

This suggested the need to continue with a risk based approach to agenda setting to cover off the key areas of Committee business in order to provide assurance to the Board on the management of key risks throughout the year. The key relationship between the ARAC, the QSEAC and the BPPAC should be considered as part of the review of their respective Terms of Reference, and the arrangement whereby the Lead Directors for both the QSEAC and the BPPAC are invited to attend the ARAC at least annually to receive assurance that they are effectively discharging their Terms of Reference should continue. Development of each Committee's Decision Tracker into an overall Board and Committees Decision Tracker should further assist with this.

Given the above outline of the work of the ARAC, the following specific comments/ observations, in addition to those deemed as requiring Board Level Consideration or Approval, were noted during the year:

- Continued concerns regarding Clinical Audit and governance regarding non-participation, with it noted that this is an area where decisions would be raised to Board level;
- Revisions made to the Internal Audit Charter, including new escalation protocols, timescales, processes and rules;

- The revised Audit Tracker holding to account arrangements;
- Concern regarding and the risks to, the financial position and delivery of the planned deficit position;
- Concerns regarding the potential resource impacts (both financial and staff) on Hywel Dda's Public Health Wales Resources arising from the WAO report on Collaborative Arrangements for Managing Local Public Health Resources;
- The continuing concerns regarding the Physical Verification of Fixed Assets & PII Internal Audit report;
- Monitoring of the Joint Escalation & Intervention Arrangements;
- Disquiet regarding delays in payments to suppliers, particularly in the case of smaller companies where this can result in significant impact;
- The need for the HB to strengthen its governance and reporting regarding Maternity Services due to the inherent risks and potential cost, both in human terms and clinical negligence claims;
- Risks in dealing with private sector companies for capital projects.

**2.2 Business Planning & Performance Assurance Committee (BPPAC)**

In keeping with its purpose as outlined in its Terms of Reference, the BPPAC has provided support to the Board on the following:

- The development of delivery plans within the scope of the Committee, their alignment to the IMTP, their delivery, and any corrective action needed when plans are off track;
- Monitor the development and delivery of the enabling strategies within the scope of the Committee, aligned to organisation objectives and the Integrated Medium Term Plan for sign off by the Board;
- Quality assure and approve all delivery plans required by WG, ensuring alignment with the HB's strategy and priorities;
- Assure that best practice and national guidelines are adopted in service development plans and pathways;
- Ensure significant service change proposals approved by the Board pass through a gateway process before being approved by the Committee for implementation;
- Develop and regularly review the performance management framework and reporting template, ensuring it includes meaningful, appropriate and integrated performance measures, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible, including workforce performance matters;
- Scrutinise the performance reports prepared for submission to the Board, provide exception reports where performance is off track, and undertake deep dives into areas of performance as directed by the Board;
- Scrutinise the performance reports for submission to the Board and related to external providers, the Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee, the NHS Wales Shared Services Partnership, and the Joint Regional Planning & Delivery Committee, and hosted services (including the Low Vision Service Wales), provide exception reports where performance is off track, and undertake deep dives into areas of performance as directed by the Board;
- Ensure robust interface protocols are in place with regard to the NHS Wales Shared Service Partnership and test their efficacy on a planned programme of review;
- Monitor performance and controls with regard to Primary Care contracts;
- Approve the criteria for usage of Prescribing Management Savings and sign off individual applications;
- Provide advice and assurance to the HB in relation to the effectiveness of local partnership governance arrangements;
- Provide assurance to the Board that arrangements for Capital, Estates and IM&T are robust and consider proposals from the Capital, Estates and IM&T Sub Committee on the allocation of capital and agree recommendations to the Board;

- Agree usage of in-year monies from WG, ensuring alignment with the HB's strategy and priorities and sign off business cases;
- Provide assurance to the Board that arrangements for information governance are robust;
- Provide assurance to the Board in relation to the organisation's arrangements for health, safety, security, fire and emergency preparedness, resilience and response, including business continuity;
- Refer business and planning matters which impact on quality and safety to the Quality, Safety Experience & Assurance Committee, and vice versa;
- Receive advice from the Medicines Management Group and agree on the managed entry of new drugs, taking into account the resource and service implications;
- Approve corporate policies and plans within the scope of the Committee;
- Review and approve the annual work plans for the Sub-Committees which have delegated responsibility from the BPPAC and oversee delivery;

Specific comment made during the year by the Committee included the following:

- The scale of the issues involved in relation to the diminishing and sub-standard accommodation facilities in place across the HB;
- Pressure points within unscheduled care which are having an effect on access, quality and patient experience;
- Monitoring of Welsh Health Circulars (WHCs) - Recognising the implications for quality and safety of non-compliance with a number of these circulars, the Committee requested assurance that these were being addressed and directed that firmer updates on progress were required for monitoring by BPPAC in future. The need to ensure the quality & safety implications that derive from these are programmed into QSEAC's agenda was agreed;
- Mortality Exception Report - The Committee received the HB's mortality indicators and members were assured that following a significant review of the handling of the HB's mortality review arrangements, variations in the way in which reviews are undertaken were to be addressed and changed to the All Wales process;
- Concerns regarding the HB's deteriorating financial run rate to be mitigated through operational savings delivering at pace, with the recently established CEO Holding to Account meetings helping to build a rhythm and focus for this work;
- Concerns in regard to the delay in implementing WEDS and other national IT programmes, given the HB's reliance on these and the limited exercise it can individually control;
- Concerns regarding recruitment performance to be considered by the Workforce & OD Sub-Committee;
- Concerns regarding the varied performance with clinical coding across the organisation, with an acknowledgement that although funding for additional coders has been escalated, a resolution would not be forthcoming in the short term;
- Concerns regarding the HB's lack of an organisational wide policy for the storage of confidential waste, to be addressed through guidance issued to staff highlighting the importance of storing confidential waste, with an update on improvements to be presented to the Sub-Committee;
- Concerns that non-compliance against the NIS Directive project could result in a £17million fine, with an All Wales strategy required to address this, and cyber security risks going forward;
- Concerns regarding the number of objectives within the 2018/2019 Annual Plan making it difficult to monitor and provide assurance, with the suggestion that each Director look at their own particular area to reduce the number of objectives and agreed the most 'impactful' actions;

- Concerns that the £2.5million for pre-commitments in association with the 2019/2020 Discretionary Capital Programme (DCP) are significantly higher than that which has previously been considered by BPPAC which could impact on other requests;
- Concerns regarding the delay in implementing the HB's Lockdown Policy;
- Concerns regarding to the increased risk in the HB's ability to provide aseptic medicines due to having to outsource aseptic unit work given the two transgressions of water in the GGH Aseptic Unit during the past 2 months and information requested on the actions taken to manage the risks involved;
- Concerns regarding the roll out of MTED in BGH given that Executive Team had agreed the system is not a sufficient priority for the HB, and suspended further roll out.

**2.3. Quality, Safety & Experience Assurance Committee (QSEAC)**

In accordance with its Terms of Reference, specific comment was made by the Committee on the following:

- Patient quality and safety concerns due to the on-going challenges in regard to medical recruitment within mental health services, where medical resources will be re-directed to provide essential medical cover where necessary;
- As the Directorate is heavily reliant on locum cover, measures will be established to increase psychiatric training to reduce the impact of this on service provision for patients;
- Continuing concerns in regard to access for children and young people of Hywel Dda to the Sapphire Suite at the SARC in Swansea Bay HB. To ensure regional SARC provision for Hywel Dda patients, a service level agreement has been established with Cardiff & Vale Health Board;
- Concerns with regard to patient impact once the refurbishment works on the aseptic units commence;
- Given the Committee's concerns regarding the current dermatology pathway due to a lack of Consultant capacity, a report on dermatology and the mitigating actions to address these concerns will be presented;
- Given the concerns raised in regard to delayed follow up appointments, a further report to be presented to QSEAC in April 2019 to provide assurance that the current mitigations in place are having an effect;
- Vascular Service Clinical Progress Report and Action – Given the Committee's concerns regarding the impact on patient outcomes due to delays in vascular service provision, an update on recent outcome data will be presented to QSEAC in April 2019;
- Dementia Care Progress Report - Given that funding will be required to increase the workforce to improve patient access to Dementia services, a further report will be provided for the Board's assurance;
- Fragility of Mental Health Services - concerns regarding the 18 month delay on progression to a new Patient Administration System within Mental Health to be addressed by an interim plan put in place by the Assistant Director of Informatics to mitigate against the fragilities within the current system;
- Strategic Safeguarding Sub-Committee Exception Report - concerns regarding learning from safeguarding reviews which regularly identify poor record keeping, information sharing and communication to be addressed both in action plans and in staff training;
- Histopathology Staffing And Accommodation Issues – key service risks facing the Cellular Pathology (Histopathology) service and the potential consequences of these on the HB's patients and staff to be mitigated by consideration of the appointment of Advanced Nurse Practitoners to undertake some of the duties routinely undertaken by Consultant staff within this specialty which is currently a shortage profession, together with an exploration of regional solutions with Swansea Bay HB and the JRPDC.

## Appendix 3 – Highest Scoring Strategic Risks on CRR/BAF

| *Risk 626 Failure to realise all the efficiencies and opportunities from the Turnaround Programme* | | |
|---|---|---|
| Current Risk Score: 20 | Target Risk Score: 8 | Tolerable Risk Level: 8 |
| This risk represented the possibility that the HB would fail to deliver the full £30.7million savings. The HB did deliver £30.7million savings by the agreed date of 31 March 2019. This was achieved through operational savings of £26.4million with the gap mitigated through a range of recovery savings actions to the value of £6million. A new risk to reflect the HB's new savings target for delivery in 2019/2020 is being drafted and will be considered by Executive Team for the CRR. | | |

| *Risk 627 Ability to implement the HB Digital Strategy within current resources to support the HB's long term strategy* | | |
|---|---|---|
| Current Risk Score: 20 | Target Risk Score: 6 | Tolerable Risk Level: 6 |
| Suitable resources as outlined within the Digital Futures Programme will allow the programme to the delivered in line with the HB's Health and Care Strategy, and therefore realise the benefits. | | |

| *Risk 628 Fragility of therapy provision across acute and community services* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 16 | Tolerable Risk Level: 8 |
| There are significant gaps in the therapy service provision across acute, community and primary settings from under-resourcing and vacancies due to recruitment/retention issues and national shortages. Across all therapy services, current demand does not always align to current capacity and whilst this is being mitigated by the controls in place, it is not sustainable and a long term solution needs to be developed and resourced. | | |

| *Risk 624 Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 16 | Tolerable Risk Level: 6 |
| Although there are a number of controls in place, the risk score cannot be reduced significantly within the current capital allocation. The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk. | | |

| *Risk 629 Ability to deliver against Annual Plan targets against rising demand in unscheduled care* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 12 | Tolerable Risk Level: 8 |
| Whilst current performance shows an improving trend since December 2017 across Unscheduled Care for 4 hour waits in A&E and ambulance delays, the number of 12 hour waits in A&E continues to increase. In addition, the recent Delivery Unit report on complex discharge advised that although the HB is taking the right actions, they are not being consistently implemented across the system due to workforce and capacity pressures. It is unlikely that the current workforce and service models will support the HB to meet current standards and improve unscheduled care performance. The HB's current financial position makes it unrealistic to reduce the target risk score of 12 at this point in time. | | |

| *Risk 625 Ability to recruit, retain and engage clinical staff to meet rising demand and deliver the long term clinical services strategy* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 8 | Tolerable Risk Level: 8 |
| The HB's current reliance on locum and agency staff use remains higher than it would wish it to be. The fill rates for agency and locum staff however remain good. Recognising the national shortages across a number of areas and our geographical area, it will take a number of years to know whether planned actions are successful in addressing the current recruitment issues. There is renewed focus on retaining staff already employed by the HB by reinforcing the values and behaviours framework and through targeted OD activities to reduce the need to recruit new staff. | | |

| *Risk 632 Ability to fully implement WG Eye Care Measures (ECM)* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 8 | Tolerable Risk Level: 6 |
| The known number of current delays in ophthalmology follow-ups would indicate that the HB would not currently meet the new ECM standards. The HB is developing a 3 year eye care plan and has recently received £196,117 in capital funding to support infrastructure deficits which will help to enable the future implementation of a sustainable model of care. | | |

| *Risk 686 Delivering the Transforming Mental Health Programme by 2023* | | |
|---|---|---|
| Current Risk Score: 16 | Target Risk Score: 8 | Tolerable Risk Level: 6 |
| The Mental Health and Learning Disabilities Directorate have completed a consultation in respect of a revised service model which should reduce the reliance on our inpatient services. Delivery of the TMH programme within the timescales agreed by Board is dependent on securing the required capital and programme support therefore the target score reflects the uncertainty associated with both these requirements. | | |

**Highest Scoring Operational Risks on CRR**

| *Risk 451 Cyber Security Breach* | | |
|---|---|---|
| Current Risk Score: 20 | Target Risk Score: 12 | Tolerable Risk Level: 6 |
| There are daily threats to systems which are managed by NWIS and HB. Increased patching levels will help to reduce to impact of disruption from a cyber threat however this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. | | |

| *Risk 245 Inadequate facilities to store patient records and investment in electronic solution for sustainable solution* | | |
|---|---|---|
| Current Risk Score: 20 | Target Risk Score: 4 | Tolerable Risk Level: 6 |
| This risk needs significant resources and planning to identify, fund and implement a long term sustainable solution that will provide more effective patient care, more appropriate working conditions for staff and financial sustainability. Without this, the risk will not be reduced in the near or long term | | |

| |
|---|
| future. |

| *Risk 634 Overnight theatre provision in Bronglais General Hospital* | | |
|---|---|---|
| Current Risk Score: 15 | Target Risk Score: 5 | Tolerable Risk Level: 6 |
| There is currently a resident Operating Department Practitioner 24/7 at Bronglais Hospital alongside a resident anaesthetic and obstetric team. The theatre scrub team currently works on an on-call basis from home, which must be within 20 minutes travelling distance from the site. There is the potential for outside factors to impede timely arrival on site which are outside the control of the team which is reflected in the likelihood score of 3. While there have been no breaches of the 30 minute target it remains a potential risk which could have significant consequences. The Bronglais unit is classified as a low risk midwifery centre, with mothers assessed as being at high risk of complications during labour requiring medical intervention, being managed though the Maternity Unit in Carmarthen. | | |

| *Risk 508 Insufficient resources in fire safety management to undertake appropriate PPMs, risk assessments and audits* | | |
|---|---|---|
| Current Risk Score: 15 | Target Risk Score: 5 | Tolerable Risk Level: 6 |
| Significant progress has been made since the NWSSP IA Fire Precautions Report in May 2017 to improve fire safety. Additional resources have been now been approved and posts will be appointed to by March 2019. These posts will help to increase the pace of delivery of required improvements which will lead to an improvement in compliance and the level of fire safety in the HB. | | |

## Appendix 4 – HIW Activity

In respect of inspection activity in the HB's acute hospitals, an inspection was undertaken in Wards 1, 2 and 10 in Withybush General Hospital which found that the service provided a respectful, dignified, safe and effective service; however improvements were required to further promote the safe and effective care of patients. Although there were 6 immediate concerns related to the checking of resuscitation equipment, fire escape route on Ward10 and the use of their corridor as a thoroughfare and the daily checking of drug fridge temperatures, these have all now been addressed. There were further recommendations made within the report, all except two have been implemented or are on track to be implemented within agreed timescales.

A follow up inspection took place in the Trauma and Orthopaedic Service in Bronglais General Hospital which reported that the service strived to provide safe and effective care. However, HIW found some evidence that the HB was not fully compliant with all Health and Care Standards in all areas. The HB had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection. However, some areas remained in need of improvement. There were 15 recommendations from this inspection, all except 2 have been implemented to date. HIW also undertook an announced Ionising Radiation (Medical Exposure) Regulations inspection of Bronglais General Hospital. Overall, HIW found compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 however, an additional employer's procedure was needed in respect of a quality assurance programme for X-ray equipment. 9 recommendations were made, 4 of which have been implemented, with the remaining 5 on track for delivery.

In respect of inspection activity across the HB's mental health and learning disabilities, there was an unannounced inspection of Bryngofal Ward, Prince Philip Hospital, which found that the care provided was generally safe and effective, although there was evidence that the HB was not fully compliant with all Health and Care Standards in all areas. There was a requirement to provide HIW with immediate assurance in regard to the effectiveness of the alarm system as this seemed to be an area of concern in many of the mental health and learning disability services provided by the HB which could compromise the safety of patients, staff and visitors. Recommendations made in the final reports related to the auditing of Mental Health Act documentation and the requirement to review compliance with the legislative requirements of the Act. There were also concerns regarding the fragility of the service from a medical staffing perspective. All recommendations have been implemented by the service.

During 2018/2019, HIW undertook 2 announced inspections across general practices, Meddygfa'r Sarn and Meddygfa Minafon that are in the management of the HB. At Meddygfa'r Sarn, HIW found that the HB had made some progress against the improvements identified during the inspection in 2017, although it found others had not been addressed, and additional work was still required to ensure the Health and Care Standards were being met. HIW found that the management team within the practice were committed to making positive changes for the benefit of both staff and patients, and required the support, leadership and guidance from the HB to ensure that all recommendations are achieved. 6 out of the 13 recommendations have slipped beyond the original timescales. The inspection at Meddygfa Minafon found that the practice was unable to demonstrate that progress had been made against all previously identified improvements with many needing further action. A number of additional areas were also identified where the HB was not compliant with all the Health and Care Standards. 15 recommendations were made, with 12 already implemented and the remaining 3 on track for delivery within the agreed timescales.

During 2018/2019, HIW and Care Inspectorate Wales (CIW) undertook a joint thematic review focussing on community adult mental health services (people between the ages of 18-65), looking at Community Mental Health Teams (CMHTs), with an inspection visit to one

CMHT in each HB area. As part of this joint review, an announced inspection of the Community Mental Health Team in North Ceredigion took place, which found that the service provided safe and effective care to its service users, although there was some evidence that service was not fully compliant with all Health and Care Standards (2015) and the Social Services and Wellbeing (Wales) Act 2014. It was acknowledged by HIW that the service was in a period of change, with a new model in the process of being designed and implemented, and found that there was a clear focus from management and positivity from both management and staff to implement the changes for the benefit of service users. In addition, the quality of patient care and engagement with service user and their carers was found to be of a good standard and access to the service had improved very recently, meaning that service users were being seen in a timely manner. The quality of record keeping was of a good standard, however hindered on occasion by the use of two IT systems. There was a good multidisciplinary approach with regards to service users' assessments, care planning and reviews. Care plans were strength based and recovery focussed. The Child Mental Health Team (CMHT) and the Crisis Resolution Home Treatment Team (CRHTT) demonstrated positive working relationships for the benefit of their service users. Discharge arrangements were satisfactory, in general, and tailored to the wishes and needs of service users. Staff were found to be clear about their responsibilities in relation to safeguarding adults and children and were able to describe the reporting process. 5 out of the 17 recommendations have been implemented, with the remaining 12 on track with agreed timescales.

HIW also undertook 2 further thematic reviews in 2018/2019, 1 into patient discharges from hospital to general practice which resulted in 13 recommendations, 9 of which have been implemented with the remaining 4 on track for delivery within agreed timescales. The other review related to how healthcare services were meeting the needs of young people. The HB has not yet been asked to respond to the findings within this recently published report.

## Appendix 5 Primary Care Governance

### Primary and Community Quality, Safety and Experience Working Group

Any issues related to governance including performance dashboards, exception reports and risk registers are presented at this forum. Where the issues relate to information technology (IT) or delivery of the primary care elements of the Integrated Medium Term Plan (IMTP), these issues are discussed at the BPPAC, particularly if it involves collaborative work with both primary and secondary care to resolve some of the IT and governance issues.

### Primary Care Performance Group & Performance Issues Group

These two groups meet on a bi-monthly basis to review dashboards and discuss Primary Care performance and exceptions across all the contractor groups. The Performance Concerns Group will review any issues which have been identified from a number of sources including General Medical Council, General Dental Council, complaints and incidents, Ombudsman reports, whistle-blowing relating to the performance of GP's, Dentists, Pharmacists and Optometrists in line with the relevant Performers List regulations and contracts. This Group makes decisions on whether there is sufficient information to warrant commissioning an investigation which will inform the decision regarding whether a formal Performance Concerns process is required in line with national guidance and/or WHC. The group monitors any ongoing conditions that a performer may be working to which have been imposed by the HB or by the relevant governing body.

### Clinical Governance Primary Care Self- Assessment Tool (CGPSAT)

This Tool is designed to encourage GP practices to reflect and assess the governance systems they have in place in order to facilitate safe and effective clinical practice, and can be mapped to Health and Care Standards in Wales. The CGPSAT may act as an assurance to the HB and to other bodies, such as the General Medical Council, Community Health Councils and HIW that such systems are in place and effective or, if not, that the practice is planning to introduce or improve such systems.

### Information Governance (IG) Toolkit

Due to the ongoing relaxation of Quality and Outcomes Framework (QOF) there is no formal requirement for Practices to continue to undertake the IG Toolkit; it is however recognised as good practice and Practices are advised to continue with its completion. Community pharmacy contractors must complete an on-line Clinical Governance Toolkit and an Information Security Management System Toolkit (ISMS) every year. NWIS update the HB with details of any outstanding toolkits and forward completed toolkits for responses to be reviewed. Non-response to any question or areas of concern are taken up with the individual contractor.

### Community Pharmacy Contractual and Performance Monitoring

The Community Pharmacy Dashboard monitors activity and performance. The main monitoring for Community Pharmacy is via the on-line toolkits, submission of audits, and level of complaints. Pharmacies have to complete an annual on-line Clinical Governance Self-Assessment Toolkit and an Information Security & Management System (ISMS) Toolkit by 31 March and are monitored as to whether it's been completed from the beginning of April by the NHS Wales Informatics Service. Community pharmacy contractors have been subject to Post Payment Verification (PPV) visits since early 2016 for specific services. Reports of PPV visits are provided to the HB detailing any findings and recommendations. These are reviewed and any actions notified to the PPV team. These can include revisits, or recovery of monies.

### National Enhanced Service Accreditation

In order to provide a pharmacy based National Enhanced Service, a Pharmacist (or Pharmacy Technician for some services) must complete the new National Enhanced Service

Accreditation Process (NESA). An individual must complete 9 Generic Skills & Competency modules on-line. These include; Improving Quality Together, Safeguarding Children & Young People L2, Protection of Vulnerable Adults, Patient Centred Consultation Skills, Information Governance and Making Every Contact Count. In addition a specific clinical knowledge assessment must be completed related to each enhanced service that the Pharmacist/Technician is seeking to provide e.g. Smoking Cessation, Emergency Contraception. The process is overseen by Health Education & Improvement Wales (HEIW).

**Dental Services**

A Dental Planning, Performance and Delivery Forum ensures that there is a robust process in place for the planning, delivery and monitoring of dental services performance across the whole of the HB. Dental Contractual and Performance Monitoring is undertaken at bi-monthly Dental Performance and Quality meetings whilst a Dental Quality and Safety Group oversees clinical governance in dentistry provided in salaried and contracted services across primary and secondary services, for which the HB has responsibility.

Further support is provided from the Dental Quality and Safety Group which integrates its work with the HB's wider Clinical Governance structures with its work including ensuring that there is a robust system of reporting and addressing clinical risks/incidents and this is undertaken in accordance with the HB's overarching policies and procedures.

All Primary Care Dental Practices are required to complete a self-assessment QAS questionnaire on an annual basis. The responses submitted are reviewed by the HB's Dental Practice Advisor (DPA) and reported back to the bi-monthly Dental Quality and Safety Group meetings. Recommended actions are then followed up and reported back into the Dental Quality and Safety meetings for sign off or escalation, to the HB's wider Clinical Governance structure.

**Optometry Performance**

Eye Health Examinations Wales (EHEW) and Low Vision Services Wales (LVSW) are monitored and reported at an All Wales level through the services' Joint Committees. HB reporting is through the HB's Eye Care Collaborative Group (ECCG) which feeds in to the All Wales Eye Care Steering Board. Optometry performance is shown as part of the monthly primary care performance report and is scrutinised in the Primary Care Management Group.

**Post Payment Verification (PPV)**

PPV is a process, contracted out to NWSSP Primary Care Services, which provides the HB with the assurance that practices are appropriately claiming for enhanced service activity. The PPV team will visit every GP practice on a 3 year rolling programme and audit a selection of the claims submitted in the past 3 years; any claiming errors found will result in a recovery from that practice following authorisation from the HB. If the claiming errors amount to 10% or more of the claims made, a revisit is organised to that practice, within the next 12 months, to look at all claims for that particular enhanced service for the 3 years and a further recovery of monies is made if appropriate.

The PPV team at NWSSP review specific services for Community Pharmacy, Medicine Use Reviews and Influenza Vaccinations. A selection of on-line claims is chosen and visits made to pharmacies to verify supporting documentation, including patient consent. A report of each visit is sent to the HB for review and confirmation of any action to be taken. This is usually in the form of a recovery for any unverified claims and whether a pharmacy should be listed for a follow-up visit earlier than it next scheduled 3 yearly one based on the error rate identified. During the PPV visits, a Duty of Care audit is also undertaken of the pharmacies process for accepting, storing and disposal of returned waste medicines, to measure compliance with Waste Regulations.

# Hywel Dda University Health Board

## Directors Report

## 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

## The Directors' Report

The following tables contain:

Table 1 Detailed information in relation to the composition of the Board and including Executive Directors, Independent Members, Advisory Board Members and who have authority or responsibility for directing or controlling the major activities of Hywel Dda University Health Board during the financial year 2018/2019.

Table 2 Details of company directorships and other significant interests held by members of the Board which may conflict with the responsibilities as Board members.

Table 3 Details relating to membership of the Board level assurance committees and the Audit and Risk Assurance Committee.

### TABLE 1

| Name | Date Appointed | Appointment Term | Position on Board/Board Champion |
|---|---|---|---|
| **Judith Hardisty** | 16.01.2017<br>01.03.2019 | 31.03.2020 | Vice Chair<br>Interim Chair |
| **Paul Newman** | 01.04.2017 (Independent Member)<br>06.03.2019 (Interim Vice Chair) | 31.03.2019 | Independent Member<br>Interim Vice Chair |
| **Adam Morgan** | 01.04.2016 | 31.03.2022 | Independent Member |
| **David Powell** | 01.12.2011 | 30.11.2019 | Independent Member |
| **Professor John Gammon** | 31.07.2014 | 31.07.2021 | Independent Member |
| **Cllr Simon Hancock** | 01.08.2013 | 30.09.2019 | Independent Member |
| **Delyth Raynsford** | 01.04.2017 | 31.03.2020 | Independent Member |
| **Mike Lewis** | 01.10.2017 | 30.09.2019 | Independent Member |
| **Anna Lewis** | 01.04.2018 | 31.03.2022 | Independent Member |
| **Owen Burt** | 01.05.2018 | 30.04.2021 | Independent Member |
| **Steve Moore** | 05.01.2015 | | Chief Executive |
| **Joseph Teape** | 07.09.2015 | | Deputy Chief Executive/Director of Operations |
| **Karen Miles** | 01/01/2017 (appointed to new role within the HB previously Director of Finance and Director of Finance and Planning) | | Executive Director of Planning, Performance & Commissioning |
| **Lisa Gostling** | 09.01.2015 | | Executive Director of Workforce & Organisational Development |
| **Dr Philip Kloer** | 25.6.15 (previous roles within HB) | | Executive Medical Director/Director of Clinical Strategy |

| Name | Date Appointed | Appointment Term | Position on Board/Board Champion |
|---|---|---|---|
| **Huw Thomas** | 01.09.2018 | 9.12.2018 | Interim Director of Finance |
| **Huw Thomas** | 10.12.2018 | 9.12.2020 | Executive Director of Finance |
| **Mandy Rayani** | 19.06.2017 | | Executive Director of Nursing, Quality & Patient Experience |
| **Alison Shakeshaft** | 01.01.2018 | | Executive Director of Therapies & Health Science |
| **Ros Jervis** | 17.07.2017 | | Executive Director of Public Health |
| **Jill Paterson** | 19.01.2018 (appointed to new role within the HB) | | Director of Primary Care, Community and Long Term Care |
| **Joanne Wilson** | 01.01.2018 (appointed to new role within the HB) | | Board Secretary |
| **Sarah Jennings** | 01.01.2018 (appointed to new role within the HB – previous roles Director of Governance, Communications and Engagement and Director of Partnerships) | | Director of Partnerships and Corporate Services |
| **Libby Ryan-Davies** | 12.09.2016 | | Transformation Director |
| **Andrew Carruthers** | 26.06.2017 | 25.06.2020 | Turnaround Director |
| **Jonathan Griffiths** | 01.03.2018 | 31.03.2020 | Associate Member |
| **Hilary Jones** | 19.06.2017 | 01.09.2019 | Associate Member |
| **Kerry Donovan** | 01.09.2017 | 26.09.2019 | Associate Member |
| **Michael Hearty** | 01.06.2018 | 31.05.2020 | Associate Member |
| **Bernardine Rees** | 01.07.2014 | 28.02.2019 | Chairman |
| **Stephen Forster** | 09.05.2017 | 31.08.2018 | Executive Director of Finance |
| **Julie James** | 01.05.2010 | 30.04.2018 | Independent Member |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Adam Morgan** | Independent Member (TU) | No | No | No | No | No | No | No |
| **Anna Lewis** | Independent Member (Community) | No | Sole Trader – Management Consultancy & Executive Coaching Trading under 'Together Better Collaborative Consultancy', including coaching undertaken in Cwm Taf University Health Board and consultancy work undertaken in Betsi Cadwaladr University Health Board | No | Board Trustee Tempo Time Credits (also known as Spice Innovations Ltd) | Board Trustee & Interim Chair Tempo Time Credits (also known as Spice Innovations Ltd)<br><br>Senior Consultant with IMROC Hosted by Nottinghamshire Healthcare NHS FT (Freelance)<br><br>National Expert Advisor to Mental Health Safety Improvement Programme (RCPsych. England) as of 01.10.2018 | Visiting Senior Lecturer at Swansea University (College of Human and Health Sciences) | No |
| **Andrew Carruthers** | Turnaround Director | No | No | No | No | No | No | No |
| **Alison Shakeshaft** | Director of Therapies & Health Science | No | No | No | No | No | No | No |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Bernardine Rees** | Chairman | No | No | No | No | No | No | Husband is Independent Member of Shalom House, Pembrokeshire |
| **David Powell** | Independent Member | No | | No | No | No | No | Sister works in Cardiology Department, PPH, Llanelli<br><br>Son works as a General Manager in a London Hospital |
| **Delyth Raynsford** | Independent Member | No | No | No | No | No | No | No |
| **Huw Thomas** | Director of Finance | Trustee of Healthcare Financial Management Association until end December 2018 (no remuneration received for this, purely a voluntary role) | No | No | Chair, Welsh Branch of Healthcare Financial Management Association (voluntary and not remunerated) | Chair, Welsh Branch of Healthcare Financial Management Association (voluntary and not remunerated) | No | Partner works in the Social Services Department of Pembrokeshire County Council |
| **Hilary Jones** | Associate Member (Chair, Stakeholder Reference Group) | No | No | No | Chief Executive of Bro Myrddin Housing Association | Chief Executive of Bro Myrddin Housing Association | No | No |
| **Jonathan Griffiths** | Associate Member (Director of Social Services) | No | No | No | No | No | No | No |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Joanne Wilson** | Board Secretary | No | No | No | No | No | No | Husband is employed by the HB (IG Department) |
| **Joseph Teape** | Deputy Chief Executive/ Director of Operations | No | No | No | No | No | Chartered Institute of Public Finance Accountancy<br>Healthcare Financial Management Association – Fellowship and thus free lifetime membership | No |
| **John Gammon (Professor)** | Independent Member | No | No | No | No | No | No | No |
| **Jill Paterson** | Director of Primary Care, Community & Long Term Care | No | No | No | No | No | No | No |
| **Judith Hardisty** | Independent Member | No | No | No | No | No | Assessor for the Corporate Health Standard under auspices of a2 Consultancy who are instructed by Welsh Government<br><br>Board Member of | No |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with the NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Academi Wales | |
| **Julie James** | Independent Member | No | No | No | No | No | Health Assessor for the WG Health and Wellbeing at Work Corporate Standard<br><br>Independent Member Audit Committee Local Democracy Boundary Commission Wales<br><br>Trustee of the National Botanic Garden of Wales<br><br>Member of Court Swansea University<br><br>Member of Pembrokeshire Coast National Park Authority (from 01.06.17)<br><br>Member of Court University of Luton<br><br>Non-Exec Director of WG Dept for Education and Local Government Corporate Governance | |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Committee<br><br>Trustee of Brecon Beacons Trust<br><br>External Voting Member of Carmarthenshire County Council Audit Committee (from 08.06.2016)<br><br>Member of Carmarthenshire County Council's Standards Committee (from 13.12.2017) | |
| **Karen Miles** | Director of Planning, Performance & Commissioning | No | No | No | No | No | No | Brother is an Associate Professor, Swansea University Medical School and CEO, Moleculomics<br><br>Sister is a Development officer for Centre for Excellence in Rural Health & Social Care<br><br>Sister in law is an |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Associate Professor in Information Systems, University of Wales Trinity Saint David |
| **Kerry Donovan** | Associate Member (Chair of Healthcare Professionals Forum) | No | No | No | No | No | No | No |
| **Libby Ryan–Davies** | Transformation Director | No | No | No | No | No | No | Estranged sister, is a Clinical Neuro-Psychologist with a private practice. There is a potential for her company to obtain business with the HB |
| **Lisa Gostling** | Director of Workforce & Organisational Development | No | No | No | No | No | No | No |
| **Mandy Rayani** | Director of Nursing, Quality & Patient Experience | No | No | No | No | No | No | Husband is lead for Morgannwg LMC and an observer on Dyfed-Powys LMC. He is a GP and Board Member of the General Practitioners Defence Fund (GPDF) |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Michael Hearty** | Associate Member (Finance) | No | No | No | No | Finance Advisor – Betsi Cadwaladr University Health Board | HMRC – Non-Executive Director<br><br>Blackpool Teaching Hospitals Foundation Trust – Non-Executive Director<br><br>Public Health England – Non-Executive Director | No |
| **Mike Lewis** | Independent Member (Finance) | No | No | No | Chairman of "To Russia With Love", a registered charity whose beneficiaries are exclusively in former soviet countries | No | Independent Member, South Wales Police Audit Committee<br><br>Independent Member, South Wales Police Ethics Committee<br><br>Independent Member, City & County of Swansea Standards Committee<br><br>Senior Assessor with the College of Policing (ends March 2019) | Wife works for Cwm Taf University Health Board, but has no connection with Hywel Dda University Health Board<br><br>Son is a Clinical Scientist at Velindre NHS Trust with effect from September 2018 |
| **Owen Burt** | Independent Member (Third Sector) | No | Independent consultant working with Park Inn Associates, a housing | No | Chair of Trustees SYSHP (Swansea Young Single | Chair of Trustees, SYSHP (Swansea Young Single | Independent voluntary member of the National Lottery Community | Wife is Assistant Dean (Quality) Yr Athrofa, the Institute of Education |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| | | | and social policy consultancy | | Homeless Project), and co-opted trustee, Llamau. They are currently in merger discussions | Homeless Project) and co-opted trustee, Llamau | Fund People and Places Committee (formerly known as the Big Lottery Fund) | and Humanities, University of Wales Trinity Saint David |
| **Paul Newman** | Independent Member/ Interim Vice-Chair | Bexmoor Ltd<br>Penman Properties ltd<br>Copper Court Ltd<br>Vivian Court (Swansea) Ltd<br>Llys Felin Newydd Management Company Ltd<br>Rivalsot Ltd<br>Maysouth Ltd<br>Flowlong Ltd<br>Lonpark Ltd<br>Leapgold Ltd<br>Magnetrade Ltd | No | No | No | No | No | No |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with the NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Philip Kloer** | Medical Director/ Director of Clinical Strategy | No | No | No | No | No | Member of Council of St John, Carmarthen<br><br>Honorary Professor, Swansea University, Medical School<br><br>Member of the Faculty of Medical Leadership & Management (FMLM) Council (Welsh lead for FMLM) | No |
| **Ros Jervis** | Director of Public Health | No | No | No | No | No | No, however I have fellowship membership of the Faculty of Public Health | A sister-in-law is a Senior Staff Nurse in Intensive Care at Jersey General Hospital, Health and Social Services (not NHS)<br><br>Another sister-in-law is a Non-Executive Director (NED) for Barnet Enfield and Haringey Mental Health NHS Trust. She is also a NED for First Community Health and Care (a Community |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with the NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Interest Company)<br><br>Another sister-in-law is a Senior Manager within Sandwell & West Birmingham Hospitals Trust, Birmingham |
| **Sarah Jennings** | Director of Partnerships and Corporate Services | No | No | No | Non Executive Trustee of Community Foundation in Wales – a grant giving charity | No | No | No |
| **Simon Hancock** | Independent Member (Local Authority) | No | No | No | Treasurer, Neyland Age Concern<br><br>Curator/Manager of Haverfordwest Town Museum | Chair of the West Wales Care & Repair Agency<br><br>Torch Theatre Board Member<br><br>Member of Pembrokeshire MENCAP<br><br>Member of Pembrokeshire Blind Society<br><br>Chair of the Veterans in Community Gallery Board | Vice Chair , Pembrokeshire County Council<br><br>Magistrate, Pembrokeshire-Ceredigion Bench<br><br>Member of the Court of Swansea University<br><br>Member of Neyland Town Council<br><br>Mayor of Neyland | Brother employed at Argyle Surgery, Pembroke Dock<br><br>Sister in Law: GP in Newport (Retired)<br><br>Niece: Nurse, Withybush Hospital |

| Name | Position on Board/Board Champion | Directorships held (inc non executive held in private companies/plc | Ownership/ part ownership of private companies or consultancies likely or possibly seeking to do business with NHS | Majority or controlling shareholding in an organisation likely or possibly seeking to do business with the NHS | Position of authority in a charity/ voluntary body in the field of health and social care | Connection with a voluntary or other body contracting for NHS Services | Member of any other public bodies including those unconnected with the health service | Interests relating to spouse/ partner or close family member that may relate to the conduct of NHS business |
|---|---|---|---|---|---|---|---|---|
| **Stephen Forster** | Director of Finance | No | No | No | No | No | No | Wife works for Aberystwyth University as a Lecturer/Tutor |
| **Steve Moore** | Chief Executive | No | No | No | No | No | Honorary Professor, University of Wales, Trinity Saint David | No |

**Table 3**

The membership of the Audit & Risk Assurance Committee (ARAC) during 2018/2019, providing the required expertise was as follows:

| | | |
|---|---|---|
| Mr Paul Newman | Independent Member – Community<br>Vice-Chair (06.03.19) | Chair of the ARAC |
| Mr Mike Lewis | Independent Member – Third Finance | Vice-Chair of the ARAC |
| Mr David Powell | Independent Member – Information Technology | Member of the ARAC |
| Cllr Simon Hancock | Independent Member – Local Authority | Member of the ARAC |
| Mr Owen Burt | Independent Member – Third Sector | Member of the ARAC |
| Mrs Judith Hardisty | Independent Member - Vice Chair, HB | Member of the ARAC up until 28.02.19 (became Interim Chair) |

Full details relating to the role and work of the ARAC can be found in the Committee's annual report which is available on Hywel Dda University Health Board's website.

**Information Governance**
Information relating to personal data related incidents and how information is managed and controlled is contained with the Annual Governance Statement (see page 44).

**Environmental, Social and Community Issues**
We take pride in running our healthcare services responsibly as part of the wider West Wales community. We work hard to reduce our impact on the environment, to encourage staff to make healthy lifestyle choices and to strengthen our relationships with local people. Our strategic approach to sustainability ensures that we not only look at ways to reduce fixed costs such as energy, water and waste, but we also embed efficiency principles within our processes for procuring goods and services. In terms of social and community matters, we work hard to:

- Help staff to consider different forms of transport to get to work, including more active options and those that reduce congestion as well as local air and noise pollution;
- Reduce, reuse and recycle: we continue to cut our carbon emissions, reduce the amount of waste sent to landfill sites and our energy costs, and recycle our resources wherever possible. In terms of carbon reduction we have focused on small scale efficiency improvement including changing small heating supplies from gas to LPG, trialling an electric maintenance vehicle and using smart metering to focus on utility use and identify reduction actions. We firmly believe that every little bit helps, and our plans to make significant financial efficiencies in 2018/2019 include a strong environmental sustainability strand;
- Build closer relationships with our communities including running a series of recruitment drives offering employment opportunities across the three counties, hosting regular engagement events on and offline, and reframing our approach to developing services through an unambiguous move to co-designing new delivery models with our population;
- Make a positive contribution to the work of Public Services Boards in each of our 3 local authority areas to improve the economic, social, environmental and cultural wellbeing of local people. This has resulted in HB commitment to actions within each of our 3 PSB Wellbeing Plans which by working collaboratively, will seek to achieve improvements in environmental, social and community resilience;
- Develop collaborative arrangements with partner organisations including the police, fire and rescue services, schools and universities, and the voluntary and third sector to support greater integration across the services that people need from us, and in doing so improve efficiency, reduce duplication and enhance the experience of each person;
- Continue to embed local leadership across our acute hospitals and within community settings to ensure that our frontline have the support they need to do the best they can;
- Reinforce our organisational values so that our staff are clear on what is expected of them and have a robust framework to provide them with greater resilience against pressure;
- Promote the excellent work and 'extra mile efforts' of our staff – as well as our friends in the community – through social media and other channels, so that people who go the extra mile are rightly recognised for their contributions;
- Employ cutting-edge, cost-effective technology to help communicate and engage with everyone who interacts with, or has an interest in, our services.

Information relating to Sickness Absence Data is contained within the Remuneration & Staff Report.

Where the HB undertakes activities that are not funded directly by the WG the HB receives income to cover its costs. Further detail of income received is published in the HB's Annual Accounts, within note 4 miscellaneous income.

The HB confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

**Remote Contingent Liabilities**

Remote contingent liabilities are those liabilities which due to the unlikelihood of a resultant charge against the HB are therefore not recognised as an expense nor as a contingent liability. Detailed below are the remote contingent liabilities as at 31 March 2019:

| | 2018-2019 | 2017-2018 |
|---|---|---|
| | £000's | £000's |
| Guarantees | 0 | 0 |
| Indemnities* | 536 | 266 |
| Letters of Comfort | 0 | 0 |
| | | |
| Total | 536 | 266 |

* Indemnities include clinical negligence and personal injury claims against the HB.

**Regularity of Expenditure**

As a result of pressures on public spending, the HB has had to meet considerable new cost pressures and increase in demand for high quality patient services, within a period of restricted growth in funding. This has resulted in the need to deliver significant cost and efficiency savings to offset unfunded cost pressures to work towards achieving its financial duty, which is break even over a three year period. Given the scale of the challenge and despite delivering savings in year of £26.6million, the HB has been unable to deliver the surplus required in 2018/19 to deliver a balance over 3 years of the financial Duty. The expenditure of £160.964million which it has incurred in excess of its resource limit over that period is deemed to be irregular. The HB will continue to identify efficiency and cost reduction measures in order to mitigate against future cost and service pressures and to re-establish financial balance in due course.

# Hywel Dda University Health Board

# Remuneration and Staff Report 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

**Remuneration and Staff Report**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in the HB in the financial year 2018/2019 was £180,000 - £185,000 (2017/2018, £175,000 - £180,000). This was 6 times (2017/2018, 7 times) the median remuneration of the workforce, which was £29,608 (2017/2018, £26,624).

In 2018/2019, 34 (2017/2018, 39) employees received remuneration in excess of the highest-paid Director. Remuneration for staff ranged from £17,460 to £307,299 (2017/2018, £15,404 to £295,365). The staff who received remuneration greater than the highest paid Director are all medical & dental who have assumed additional responsibilities to their standard job plan commitments as part of their medical managerial roles, necessitating extra payment.

| | 2018/2019 | 2017/2018 |
|---|---|---|
| **Band of Highest paid Director's Total Remuneration £000** | 180 - 185 | 175 – 180 |
| **Median Total Remuneration £000** | 30 | 27 |
| **Ratio** | 6 times | 7 times |

- As disclosed in the HB's Annual Accounts Note 9.6

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The membership of the Remuneration & Terms of Service Committee (RTSC) is as follows:

| | | |
|---|---|---|
| Bernardine Rees, OBE (until 28.02.19) | Chair | Chair of RTSC |
| Judith Hardisty (from 01.03.19) | Interim Chair | Chair of RTSC |
| Paul Newman | Independent Member – Community & Chair of Audit & Risk Assurance Committee<br><br>Vice Chair (06.03.19) | Vice Chair of RTSC |
| David Powell | Independent Member – Information Technology & Chair of Business Planning and Performance Assurance Committee | Member of RTSC |
| Professor John Gammon | Independent Member – University & Chair of Quality, Safety and Experience Assurance Committee | Member of RTSC |

**Statement on Remuneration Policy**

The remuneration of Senior Managers who are paid on the Very Senior Managers Pay Scale is determined by WG, and the HB pays in accordance with these regulations. For the purpose of clarity, these are posts which operate at Board level and hold either statutory or non-statutory positions. In accordance with the regulations the HB is able to award incremental uplift within the pay scale and, should an increase be considered outside the range, a job description is submitted to WG for job evaluation. There are clear guidelines in place with regards to the awarding of additional increments and during the year there have not been any additional payments agreed. No changes to pay have been considered by the Committee outside these arrangements. The HB does not have a system for performance related pay for its Very Senior Managers.

In addition to Very Senior Managers the HB has a number of employment policies which ensure that pay levels are fairly and objectively reviewed for all other staff. There is an All Wales Pay Progression Policy which from 1 April 2016 links staff performance through their pay scale and also a local HB Policy for the re-evaluation of a post which requires individuals and their managers to submit a revised job description for job matching by matching panels comprised of management and staff representatives. The Agenda for Change job matching process is utilised and all results are recorded on the Job Evaluation system. For medical and dental staff the HB complies with medical & dental terms and conditions which apply to medical remuneration.

The HB supports the development of its workforce and ensures opportunities are provided for career progression.

The only severance payment policy in place within the HB is the All Wales Voluntary Early Release Scheme, which is utilised to support organisational change, and services undertake a robust evaluation of their service and submit evidence that this scheme is value for money and financial savings are secured from the service as a result of the change.

| Name of Manager | Role | Salary (£) Bands of £5k) | Date of contract | Expiration Date | Notice period | Compensation for early termination | Awards made within year |
|---|---|---|---|---|---|---|---|
| Steve Moore | Chief Executive | 180-185 | 05/01/2015 | n/a | 3 months | n/a | None |
| Joseph Teape | Deputy Chief Executive/ Director of Operations | 145-150 | 07/09/2015 | n/a | 3 months | n/a | None |
| Mandy Rayani | Executive Director of Nursing, Quality & Patient Experience | 125-130 | 19/06/2017 | n/a | 3 months | n/a | None |
| Karen Miles | Executive Director of Planning, Performance & Commissioning | 125-130 | 01/01/2017 (appointed to new role within HB) | n/a | 3 months | n/a | None |
| Stephen Forster | Executive Director of Finance | 125-130 | 09/05/2017 | 31/08/2018 | 3 months | n/a | None |
| Huw Thomas | Interim Executive Director of Finance | 125-130 | 01/09/2018 | 09/12/2018 | 3 months | n/a | None |
| Huw Thomas | Executive Director of Finance | 125-130 | 10/12/2018 | 9/12/2020 (2 year fixed term) | 3 months | n/a | None |
| Lisa Gostling | Executive Director of Workforce & Organisational Development | 115-120 | 09/01/2015 | n/a | 3 months | n/a | None |

| Name of Manager | Role | Salary (£) Bands of £5k) | Date of contract | Expiration Date | Notice period | Compensation for early termination | Awards made within year |
|---|---|---|---|---|---|---|---|
| Jill Paterson | Director of Primary Care, Community & Long Term Care | 110-115 | 19/01/2018 (appointed to new role within the HB) | n/a | 3 months | n/a | None |
| Sarah Jennings | Director of Partnerships & Corporate Services | 100-105 | 01/01/2018 (appointed to new role within the HB) | n/a | 3 months | n/a | None |
| Dr Philip Kloer | Executive Medical Director | 165-170 | 25/06/2015 | n/a | 3 months | n/a | None |
| Alison Shakeshaft | Executive Director of Therapies & Health Sciences | 100-105 | 01/01/2018 | n/a | 3 months | n/a | None |
| Ros Jervis | Executive Director of Public Health | 110-115 | 17/07/2017 | n/a | 3 months | n/a | None |
| Libby Ryan-Davies | Transformation Director | 100-105 | 12/09/2016 | 30/04/2019 | 3 months | n/a | None |
| Andrew Carruthers | Turnaround Director | 115-120 | 26/06/2017 | 25/06/2019 | 3 months | n/a | None |
| Joanne Wilson | Board Secretary | 95-100 | 01/01/2018 (appointed to new role within the HB) | n/a | 3 months | n/a | None |

The HB can confirm that it has not made any payment to past Directors as detailed within the guidance.

Annually the RTSC receives a summary report of Executive Director Performance objectives and then periodically receives an update on performance against those agreed objectives. In support of the summarised feedback completed performance appraisal documents are also available for Committee scrutiny. No external comparison is made regarding performance.

No elements of remuneration are subject to continuous performance outcomes. There is no performance related pay for Very Senior Managers.

The HB issues All Wales Executive Director contracts which determine the terms and conditions for all Very Senior Managers. The HB has not deviated from this. In rare circumstances where interim arrangements are to be put in place a decision is made by the Committee with regards to the length of the interim post, whilst substantive appointments can be made.

Any termination payments would be discussed and agreed by the Committee in advance and where appropriate WG approval would be made. During the 2018/2019 year, no termination payments were made. However there was one Voluntary Early Release payment made to a Senior Manger (non-Director level).

Senior Manager previous post holders:

| Name of Manager | Role | Salary (£) Bands of £5k) | Date of Contract | Expiration Date | Notice Period | Compensation for Early Termination | Awards Made Within Year |
|---|---|---|---|---|---|---|---|
| Nil | | | | | | | |

**Pension Benefit Disclosure**

| Name and title | Real increase in pension at age 60 (bands of £2,500) £000 | Real increase in pension lump sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000 | Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2019 £000 | Cash Equivalent Transfer Value at 31 March 2018 £000 | Real increase in Cash Equivalent Transfer Value £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|---|---|---|---|
| Steve Moore, Chief Executive* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Joseph Teape, Deputy Chief Executive/ Director of Operations* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mandy Rayani, Executive Director of Nursing, Quality & Patient Experience | 10 – 12.5 | 30 – 32.5 | 55 – 60 | 175 – 180 | 1288 | 927 | 333 | 0 |
| Karen Miles, Executive Director of Finance, Director of Planning, Performance and Commissioning | 0 – 2.5 | 0 – (2.5) | 50 – 55 | 150 – 155 | 1,174 | 1,008 | 136 | 0 |
| Stephen Forster, Executive Director of Finance (to 31/08/2018) | 0 – 2.5 | 0 – 2.5 | 50 – 55 | 140 – 145 | 1,100 | 949 | 52 | 0 |
| Huw Thomas, Executive Director of Finance (from 01/09/2018) | 2.5 – 5 | 0 – 2.5 | 15 - 20 | 0 - 5 | 198 | 109 | 50 | 0 |
| Lisa Gostling, Executive Director of Workforce and Organisational Development | 0 – 2.5 | 0 – (2.5) | 40 - 45 | 95 - 100 | 763 | 635 | 109 | 0 |

| Name and title | Real increase in pension at age 60 (bands of £2,500) £000 | Real increase in pension lump sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000 | Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2019 £000 | Cash Equivalent Transfer Value at 31 March 2018 £000 | Real increase in Cash Equivalent Transfer Value £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|---|---|---|---|
| Dr Philip Kloer, Executive Medical Director | 2.5 – 5 | 0 – 2.5 | 50 – 55 | 110 – 115 | 874 | 701 | 152 | 0 |
| Alison Shakeshaft, Executive Director of Therapies and Health Science | 0 – 2.5 | (2.5) – (5) | 40 - 45 | 100 - 105 | 825 | 730 | 74 | 0 |
| Ros Jervis, Executive Director of Public Health | 2.5 – 5 | 0 – 2.5 | 20- 25 | 45 – 50 | 387 | 300 | 78 | 0 |
| Jill Paterson, Director of Primary, Community and Long Term Care | 0 – 2.5 | 2.5 – 5 | 35 – 40 | 115 – 120 | 0 | 0 | 0 | 0 |
| Sarah Jennings, Director of Partnerships and Corporate Services | 0 – 2.5 | 0 | 30 – 35 | 0 | 479 | 390 | 77 | 0 |
| Libby Ryan-Davies, Transformation Director | 0 – 2.5 | 0 – (2.5) | 30 – 35 | 75 – 80 | 521 | 423 | 86 | 0 |
| Andrew Carruthers, Turnaround Director | 2.5 – 5 | 0 – 2.5 | 25 – 30 | 60 – 65 | 402 | 305 | 87 | 0 |
| Joanne Wilson, Board Secretary | 0 – 2.5 | 0 – (2.5) | 20 – 25 | 45 – 50 | 324 | 256 | 60 | 0 |

| Name and title | Real increase in pension at age 60 (bands of £2,500) £000 | Real increase in pension lump sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000 | Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2019 £000 | Cash Equivalent Transfer Value at 31 March 2018 £000 | Real increase in Cash Equivalent Transfer Value £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|---|---|---|---|

* Steve Moore chose not to be covered by the NHS pension arrangements during the reporting year and Joseph Teape has previously opted out of the NHS pension arrangement

**Severance Payments**

There have been no exit packages paid to senior staff during 2018/2019.

**Single Total Remuneration**

The amount of pension benefits for the year which contributes to the single total figure is calculated similarly to the method used to derive pension values for tax purposes, and is based on information received from the NHS BSA Pensions Agency. The value of pension benefit is calculated as follows: (real increase in pension x20) + (the real increase in any lump sum) – (contributions made by member).

The real increase in pension is not an amount which has been paid to an individual by the HB during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a person's salary, whether or not they choose to make additional contributions to the pensions scheme from their pay and other valuation factors affecting the pension scheme as a whole.

**2018/2019**

| Name | Salary (Bands of £5k) | Bonus Payments | Benefits in Kind (£000) | Pension Benefits (£000) | Total (Bands of £5k) |
|---|---|---|---|---|---|
| **Executive Directors and Directors** | | | | | |
| **Steve Moore** | 180 – 185 | 0 | 0 | 0 | 180 – 185 |
| **Joseph Teape** | 145 – 150 | 0 | 0 | 0 | 145 – 150 |
| **Mandy Rayani** | 125 – 130 | 0 | 0 | 222 | 350 - 355 |
| **Karen Miles** | 125 – 130 | 0 | 0 | 18 | 145 – 150 |
| **Stephen Forster (to 31/08/18)** | 50 – 55 | 0 | 0 | 12 | 60 – 65 |
| **Huw Thomas (from 01/09/18)** | 75 - 80 | 0 | 0 | 65 | 140 - 145 |
| **Lisa Gostling** | 115 – 120 | 0 | 0 | 21 | 135 – 140 |
| **Dr Philip Kloer** | 165 – 170 | 0 | 0 | 59 | 225 – 230 |
| **Alison Shakeshaft** | 100 – 105 | 0 | 0 | 0 | 100 – 105 |
| **Ros Jervis** | 110 – 115 | 0 | 0 | 36 | 145 - 150 |
| **Jill Paterson** | 110 – 115 | 0 | 4 | 8 | 125 – 130 |
| **Sarah Jennings** | 100 – 105 | 0 | 0 | 21 | 120 – 125 |
| **Libby Ryan-Davies** | 100 – 105 | 0 | 0 | 20 | 120 – 125 |
| **Andrew Carruthers** | 115 – 120 | 0 | 0 | 39 | 155 – 160 |
| **Joanne Wilson** | 95 – 100 | 0 | 0 | 17 | 110 – 115 |

| Name | Salary (Bands of £5k) | Bonus Payments | Benefits in Kind (£000) | Pension Benefits (£000) | Total (Bands of £5k) |
|---|---|---|---|---|---|
| **Independent Members** | | | | | |
| **Bernadine Rees, Chair (to 28/02/19)** | 55 – 60 | 0 | 0 | 0 | 55 – 60 |
| **Judith Hardisty, Vice Chair (to 28/02/19), Interim Chair (from 01/03/19)** | 45 – 50 | 0 | 0 | 0 | 45 – 50 |
| **Paul Newman, Independent Member (to 28/02/19), Interim Vice Chair (from 06/03/19)** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Mike Lewis** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Professor John Gammon** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **David Powell** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Cllr Simon Hancock** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Delyth Raynsford** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Adam Morgan** | 5 – 10 | 0 | 0 | 0 | 5 – 10 |
| **Owen Burt (from 01/05/18)** | 10 - 15 | 0 | 0 | 0 | 10 - 15 |
| **Anna Lewis (from 01/04/18)** | 10 - 15 | 0 | 0 | 0 | 10 - 15 |
| **Mr M Hearty (from 01/06/18)** | 0 | 0 | 0 | 0 | 0 |
| **Julie James (to 30/04/18)** | 0 – 5 | 0 | 0 | 0 | 0 – 5 |

**2017-2018**

| Name | Salary (Bands of £5k) | Bonus Payments | Benefits in Kind (£000) | Pension Benefits (£000) | Total (Bands of £5k) |
|---|---|---|---|---|---|
| **Executive Directors and Directors** | | | | | |
| **Steve Moore** | 175 – 180 | 0 | 0 | 40 | 215 – 220 |
| **Joseph Teape** | 145 – 150 | 0 | 8.0 | 0 | 150 – 155 |
| **Mandy Davies (to 18/06/2017)** | 25 - 30 | 0 | 0 | 0 | 25 - 30 |
| **Mandy Rayani (from 19/06/2017)** | 95 – 100 | 0 | 0 | 4 | 100 – 105 |
| **Karen Miles** | 125 – 130 | 0 | 0 | 23 | 145 – 150 |
| **Stephen Forster** | 125 – 130 | 0 | 0 | 263 | 385 – 390 |
| **Lisa Gostling** | 115 – 120 | 0 | 0 | 31 | 145 – 150 |
| **Dr Philip Kloer** | 155 – 160 | 0 | 0 | 44 | 200 – 205 |
| **Alison Shakeshaft (from 01/01/2018)** | 20 – 25 | 0 | 0 | 9 | 30 – 35 |
| **Ros Jervis (from 17/07/2017)** | 75 – 80 | 0 | 0 | 44 | 120 - 125 |
| **Jill Paterson** | 110 – 115 | 0 | 7.6 | 23 | 140 – 145 |
| **Sarah Jennings** | 100 – 105 | 0 | 0 | 0 | 100 – 105 |
| | | | | | |
| **Libby Ryan-Davies** | 100 – 105 | 0 | 0 | 14 | 115 – 120 |
| **Andrew Carruthers (from 26/06/2017)** | 85 – 90 | 0 | 0 | 52 | 135 – 140 |
| **Joanne Wilson** | 90 – 95 | 0 | 0 | 22 | 110 – 115 |
| | | | | | |
| **Independent Members** | | | | | |
| **Bernadine Rees, Chair** | 55 – 60 | 0 | 0 | 0 | 55 – 60 |
| **Judith Hardisty, Vice Chair** | 45 – 50 | 0 | 0 | 0 | 45 – 50 |
| **Mr Donald Thomas (to 30/09/2017)** | 5 – 10 | 0 | 0 | 0 | 5 – 10 |
| **Mike Lewis (01/10/2017)** | 5 – 10 | 0 | 0 | 0 | 5 – 10 |
| **Mike Ponton** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |

| Name | Salary (Bands of £5k) | Bonus Payments | Benefits in Kind (£000) | Pension Benefits (£000) | Total (Bands of £5k) |
|---|---|---|---|---|---|
| **Paul Newman** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Professor John Gammon** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Julie James** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **David Powell** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Cllr Simon Hancock** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Delyth Raynsford** | 10 – 15 | 0 | 0 | 0 | 10 – 15 |
| **Adam Morgan** | 5 – 10 | 0 | 0 | 0 | 5 – 10 |

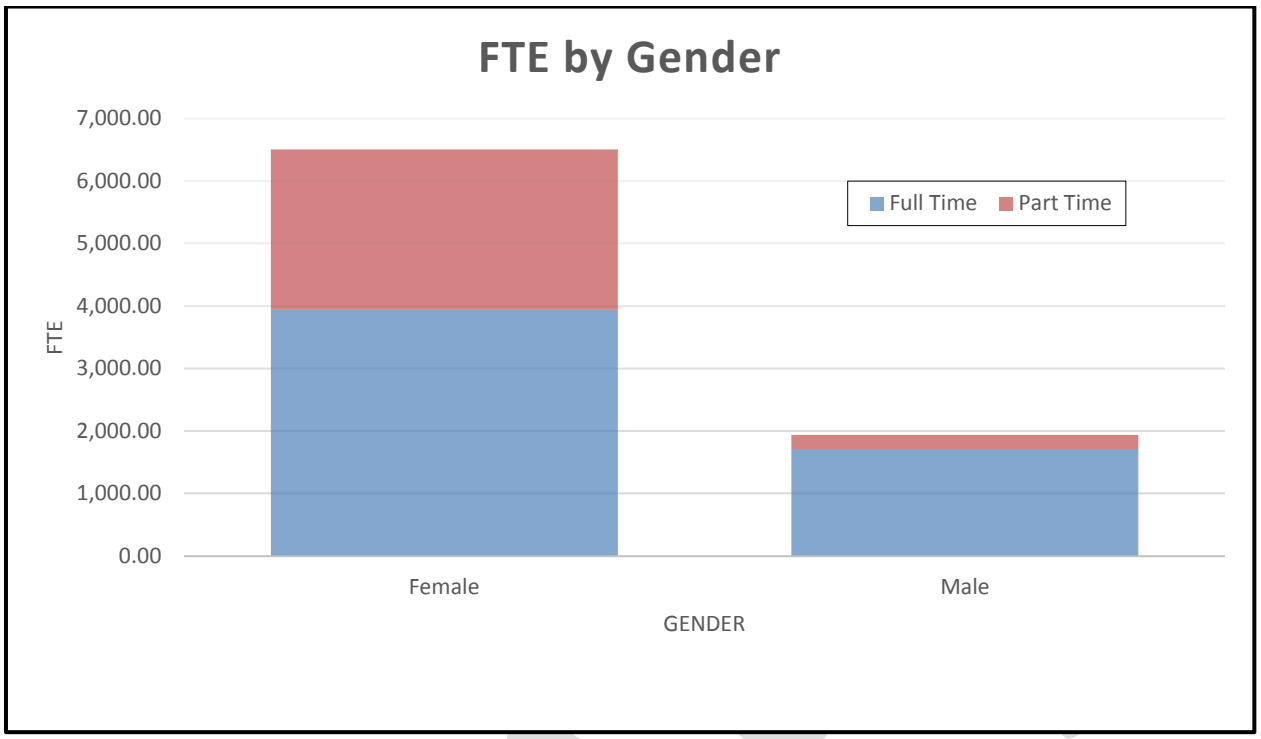
**Staff Composition**

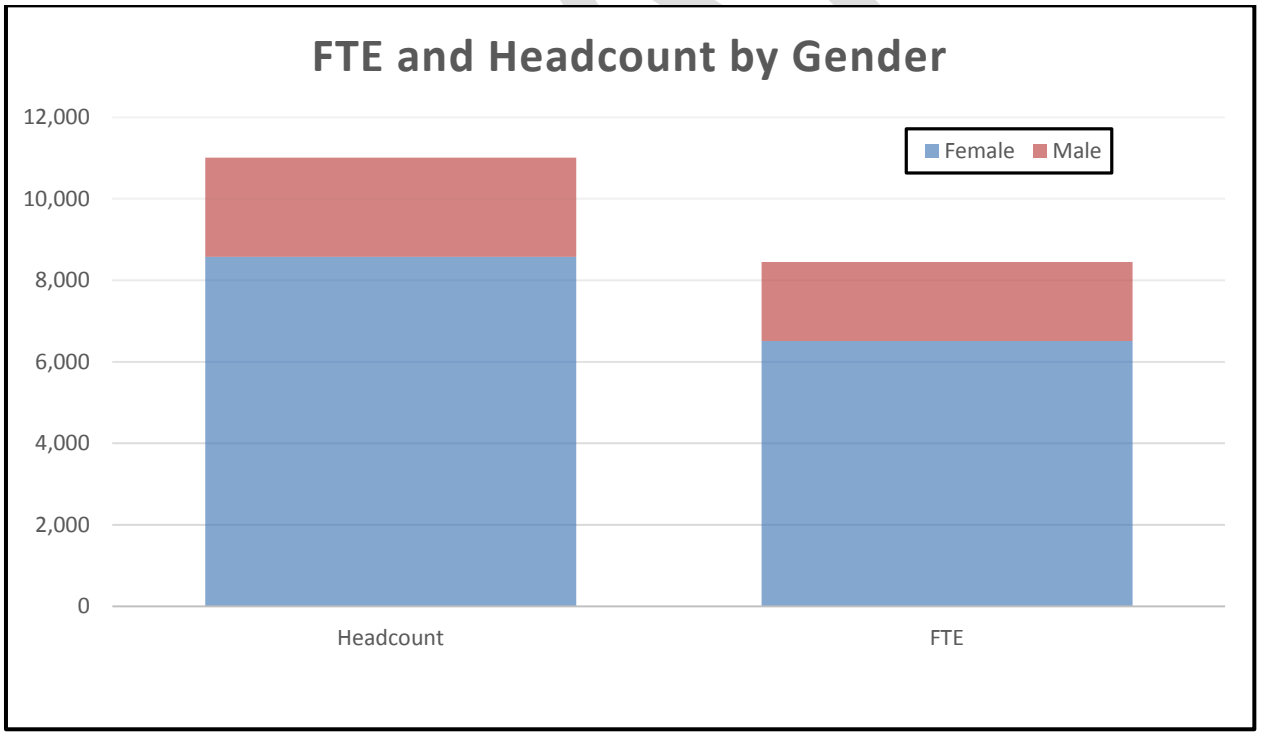
## Staff Composition 31.03.2019

| | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | FTE | Headcount | FTE | Headcount | FTE | Headcount |
| **Executive Team*** | **9.00** | **9** | **5.00** | **5** | **14.00** | **14** |
| **Chairman and Independent Members** | N/A In line with Public Appointments | **4** | N/A In line with Public Appointments | **7** | N/A In line with Public Appointments | **11** |
| **Total** | | **13** | | **12** | | **25** |
| The Executive Team consists of 9 Executive Directors who are voting members of the Board. In addition there are 4 additional Directors and the Board Secretary (all non-voting) who are members of the Executive Team and who also attend Board meetings. Two of these posts are fixed term contracts. | | | | | | |
| | Female | | Male | | Total | |
| | FTE | Headcount | FTE | Headcount | FTE | Headcount |
| **Additional Prof Scientific and Technic** | **209.32** | **240** | **107.30** | **125** | **316.62** | **365** |
| **Additional Clinical Services** | **1,398.75** | **2,165** | **310.53** | **386** | **1,709.28** | **2,551** |
| **Administrative and Clerical** | **1,305.91** | **1,541** | **272.23** | **291** | **1,578.13** | **1,832** |
| **Allied Health Professionals** | **444.13** | **520** | **98.54** | **107** | **542.67** | **627** |
| **Estates and Ancillary** | **369.86** | **597** | **401.34** | **533** | **771.19** | **1,130** |
| **Healthcare Scientists** | **94.47** | **105** | **79.20** | **80** | **173.67** | **185** |
| **Medical and Dental** | **242.68** | **383** | **441.64** | **656** | **684.32** | **1039** |
| **Nursing and Midwifery Registered** | **2,435.71** | **3,016** | **229.02** | **256** | **2,664.73** | **3,272** |
| **Students** | **5.00** | **6** | **0.00** | **0** | **5.00** | **6** |
| **Grand Total** | **6,505.83** | **8,573** | **1,939.80** | **2,434** | **8,445.61** | **11,007** |

| | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| Senior Managers | FTE | Headcount | FTE | Headcount | FTE | Headcount |
| Band 8a | 41.20 | 42 | 23.00 | 23 | 64.20 | 65 |
| Band 8b | 22.80 | 23 | 21.00 | 21 | 43.80 | 44 |
| Band 8c | 14.39 | 15 | 7.00 | 7 | 21.39 | 22 |
| Band 8d | 7.00 | 7 | 5.00 | 5 | 12.00 | 12 |
| Band 9 | 2.00 | 2 | 5.85 | 6 | 7.85 | 8 |
| Grand Total | 87.39 | 89 | 61.85 | 62 | 149.24 | 151 |

The above can be demonstrated pictorially as follows:




At the end of March 2019 the HB employed 11,007 staff including bank and locum staff; this equated to 8,446 Full Time Equivalent (FTE). 78% of the workforce was female and 22% male. The staff covered a wide range of professional, technical and support staff groups. Over 50% were within the Nursing and Midwifery and Additional Clinical Services staff groups. Senior Manager (Band 8a and above) were 1.4% of the workforce - 59% of these were Female and 41% Male. The Board does not have any issue with its staff composition.

## Sickness absence data

| | 2018/19 | 2017/18 |
|---|---|---|
| **Days lost (long term)** | **105,591** | **104,117** |
| **Days lost (short term)** | **42,578** | **44,793** |
| **Total days lost** | **148,169** | **148,910** |
| **Total FTE as at 31 March** | **8,445.61** | **8,328.06** |
| **Average Working Days Lost** | **11.10** | **11.08** |
| **Total Staff employed as at 31 March (headcount)** | **11,007** | **10,842** |
| **Total Staff employed in period with no absence (headcount)** | **3,534** | **3,609** |
| **Percentage of staff with no sick leave** | **37.09%** | **37.20%** |

The percentage and total number of staff without absence in the year has been sourced from the standard ESR Business Intelligence (BI) report. With regard to the reporting in relation to the percentage of staff with 'no sickness', the standard BI report excludes new entrants and also bank and locum assignments.

The main reasons for long term sickness absence are anxiety/stress/depression, followed by musculoskeletal problems. For short term sickness absence the most prevalent reason stated relates to colds/flu and gastrointestinal problems.

Managers are provided with Directorate sickness absence metrics on a monthly basis which highlight the sickness absence rates for their areas split by department along with reasons for absence, days lost and cost.

There has been a new All Wales Attendance at Work Policy implemented, along with an All Wales training package which is being rolled out to all those with responsibility for managing absence. This consists of a Workshop and there will be a shorter core module included for experienced managers who require refresher training. The audit programme to assess compliance with the All Wales Attendance Policy includes an action plan provided to the manager which is further monitored. This arrangement has been in place for some time and is continuing.

The HB has an in-house Occupational Health Service with a Consultant Occupational Health Physician and a Staff Psychological Well-being Service which staff are able to self-refer to.

## Staff Policies

The majority of key employment policies are developed on an All Wales basis and then ratified locally by the Workforce & Organisational Development Sub-Committee (W&OD-SC). These policies are developed in partnership with Trade Unions and are approved though the WG Partnership Forum Business Committee. Equality Impact Assessments are produced, recorded, and made available for All Wales policies by a sub-group of the Partnership Forum.

Other employment policies are developed and reviewed through the Employment Policy Review group that is chaired by a senior member of the Workforce & Organisational Development Directorate. The group membership consists of Managers, Trade Union representatives and other Specialist Advisors such as those with specialist knowledge of equality and diversity and data protection. Local policies are produced in partnership with Trade Union colleagues and are issued for general consultation. Equality Impact assessments are developed by a sub-group of the Employment Policy Review group that includes a specialist advisor for equality and diversity.

Local policies are subject to formal sign off through both the HB's Partnership Forum and the W&OD-SC. The HB's employment policies can be found - http://www.wales.nhs.uk/sitesplus/862/page/62308.

The aim of the HB's Equality and Diversity policy is to ensure that equality and diversity considerations underpin the recruitment, employment and development of staff and the development and delivery of the HB's services to patients and service users. Policies and practices within HB must demonstrate appropriate due regard to relevant equality and diversity issues, thereby ensuring that recruitment and employment and service delivery practices are designed, developed and delivered fairly and equitably, in accordance with equality and human rights legislation.

## Expenditure on Consultancy

Consultancy services are a provision for management to receive objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuant of its purposes and objectives. During the year the HB spent £1,620,082.73 on consultancy services.

| | |
|---|---|
| Estates Reviews | £25,148.92 |
| Other Service Reviews | £888.75 |
| Legal Advice and Redress | £203,101.64 |
| VAT | £96,716.05 |
| Transforming Clinical Services | £898,169.77 |
| Referral to Treatment | £378,057.60 |

## Tax Assurance for Off-Payroll Appointees

In response to the Government's review of the tax arrangements of public sector appointees, which highlighted the possibility for artificial arrangements to enable tax avoidance, WG has taken a zero tolerance approach and produced a policy that has been communicated and implemented across the WG. Tax assurance evidence has been sought and scrutinised to ensure it is sufficient from all off-payroll appointees.

Details of these off-payroll arrangements will be published on the HB's website http://www.wales.nhs.uk/sitesplus/862/page/89388 following publication of the Annual Report.

**Exit Packages**

There have not been any costs associated with redundancy in the last year. There has been one Voluntary Early Release which was processed in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). The exit costs detailed below are accounted for in full in the year of departure on a cash basis as specified in EPN 380 Annex 13C. Where the HB has agreed voluntary early retirement, the additional costs are met by the HB and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table below.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

The HB receives a full business case in respect of each application supported by the line manager. The Directors of Finance & Workforce & Organisational Development approve all applications prior to them being processed. Any payments over an agreed threshold are also submitted to WG for approval prior to HB approval. Details of exit packages and severance payments are as follows:

| | 2018-2019 | 2018-2019 | 2018-2019 | 2018-2019 | 2017-2018 |
|---|---|---|---|---|---|
| Exit packages cost band (including any special payment element) | Number of compulsory redundancies | Number of other departures | Total number of exit packages | Number of departures where special payments have been made | Total number of exit packages |
| | Number | Number | Number | Number | Number |
| less than £10,000 | 0 | 1 | 1 | 1 | 0 |
| £10,000 to £25,000 | 0 | 0 | 0 | 0 | 0 |
| £25,000 to £50,000 | 0 | 0 | 0 | 0 | 0 |
| £50,000 to £100,000 | 0 | 0 | 0 | 0 | 1 |
| £100,000 to £150,000 | 0 | 0 | 0 | 0 | 0 |
| £150,000 to £200,000 | 0 | 0 | 0 | 0 | 0 |
| more than £200,000 | 0 | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 0 | 0 | 0 |

| | 2018-2019 | 2018-2019 | 2018-2019 | 2018-2019 | 2017-2018 |
|---|---|---|---|---|---|
| Exit packages cost band (including any special payment element) | Cost of compulsory redundancies | Cost of other departures | Total cost of exit packages | Cost of special element included in exit packages | Total cost of exit packages |
| | £'s | £'s | £'s | £'s | £'s |
| less than £10,000 | 0 | 6,180 | 6,180 | 6,180 | 0 |
| £10,000 to £25,000 | 0 | 0 | 0 | 0 | 0 |
| £25,000 to £50,000 | 0 | 0 | 0 | 0 | 0 |
| £50,000 to £100,000 | 0 | 0 | 0 | 0 | 76,203 |
| £100,000 to £150,000 | 0 | 0 | 0 | 0 | 0 |
| £150,000 to £200,000 | 0 | 0 | 0 | 0 | 0 |
| more than £200,000 | 0 | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 0 | 0 | 0 |

# Hywel Dda University Health Board

# Statement of Accountable Officer's Responsibilities 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Statement of the Chief Executive's Responsibilities as Accountable Officer of Hywel Dda University Health Board**

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer to Hywel Dda University Health Board.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I can confirm that there is no relevant audit information of which Hywel Dda University Health Board's auditors are unaware and I have taken all steps that ought to have been taken to make myself aware of any relevant audit information and established that the auditors are aware of that information.

I can confirm that the annual report and accounts as a whole is fair, balanced and understandable and I take personal responsibility for the annual report and accounts and the judgements required for determining that is fair, balanced and understandable.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Date.....2019..... Chief Executive

**Statement of Directors' responsibilities in respect of the accounts**

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of Hywel Dda University Health Board and of the income and expenditure of the Hywel Dda University Health Board for that period.

In preparing those accounts, the Directors are required to:

- Apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- Make judgements and estimates which are responsible and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account

The Directors confirm that they have complied with the above requirements in preparing the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers

**By Order of the Board**
**Signed on behalf of:**

The Chairman: ..... Dated: .....2019

Chief Executive: .....Dated: .....2019

Director of Finance: ..... Dated: .....2019