Bundle Extraordinary Public Board 29 May 2019

1	13:30 - Governance / Llywodraethu
1.1	Apologies / Ymddiheuriadau
	Presenter: Chair
1.2	Declaration of Interests / Datganiad o Ddiddordeb
	All
2	13:35 - Assurance / Sicrwydd
2.1	Committee Annual Reports / Adroddiadau Blynyddol Pwyllgorau
2.1.1	Audit & Risk Assurance Committee / Pwyllgor Archwilio a Sicrwydd Risg
	Presenter: Paul Newman
	SBAR ARAC Annual Report 2018/19
	ARAC Annual Report 2018/19
2.1.2	Business Planning & Performance Assurance Committee / Pwyllgor Cynllunio Busnes a Sicrwydd Perfformiad
	Presenter: David Powell
	BPPAC Annual Report 2018/19 revised version
	BPPAC Annual Report 2018/19
	Appendix 1 - CEIM&TSC Annual Report 2018/19
	Appendix 2 - HS&EPSC Annual Report 2018/19
	Appendix 3 - IGSC Annual Report 2018/19
	Appendix 4 - Planning SC Annual Report 2018/19
2.1.3	Quality, Safety & Experience Assurance Committee / Pwyllgor Sicrwydd Ansawdd, Diogelwch a Phrofiad
	Presenter: Professor John Gammon
	QSEAC Annual Report 2018/19
	Appendix 1 - OQSESC Annual Report 2018/19
	Appendix 2 - MMSCSC Annual Report 2018/19
	Appendix 3 - MHLDSC Annual Report 2018/19
	Appendix 4 - W&ODSC Annual Report 2018/19
	Appendix 5 - ECPSC Annual Report 2018/19
	Appendix 6 - IESC Annual Report 2018/19
	Appendix 7 - IPSC Annual Report 2018/19
	Appendix 8 - SSSC Annual Report 2018/19
2.1.4	Charitable Funds Committee / Pwyllgor Elusennau Iechyd
	Presenter: Simon Hancock
	CFC Annual Report 2018/19
2.1.5	Finance Committee / Pwyllgor Cyllid
	Presenter: Mike Lewis
	Finance Committee Annual Report 2018/19
2.1.6	Mental Health Legislation Assurance Committee / Pwyllgor Deddfwriaeth Iechyd Meddwl
	Presenter: Judith Hardisty *DEFERRED to 25th July 2019 meeting*
2.1.7	Primary Care Applications Committee / Pwyllgor Ceisiadau Gofal Sylfaenol
	Presenter: Judith Hardisty
	PCAC Annual Report 2018/19
2.1.8	University Partnership Board / Bwrdd Partneriaeth Prifysgol
	Presenter: Professor John Gammon
	UPB Annual Report 2018/19

2.2 Governance, Leadership and Accountability Standard / Y Safon Llywodraethu, Arweinyddiaeth ac Atebolrwydd

Presenter: Steve Moore

SBAR GLA Standard 2018/19

GLA Standard 2018/19

2.3 Accountability Report / Adroddiad Atebolrwydd

Presenter: Steve Moore

SBAR Accountability Report 2018/19

Accountability Report 2018/19 Board

2.4 Annual Quality Statement / Datganiad Ansawdd Blynyddol

Presenter: Mandy Rayani

SBAR Annual Quality Statement 2018/19

Annual Quality Statement 2018/19

2.5 Wales Audit Office ISA 260/Letter of Representation / Swyddfa Archwilio Cymru SRA 260/Llythyr o Gynrychiolaeth

Presenter: Wales Audit Office

HDdUHB ISA260 Final

2.6 Final Accounts for 2018/19 / Cyfrifon Terfynol 2018/2019

Presenter: Huw Thomas

HDdUHB Annual Accounts 2018/19

HDdUHB Annual Accounts 2018/19 (revised version)

3 15:45 - For Information / Er Gwybodaeth

3.1 Head of Internal Audit Opinion / Pennaeth Barn yr Archwiliad Mewnol

SBAR Head of Internal Audit Annual Report and Opinion

Head of Internal Audit Annual Report and Opinion 2018/19

4 15:55 - Any Other Business / Unrhyw fater arall

All

5 Date and Time of Next Meeting / Dyddiad ac amser y cyfarfod nesaf

9.30am, Thursday 30th May 2019, Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit and Risk Assurance Committee Annual Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Newman, Chair, Audit & Risk Assurance Committee
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Newman, Chair, Audit & Risk Assurance Committee

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of the paper is to present the Audit and Risk Assurance Committee (ARAC) Annual Report to the Board. The attached report provides assurances in respect of the work that has been undertaken by the ARAC in the 2018/19 financial year and provides information relating to the continued development of the role of the committee and its members.

The attached report supports the compilation of the Annual Governance Statement and sets out how the ARAC has met its Terms of Reference, and has been compiled by the Chair of the ARAC with support from the Board Secretary.

Cefndir / Background

The ARAC has a broad role within the Health Board, encompassing a focus on the key purpose of the organisation to deliver safe and effective services and to meet the broad range of stakeholder needs, matters relating to internal financial control, maintenance of proper accounting records and the reliability of financial information. The Committee's primary role is therefore to scrutinise and comment upon the adequacy and effective operation of the organisation's overall internal control system. In addition, the Committee provides a form of independent check upon the executive arm of the Health Board.

The Committee, through its in-year reporting, has regularly kept the Board informed about the results of its reviews of assurances together with any exceptional issues that arose. In accordance with the NHS Wales Audit Committee guidance and generally accepted standards of good practice, the ARAC is required to issue an Annual Report of the Committee Chair, constituting a formal report of the matters that have been considered by the Committee.

The report provides the Board and the Accountable Officer with assurance in respect of the adequacy and effectiveness of the UHB's procedures and systems in maintaining a sound system of internal control and the conclusions drawn for the 2018/19 financial year. This is to include assurance about the rigour of the processes and the quality of the data which lie behind the statements and provide its own assurance about the reliability of the disclosures when they are submitted to the Board for approval.

Asesiad / Assessment
Please see the attached ARAC Annual Report.
Argymhelliad / Recommendation
The Board is asked to endorse the Audit & Risk Assurance Committee Annual Report for 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	ARAC Agenda & Papers
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Audit & Risk Assurance Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of financial control enacts robust financial control, safeguards public funds and the Health Board's assets and resources. Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	If applicable, included within the report.
Gweithlu: **Workforce:**	If applicable, included within the report.
Risg: **Risk:**	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.
Cyfreithiol: **Legal:**	If applicable, included within the report.
Enw Da: **Reputational:**	If applicable, included within the report.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

AUDIT AND RISK ASSURANCE COMMITTEE

ANNUAL REPORT

2018/19

Table of Contents

1 Introduction

1.1 The Audit and Risk Assurance Committee is established under Board delegation with approved Terms of Reference and Operating Arrangements that are aligned to the NHS Wales Audit Committee Handbook, published by the Welsh Government. The Committee is an independent Committee of the Board and has no Executive powers other than those specifically delegated in the Terms of Reference.

1.2 The Committee, through its in-year reporting, has regularly kept the Board informed regarding the results of its reviews of assurances together with any exceptional issues that arose. In accordance with the NHS Wales Audit Committee Handbook guidance and generally accepted standards of good practice, the Audit and Risk Assurance Committee is required to issue an Annual Report of the Committee, constituting a formal report of the matters that have been considered by the Committee. The purpose of this report therefore is to provide the Board and the Accountable Officer with assurance in respect of the adequacy and effectiveness of the University Health Board's (UHB) procedures and systems in maintaining a sound system of internal control and the conclusions drawn for the 2018/19 financial year. This report supports the compilation of the Accountability Report and sets out how the Committee has met its Terms of Reference.

2 Role and Purpose

2.1 The Audit and Risk Assurance Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. The primary role of the Committee is therefore to ensure the system of assurance is valid and suitable for the Board's requirements and it should review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

The Committee is a key source of assurance to the Board ensuring that the organisation has effective controls in place to manage the significant risks to achieving its objectives and that controls are operating effectively. The Committee's principle duties have constantly included "reviewing the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical". Integral to this is the Committee's focus on seeking assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal control to address principal risks and that the effectiveness of the framework is regularly reviewed.

2.2 During the year the Committee has supported the Board by seeking and providing assurance that controls are in place and are working as designed and

by challenging poor sources of assurance. The Committee therefore has a relatively broad role encompassing scrutiny of, and comment upon, the adequacy and effectiveness of the UHB's overall governance, risk management and internal control, covering both clinical and non-clinical areas. This also includes reviewing the Accountability Report before it is submitted to the Board for approval.

2.3 The Committee discharges this duty by fulfilling its responsibilities as outlined in its Terms of Reference. In performing its duties the Committee works to an approved work plan, based on scheduled agenda topics together with a range of specific issues which are subject to review. It is supported by the activities of Wales Audit Office as the External Auditor; NHS Wales Shared Services Partnership (NWSSP): Audit and Assurance – Internal Audit and Specialist Services Unit, and Local Counter Fraud Specialists.

2.4 In discharging these responsibilities, the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- Adequacy of disclosure statements, (Annual Governance Statement, Accountability Report, Annual Quality Statement, Annual Report) which are supported by the Head of Internal Audit opinion, the Wales Audit Office Annual Audit Report and other opinions;
- The adequacy of relevant policies, legality issues and the Codes of Conduct;
- The policies and procedures relating to fraud and corruption;
- That the system for risk management is robust in identifying and mitigating risks, enabling the Audit and Risk Assurance Committee to provide the Board with assurance that the risks impacting on the delivery of the UHB's objectives are being appropriately managed.

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

- 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 Wales Audit Office (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 UHB 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 UHB's financial position, and the risks to delivery of the planned deficit position;

- Concerns regarding ongoing Welsh Government 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.

2.6 Throughout the course of the year the Audit and Risk Assurance Committee has also made recommendations/undertaken the following actions which have in turn led to improvements in the UHB's governance and assurance systems:

- Recommendation by the Committee of the Hywel Dda University Health Board's Annual Report 2017/18 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 Audit & Risk Assurance Committee's revised Terms of Reference for ratification by the Board.

2.7 In enacting its responsibilities, the Audit and Risk Assurance Committee 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.

3 Committee Structure and Meetings

3.1 A key element of the Committee is that it solely comprises of Independent Members, providing a basis for it to operate independently of any decision making process and to apply an objective approach in the conduct of its business.

3.2 As a result of turnover of Independent Members and, in accordance with good governance practice regarding rotation of Committee membership, a number of changes had already occurred during the previous financial year. The

membership of the Committee has, therefore, remained largely unchanged during 2018/19, providing stability and expertise and was as follows:

Paul Newman, Independent Member – Community, Chair (Interim Vice Chair UHB from 06/03/19)*;
Mike Lewis, Independent Member – Finance (Vice Chair);
David Powell, Independent Member – Information Technology;
Cllr. Simon Hancock, Independent Member – Local Authority;
Owen Burt, Independent Member – Third Sector,
Judith Hardisty, Independent Member (Vice Chair UHB – 01/03/19; ARAC membership ended due to becoming the Interim Chair, UHB)

(*It should be noted that the UHB is aware of the guidance contained within the NHS Wales Audit Committee handbook in respect of section 5.2 where it is considered best practice that an organisation's Vice Chair does not chair the Audit Committee. The UHB has considered the balance of risk and believes as this is an interim appointment for a limited period of time, the greater risk would be to appoint an Interim Audit Committee Chair during the year end reporting period. This approach has been agreed with the Minister for Health and Social Services).

During the financial year 2018/19, 8 scheduled meetings of the Audit and Risk Assurance Committee were convened. A high level of commitment from Committee Members has been demonstrated throughout the year, as recorded in the attendance of meetings held.

Although invited to attend certain meetings to provide assurances and explanations to the Committee on specific issues, neither the Chair, Chief Executive Officer, nor any other Executive Director of the UHB, are members of the Committee. In particular, the Chief Executive Officer is invited annually to present the Accountability Report and, during the year, to discuss the UHB's arrangements further to its continued escalation at Targeted Intervention status.

Having a key role to play in establishing and maintaining a sound system of internal financial control, the Director of Finance (and/or the Assistant Director of Financial Planning, being a designated deputy) has been in attendance at all meetings. The Committee has also been supported on key matters at all meetings from attendance by the Board Secretary who is the Lead Officer for the Committee and has been present at all meetings.

The Committee also has regular attendance from representatives of:

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

4 Committee Work Programme 2018/19

4.1 The Committee reviewed and approved the audit strategies and plans for the auditors as listed below, and received audit reports produced in support of them during 2018/19:

- External Auditors, Wales Audit Office;
- NWSSP Audit and Assurance Services:
    - Internal Auditors;
    - Specialised Services Unit.

4.2 Acting upon the outcomes of effectiveness reviews is as important as undertaking them and it is essential that outcomes and associated actions are reported appropriately. Where reports received a less than Reasonable Assurance audit rating, or where there are specific areas of concern, the appropriate Executive Directors and lead officers 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, with recommendations implemented to address control weaknesses or compliance issues.

4.3 The Audit and Risk Assurance Committee 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 and Experience Assurance Committee. Other specific reports, e.g. those relating to Estates, Capital Projects and Information Governance issues were also referred to the Business Planning and Performance Assurance Committee, for regular management until all issues were resolved. In addition, each of the Board Committee Lead Executives are requested to attend the Audit and Risk Assurance Committee 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.

4.4 The Audit and Risk Assurance Committee is responsible for overseeing risk management processes across the organisation and has a particular focus on seeking assurance that effective systems are in place to manage risk, and that the UHB has an effective framework of internal controls that addresses principal risks. Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed and that appropriate controls are in place. The Committee is responsible for monitoring the assurance environment and challenging the build-up of assurance on the management of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied on, and reviewing the internal audit plan in year as the risk profiles change.

5 External Audit – Wales Audit Office (WAO)

5.1 External Audit is provided by the Wales Audit Office (WAO) with its work divided into the two broad headings of:

- Audit of the financial statements and to provide an opinion thereon;

- Forming an assessment of the UHB's use of resources and performance work.

5.2 The Committee approved the External Audit Outline 2018, ensuring that it was linked to strategic priorities and the financial and operational risks facing the organisation, with progress reports against delivery being received at each meeting. The Committee also received individual performance audit reviews. Where necessary, additional assurances were sought from appropriate Executive Directors and other senior managers to confirm that recommendations made in such reviews were being addressed accordingly.

5.3 It is pleasing for the Audit and Risk Assurance Committee to note that WAO recognise that the Committee functions generally well, and that it is chaired effectively. It was confirmed by WAO that the UHB has robust arrangements in place to keep track of recommendations, not only of those identified by External and Internal Audit but those made by all external review bodies. This has been identified by WAO as good practice. The audit tracker has been regularly reported to this Committee and following the introduction of an escalation process, Executive Directors and officers have been held to account for the pace of delivery, with detailed progress updates having been received at regular intervals. The Audit and Risk Assurance Committee will continue to monitor the UHB's Audit Tracker scrutinising management responses to external audit reports through 2019/20.

5.4 With reference to the performance audit work undertaken in 2018/19, WAO concluded that:

- District Nursing: Although the UHB is awaiting national guidance before it can fully address certain issues, a clear service specification has been written for its district nursing service. The UHB also has a greater understanding of demand, deployment and performance.
- Review of Operating Theatres: The report concluded that management arrangements are stronger and the UHB has made some progress in monitoring staffing levels and skill mix. However, as the theatres IT systems are inadequate, it is challenging to get useful activity and performance data.
- Maternity Services: The overall conclusion was that the UHB now has strong leadership in its maternity services and has substantially addressed the operational & strategic challenges posed by the service. However, Caesarean Section rates remain high.
- Review of Primary Care Services: The overall conclusion was that the UHB has ambitious plans for Primary Care and is taking steps towards implementing key aspects of the national vision. However, financial pressures are making it difficult to redirect funds to primary care, workforce challenges are threatening the sustainability of services and performance levels are generally worse than the rest of Wales.
- Clinical Coding Follow Up Review: WAO concluded that coding continues to be a low priority for the UHB and non-compliance with the completeness target is impacting on overall improvement in accuracy and staff morale. The use of coding data as business intelligence remains underdeveloped and there is still considerable room for progress against previous recommendations.

- Hospital Catering & Patient Nutrition Follow-up Review: The Committee noted that substantial work has taken place in an attempt to address recommendations made by both WAO & Healthcare Inspectorate Wales (HIW), with two WAO recommendations remaining outstanding. The Audit and Risk Assurance Committee expressed concerns, however, regarding the lack of a patient experience strategy which could capture high levels of patient feedback on a habitual basis regarding patient nutrition & hydration.
- Public Health Wales Review Report: Concerns were expressed about the financial resource the UHB will lose which is deemed as being counter-intuitive at a time when the profile of health promotion and illness prevention is being raised. There was also dissatisfaction around the method used for calculating the UHB's allocation of resources, with the Committee agreeing that the Director of Finance and Director of Public Health would write expressing concern regarding this.
- WAO National Review of Primary Care: In terms of the overall report, which was welcomed as particularly timely in view of the newly agreed Health & Care Strategy *'A Healthier Mid and West Wales'*, it was felt that the UHB is generally in a good place with regards to Primary Care. It was agreed that there will be a further review by the Audit and Risk Assurance Committee to update on progress, improvements and share experiences, timed to coincide with the national WAO Primary Care report being published in April 2019.
- It was also pleasing for the Committee to note WAO's comment that the UHB has made good progress in addressing recommendations from previous audit work, although a number remain outstanding with certain of these being reliant on national guidance and improvements in IT systems.

5.5 The Committee received the WAO Annual Audit Report 2018, which concluded that the Auditor General for Wales had issued an unqualified opinion on the accuracy and proper preparation of the UHB's 2017/18 financial statements. However, a qualified audit opinion was issued on the regularity of the financial transactions within the UHB's 2017/18 accounts as it did not achieve financial balance for the three year period ending 31st March 2018. The Auditor General, alongside his audit opinion, placed a substantive report on the UHB's financial statements to highlight its failure to achieve financial balance and its failure to have an approved three-year plan in place. The Audit and Risk Assurance Committee however, had consistently highlighted concerns regarding the significant financial challenge faced by the UHB in 2017/18 and beyond, and has continued to seek assurance regarding the financial controls and any financial movements. The work undertaken by WAO in the Structured Assessment of the UHB, which examined the arrangements to support good governance, effective quality assurance and the efficient, effective and economical use of resources, also contributed to the Annual Report. Having discussed the report in depth, the Committee concurred that it presented a fair and balanced view of the organisation and recommended it to the Board.

6 NWSSP - Internal Audit

6.1 At the direction of the Minister for Health and Social Services, Internal Audit is provided by the NHS Wales Shared Services Partnership (NWSSP). The service

provision is in accordance with a Service Level Agreement agreed by the Shared Services Partnership Committee, on which the UHB has permanent membership.

6.2 Internal Audit provides an independent and objective opinion to the Accountable Officer, the Board and the Audit and Risk Assurance Committee, on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives. The Committee reviewed and approved the content of the Internal Audit plan based on the UHB's risk profile and its detailed programme of work for 2018/19. During the year, this plan was flexed and adapted as necessary in order to respond to key risks.

6.3 During the year, the Audit and Risk Assurance Committee also reviewed and approved a revised Internal Audit Charter. The Charter sets out the responsibilities of Internal Audit to the UHB, and vice versa, including the requirement for the UHB to respond to Internal Audit reports and recommendations in a timely manner, accompanied with an escalation policy. Whilst in the main, the escalation policy had been operating effectively, since 2017/18 there have been several instances where reports breached the time limits, causing delays to reports being submitted to the Committee. The revised Internal Audit Charter has been strengthened to ensure management responses are of a high standard, with specific timescales ensuring escalation at an earlier stage, thereby reducing the time that reports take to be finalised and presented to the Committee.

6.4 The Committee has received progress reports against delivery of the plan at each meeting, with individual assignment reports also being received. The outcome of each audit, providing an overall conclusion on the adequacy and application on internal controls for each area under review, was considered by the Committee. The assessment on adequacy and application of internal control measures can range from "No Assurance" through to "Substantial Assurance".

6.5 The table below summarises the UHB's Internal Audit report ratings for 2018/19, compared to the previous year.

Table 1

Internal Audit Assurance Rating	2018/19		2017/18	
	No	%	No	%
Substantial	8	23	8	29
Reasonable	19	56	14	50
Limited	4	12	4	14
None	0	0	0	0
Rating Not Applicable	3	9	2	7
Total	**34**	**100**	**28**	**100**

79% of the Internal Audit reports achieved a rating of substantial or reasonable assurance with 12% of the reports receiving a limited assurance rating.

7 NWSSP – Specialised Services Unit (Capital Audit and PFI)

7.1 The role of Capital and PFI Audit Services is to provide an objective assessment on whether the UHB's systems and controls for Capital and Estates projects are working effectively. During 2018/19, the Audit and Risk Assurance Committee has continued to work effectively with the Audit Team to further strengthen the UHB's internal control processes surrounding capital projects and estates assurance.

7.2 The Committee approved a risk based Capital and PFI 2018/19 Annual Audit Plan. Consideration has been given to the audit opinion awarded to each assignment that has been reported to the Committee throughout the year. Where limited assurances have been reported, further scrutiny or review of the actions recommended has been activated, with Executive Directors or other officers held to account as appropriate. If deemed necessary, representation at Committee meetings has been forthcoming in order to confirm that issues are being addressed in order to achieve an adequate level of assurance.

Table 2

Capital and PFI Audit Assurance Rating	2018/19	
	No.	%
Substantial	1	10
Reasonable	6	60
Limited	1	10
No Assurance	0	0
Rating Not Applicable	2	20
Total	**10**	**100**

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 limited assurance with a further 20% where a rating was not applicable.

8 Head of Internal Audit Opinion

8.1 The Head of Internal Audit provided the Opinion Report for 2018/19 to the Committee at its meeting on 29th May 2019. In the report, the Head of Internal Audit concluded:

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

The revised 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 UHB. Internal Audit is aware of the plans and actions put in place by the UHB in response to their recommendations, and will follow these up in the 2019/20 year to ensure they have been enacted.

The work of the Internal Audit service is informed by an analysis of the risks to which the UHB 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 within this context.

8.2 The Audit and Risk Assurance Committee is of the opinion that selecting Internal Audit Reviews based on risk as opposed to selecting areas that may consistently have had a higher internal audit rating is a far more rigorous process of assurance. On that basis, the Audit and Risk Assurance Committee believes that the overall Head of Internal Audit (HoIA) Opinion of 'reasonable assurance' for the year is a positive outcome and reflects the Internal Audit risk based programme.

8.3 This Opinion contributed to the Board's assessment of the effectiveness of the organisation's system of internal control and to the completion of the Annual Governance Statement. The basis for forming the opinion can therefore be summarised as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within both the Internal Audit and Specialist Services Unit risk-based plans that have been reported to the Audit and Risk Assurance Committee throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
- The review of the process for self-assessment of Health and Care Standards for Health Services in Wales. Evidence is available in support of the Board's declaration in respect of the assessment for the Governance, Leadership and Accountability Standard;
- Other assurance reviews including audit work performed in relation to systems operated by the NHS Wales Shared Services Partnership.

8.4 The Head of Internal Audit stood down at the end of December 2018, and through early discussion with NHS Wales Shared Services Partnership, a seamless handover was achieved with the current postholder.

9 Counter Fraud

9.1 During the year, the Audit and Risk Assurance Committee was consulted on the All Wales Counter Fraud Policy which is required to demonstrate compliance with the Welsh Assembly Government Directions 2006 in Countering Fraud in the NHS**.** This policy provides clear guidance for staff considering reporting concerns of fraud, bribery and corruption which may have been perpetrated against the interests of the UHB, and is accompanied by the response plan for action where suspicious activity is suspected or detected and/or may be reported**.** The UHB 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 Audit and Risk Assurance Committee is to ensure the promotion and implementation of the policy, with compliance monitored by the Committee through the reports of counter fraud activity received and the Annual Counter Fraud Work Plan.

9.2 The Committee received the 2018/19 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 UHB. The Counter Fraud Service is taking various approaches to achieve this, including the use of tools such as the new Twitter account.

9.3 The Counter Fraud Annual Report 2018/19 concluded that the UHB's counter fraud provision had demonstrated compliance with the requirements of the Welsh Government's Directions 2006. The Committee was assured that liaison has continued between the Local Counter Fraud Officer and Internal Auditors and other relevant parties where appropriate. In addition to the service provided from the Local Counter Fraud Specialist, the UHB is fortunate to have access to a large skill set of counter fraud specialists who work across Wales.

9.4 In addition to the above, during the year the UHB's counter fraud arrangements were subject to a "Focused Quality Assessment of Compliance against NHS Counter Fraud Authority Standards for NHS Bodies 2018/19 (Wales). It is pleasing to note that positive feedback was provided by the assessor, with no concerns regarding the counter fraud provision in the UHB. The organisation is performing well with real improvement having been achieved within limited time, whilst further development areas were also highlighted to the Committee.

9.5 The Local Counter Fraud Officer has been in regular attendance at Audit and Risk Assurance Committee meetings, and issues have been discussed in greater detail, if appropriate, with Committee members.

10 Financial Reporting and Financial Position

10.1 The Audit and Risk Assurance Committee considered the Annual Accounts for 2018/19 in May 2018, including the organisation's Annual Governance Statement and Accountability Report, with a subsequent recommendation made to the Board for approval. In making its recommendation, the Committee confirmed that the draft Accountability Report was consistent with the Committee's view on the UHB's system of internal control.

At the end of the previous financial year, following the establishment of the new Finance Sub-Committee, regular Financial Assurance Reports have been presented to the Audit and Risk Assurance Committee. 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. Matters discussed by this Committee during the year and on which assurances were provided included the number of 'No PO, No Pay' breaches and compliance with HMRC employment tax regulations.

10.2 Whilst the Audit and Risk Assurance Committee was assured that the financial reporting and financial controls were robust, the Committee regularly escalated its concerns regarding the UHB's financial position to the Board. Concerns were also escalated around ongoing questions from Welsh Government regarding the organisation's underlying deficit and suggestions that the reasons for this are not sufficiently understood.

10.3 Following the welcome elevation of the Finance Sub-Committee to a Board level Committee in September 2018, the Audit and Risk Assurance Committee will seek an assurance, through the Finance Committee's increased scrutiny, on the UHB's financial position, underlying deficit and savings plans.

11 Standing Orders, Standing Financial Instructions and Financial Procedures

11.1 The UHB's Standing Orders, supporting Schedules and Standing Financial Instructions were reviewed and considered by the Audit and Risk Assurance Committee and recommended for Board approval.

12 Losses and Special Payments

12.1 If necessary, to comply with Standing Orders and Standing Financial Instructions, the Committee receives losses and special payments reports for consideration and where appropriate, recommends them to the Board for approval. A report of the write off of bad debts for 2018/19 is to be considered by the Audit and Risk Assurance Committee at its May 2019 meeting.

13 Assurance on Clinical Governance

13.1 It is a requirement of the NHS Wales Audit Committee Handbook that the Audit and Risk Assurance Committee reviews the clinical audit programme at the beginning of each year. As previously, it continues to be recognised that the Committee needs to strengthen its arrangements for receiving assurances on clinical audit.

13.2 The Committee was presented with the current 2018/19 Clinical Audit Programme and provided with details on how this was being developed at the beginning of the year. The Clinical Audit Department compiled a UHB-wide forward programme for 2018/19 by asking groups/sub-committees within the existing governance framework to submit a list of audits that they supported being undertaken in 2018/19. The programme was approved by the Effective Clinical Practice Sub-Committee, subject to a few conditions which focused on improving the rationale for project inclusions, and creating better links to NICE guidance and UHB policies. The Audit and Risk Assurance Committee was advised that all projects on the programme will proceed through additional layers of scrutiny via the Clinical Audit Department and Locality Clinical Audit Support Committees (CASC) to ensure that they meet the criteria for inclusion on the programme. The Clinical Audit Department will also take into consideration high priority or risk associated audits which are identified throughout the year.

The Audit and Risk Assurance Committee was assured that with regard to Mandatory National Audit Compliance, the decision was taken not to develop a system whereby services can 'opt out' of participation in a mandatory clinical audit. The assumption that all of these projects will be participated in is still the view of this UHB and Welsh Government. To this end, any service that is not able to participate fully in a mandatory audit will instead be required to risk assess the impact of this, utilising existing risk management procedures. The governance regarding non-participation was highlighted, with it being noted that this is an area in which decisions would be raised to Board level.

The Clinical Audit Department has been seeking to improve on the robustness of the above process with an aim to increasing both the quality of action plans and

the level of assurance that they can provide. The Quality, Safety and Experience Assurance Committee continues with its remit of seeking more detail on the clinical outcomes and improvements made as a result of clinical audit.

The Audit and Risk Assurance Committee requested that an annual report, to include audit compliance/participation rates, issues/challenges and outcomes, be prepared. The Committee also requested a sample of outcomes and improved clinical practice as a result of national clinical audits be undertaken with particular reference being made to the impact on culture, lessons learnt and benchmarking information.

14. Other Committee Work

14.1 Targeted Intervention Arrangements

The tri-partite arrangements involve information sharing and dialogue between the Welsh Government, the Auditor General for Wales and HIW. Under these arrangements, twice-yearly meetings are held to discuss the overall position of the UHB (as with all other Health Boards and Trusts in Wales), and to agree on the best way to respond to any issues affecting service delivery, quality and safety of care and/or organisational effectiveness.

The UHB'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 UHB faces. The Committee has closely monitored the enhanced escalation status of the UHB during the year with the Joint Escalation & Intervention Arrangements being a standing agenda item for its meetings, with the Chief Executive requested to provide an update on the position on a regular basis.

Although the organisation remains at this targeted intervention level there is positive recognition of the UHB's improved performance and Welsh Government was pleased that the UHB remains confident of delivering the control total of £35.5m at the end of 2018-19. However, Welsh Government remains concerned that the UHB does not fully understand the reasons behind the underlying financial deficit. Whilst Welsh Government has remained positive regarding performance and the organisation's commitment on progressing the Transforming Clinical Services Programme, which is recognised as moving towards the delivery phase, they are less assured around the UHB's financial position and that finance remains challenged in terms of the outlook for 2019/20.

Welsh Government has emphasised the importance of the UHB having a sound financial plan for 2019/20 and have expressed concern regarding the current plan having a high level of cost growth, with only £10m of firm savings identified against a £27m savings requirement. The main reasons identified which need resolving before an annual plan can be considered for approval are: the requirement for meeting national performance targets to be a core part of the plan, confirmation of the forecast deficit for year end 2019/20 and actions for meeting delivery of that position, including the costs of meeting all performance targets and the need for full alignment of performance and finance.

The Committee has welcomed the strong engagement with Welsh Government recognising the incremental gains and challenges ahead.

14.2 Reports of Other Committees

Lead Executive Directors of the Board level Committees attend the Audit and Risk Assurance Committee on an annual basis to allow the Committee the opportunity to scrutinise the controls and assurances on which it relies, agreeing actions where appropriate, including proposals for future internal audits.

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

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

Whist 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 QSEAC has been on a development journey, with this work continuing.

14.3 Adequacy of Arrangements for Declaring, Registering and Handling Interests Gifts, Hospitality, Honoraria and Sponsorship

In accordance with the Audit Committee Handbook, the Committee reviewed the adequacy of arrangements for declaring, registering and handling gifts, hospitality, honoraria and sponsorship currently being enacted, and noted the proposed steps to improve the adequacy of these arrangements during 2019/20. This included the introduction of bespoke links between the on line reporting system introduced in October 2018 and the UHBs Electronic Staff Record, with a view to substantially increasing the numbers of declarations made.

14.4 Single Tender Action and Quotation Reports

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**.** This was supported at year end by a schedule of all such transactions during the course of the year being presented to the Committee in order to obtain assurance that there were no consistent or recurring themes which might indicate any attempt to circumvent due process, thereby enabling any trends or other issues of concern to be monitored and acted upon.

No such trends were identified during the year. Whilst 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. The Audit and Risk Assurance Committee was informed that this was partly due to a more robust process being in place and that a substantial number of these were for maintenance contracts. The Committee received assurances that where there have been queries regarding particular Single Tender Actions, these have been referred back to lead officers.

14.5 Audit and Risk Assurance Committee Development and Self Assessment of Effectiveness

Members participated in a self-assessment and evaluation exercise of the Audit and Risk Assurance Committee's performance and operation towards the end of the year. The main conclusion drawn was that the Audit and Risk Assurance Committee is operating in accordance with its terms of reference. Positive responses were received in relation to the role and purpose of the Committee and support for the Committee. No major shortcomings in the past year were identified. The findings of the self-assessment exercise will be considered by the Chair and Independent Members to design a development programme for 2019/20.

Members also participated in a Board Seminar session on Risk Management and the role of the Audit and Risk Assurance Committee in this process in August 2018.

14.6 Private Meeting of Audit and Risk Assurance Committee Members with the Auditors

In line with the Audit Committee Handbook and the Audit and Risk Assurance Committee Terms of Reference, Committee Members met privately with Internal Audit Service, the Specialised Services Unit, Wales Audit Office and Counter Fraud during the year, as shown in the table below.

ARAC Meeting Date	Topic/Subject Covered	Attended by
19th February 2019	Independent Members met Counter Fraud, Internal Audit and Wales Audit Office without UHB officers present	Matthew Evans, Counter Fraud Officer Simon Cookson, Director of Audit and Assurance, and James John, Head of Internal Audit (NWSSP) Ann-Marie Harkin, Anne Beegan and Jeremy Saunders, Wales Audit Office

15. Forward Plan

A number of areas for further development were identified in last year's report in order that the Audit and Risk Assurance Committee could provide additional assurance that the Board is functioning effectively. It has been a positive year with significant improvements made.

The Committee will require that these areas will continue to be subject to increased scrutiny, not least the organisation's financial challenge which remains a serious concern, which will be scrutinised through the UHB's Finance Committee. As has been constantly reported in previous years with increased focus continuing this last year, it is clear that the financial position will continue to be a significant challenge in 2019/20. Work will therefore be undertaken through the Finance Committee to ensure the Health Board is in a position to understand fully the underlying deficit and to provide an assurance on this to the Audit and Risk Assurance Committee.

Assurances will also be sought by the Committee that the recommendations from the 2018 WAO Structured Assessment Report have been implemented. The UHB's process for tracking recommendations by all regulators has been particularly recognised by WAO as good practice and a welcome addition to the process of holding to account those charged with addressing these recommendations.

Any areas of Committee concern raised during 2018/19, including clinical audit, radiology, theatres, estates, private patients will be followed up in 2019/20. Learning will also be taken from the 2018/19 Self Assessment of Committee Effectiveness exercise with the key themes thus far identifying enforcement of the revised Internal Audit Charter to improve the quality of management responses to audit recommendations and holding to account on those that have passed their deadline. There will also be a focus on members' further understanding of risk to provide an assurance on the effectiveness of the risk management framework, together with a focus on a more general level of members understanding supported by the localised Committee Handbook designed to strengthen induction and members' on-going development.

The Board at its March 2019 meeting approved the 2019/20 Annual Plan for submission to the Welsh Government as an interim draft plan reflecting the fact that it does not satisfy the UHB's statutory duty for financial break even.

In order to continue with triangulation of assurance for the Board, together with providing the required degree of scrutiny, it is Audit and Risk Assurance Committee's intention to further build relationships with the Quality, Safety and Experience Assurance Committee, the Business Planning and Performance Assurance Committee and the Finance Committee.

16. Conclusions

It is acknowledged that the Audit and Risk Assurance Committee is a well-established Committee of the Board with a detailed annual work plan in place.

Whilst the Committee believes it has met the duties of its Terms of Reference and has provided assurance to the Board on a significant number of matters, during the course of the year there were several areas where the Committee itself expressed concern that it was not being provided with the required degree of assurance enabling it to discharge its duties in informing the Board appropriately.

The Internal Audit work programme has been aligned to the UHB's risk profile in order to provide assurance to the Audit and Risk Assurance Committee that the identified mitigation is reducing or maintaining the level of identified risk. The Audit and Risk Assurance Committee will also ensure that Internal Audit reviews are undertaken of those areas which received limited assurance during 2018/19 in the early part of the current year, and the implementation of the agreed management action plans will be a focus for the Committee's attention. The plan will be flexible in order to test the assurance flows which are an integral part of the Board Assurance Framework.

The Audit and Risk Assurance Committee will also continue to request the attendance of the Chief Executive Officer on a regular basis to provide assurance that the position relating to the UHB's targeted intervention status is being carefully managed and that no further escalation would be forthcoming.

Finally, focus will continue to be placed on work that is undertaken in collaboration and partnership, with the Audit and Risk Assurance Committee seeking the assurance that robust processes and reporting arrangements are in place where significant activity is shared with another organisation, e.g. NHS Wales Shared Services Partnership (NWSSP), Emergency Ambulance Services Committee (EASC), Welsh Health Specialised Services Committee (WHSSC), Collaboratives.

The Committee is well attended by both members and those in attendance, with a focus on the critical risks facing the UHB creating a balanced discussion between financial and non-financial/clinical risks. During the year, the Committee has received development/training sessions on specific areas such as internal audit assurance ratings, enabling Members to obtain a better understanding and thereby improving the effectiveness of the scrutiny provided.

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. In a period of rapid change where far-reaching decisions have to be made, it is vital that risk management is at the heart of this process. The Committee has continued to make progress in moving to a position where it can be used effectively to help achieve the UHB's objectives and improve decision making. Work will take place during 2019/20 to enable the Committee to receive

assurance on the effectiveness of the risk management framework. By monitoring the performance of risk management and any obstacles to improvement, the Audit and Risk Assurance Committee has helped to ensure the adoption of good practice across the organisation.

This report demonstrates that the Committee has fulfilled its responsibilities as detailed in its Terms of Reference, through the completion of a comprehensive work plan, and from the reports it has received throughout the course of the year from a range of support services and sources. The Audit and Risk Assurance Committee has successfully overseen a programme of work to provide the Board with assurance in respect of the adequacy and effectiveness of the organisation's functions and systems to maintain a sound system of governance and internal control.

It is the opinion of the Audit and Risk Assurance Committee that the Accountability Report incorporating the Annual Governance Statement, is consistent with the view of the Committee on the UHB's system of internal control. In forming this opinion the following factors have been considered:

- The system of risk management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks, whilst noting work is continuing in refining risks to be undertaken at an operational level to enable the UHB to become a risk mature organisation;
- The reliability and integrity of its sources of assurance encompassing the work of both Internal and External Audit together with the assurances forthcoming from the Sub-Committees of the Board;
- The Committee, in reviewing the system of assurance, whilst acknowledging the potential for improvement, believes the UHB had the necessary controls in place during the reporting period.

The Board is therefore asked to endorse the contents of this report as a summary of the work and findings of the Audit and Risk Assurance Committee for the financial year 2018/19.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Business Planning & Performance Assurance Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	David Powell, Chair, Business Planning & Performance Assurance Committee
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Miles, Director of Planning, Performance & Commissioning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Business Planning & Performance Assurance Committee (BPPAC) Annual Report 2018/19 to the Board for approval.

The BPPAC Annual Report provides assurances in respect of the work that has been undertaken by the Committee during 2018/19, and outlines the main achievements which have contributed to robust business planning and performance assurance across the Health Board.

Cefndir / Background

Hywel Dda University Health Board's Standing Orders and the Terms of Reference for the Business Planning & Performance Assurance Committee require the submission of an Annual Report to the Board to summarise the work of the Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Committee is to assure the Board on the following:

1. Provide assurance that the planning cycle is being taken forward and implemented in accordance with University Health Board and Welsh Government requirements, guidance and timescales.
2. Provide assurance that all plans put forward for the approval of the Health Board 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.
3. Provide assurance to the Board that, wherever possible, University Health Board plans are aligned with partnership plans developed with Local Authorities, Universities, Collaboratives, Alliances and other key partners.
4. Provide support to the Board in its role of scrutinising performance and assurance on overall performance and delivery against Health Board plans and objectives, including delivery of Tier 1 targets and the financial control total, 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.

5. Assure the Board that the data on which performance is assessed is reliable and of high quality and that any issues relating to data accuracy are addressed.
6. Seek assurance on the management of principal risks within the BAF and CRR allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
7. Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.
8. Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

Asesiad / Assessment

The Business Planning & Performance Assurance Committee has been established under Board delegation with the Health Board initially approving Terms of Reference for the Committee at its Board meeting on 30th July 2015. These were subsequently revised and approved by the Board as part of its annual cycle of review of Committees Terms of Reference at its meetings on 26th November 2015, 26th January 2017, 29th March 2018, 27th September 2018 and 28th March 2019.

The revision to the Committee's Terms of Reference in September 2018 was informed by the decision to elevate the Finance Sub-Committee to a formal Committee of the Board necessitating amendments to BPPACs Terms of Reference to remove roles and responsibilities in relation to financial planning and performance.

In discharging its role, the Committee is required to oversee and monitor the business planning and performance assurance agenda for the Health Board, and in respect of its provision of advice to the Board, ensure the implementation of the business planning and performance assurance agenda against the following areas of responsibility:

Business Planning

- Assure the development of delivery plans within the scope of the Committee, their alignment to the Integrated Medium Term Plan (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 IMTP for sign off by the Board.
- Quality assure and approve all delivery plans required by Welsh Government, ensuring alignment with the University Health Board'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.

Performance Management

- On behalf of the Board, and subject to its direction and approval, 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 and 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.

Governance
- Provide advice and assurance to the University Health Board 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.
- 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 Welsh Government, ensuring alignment with the University Health Board'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 (QSEAC), 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 Business Planning and Performance Assurance Committee, and oversee delivery.
- Agree issues to be escalated to the Board with recommendations for action.

Sub-Committees
The Sub-Committees reporting to Business Planning & Performance Assurance Committee during 2018/19 were as follows:

- **Capital, Estates & IM&T Sub-Committee** – established to:
  - Oversee the development of the estates strategy linked to the Integrated Medium Term Plan for consideration by the Business Planning & Performance Assurance Committee, before approval by the Board.
  - Oversee the development of an innovative strategy for information technology and information analytics (to cover all functions of the University Health Board's services i.e. primary, community, hospital, etc) that supports delivery of the integrated medium term plan for consideration by the Business Planning & Performance Assurance Committee, before approval by the Board.
  - Oversee the development and delivery of implementation plans for the estates and informatics strategy, agreeing corrective actions where necessary and monitoring its

effectiveness.

- **Health & Safety and Emergency Planning Sub-Committee** – established to:
  - Provide assurance around the Health Board's arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities such as patients, members of the public, volunteers, contractors, etc.
  - Provide advice on compliance with all aspects of health and safety, and emergency planning legislation.
  - Oversee the development, maintenance and evaluation of the Health Board's Emergency Management Plan that will be underpinned by policy and protocols, planning and performance targets and strategies to address risks to business continuity.

- **Information Governance Sub-Committee** – established to:
  - Provide assurance to the Business Planning & Performance Assurance Committee on compliance with information governance legislation, guidance and best practice, and to:
  - Provide evidence based and timely advice to assist the Health Board in discharging its functions and meeting its responsibilities with regard to the quality and integrity; safety and security; and appropriate access and use of information (including patient and personal information) to support its provision of high quality healthcare.
  - Provide assurance in relation to the Board's arrangements for creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information in accordance with its stated objectives; legislative responsibilities, e.g. the Data Protection Act and Freedom of Information Act; and any relevant requirements and standards.
  - Provide assurance that risks relating to information governance are being effectively managed across the whole of the Health Board's activities (including for hosted services, through partnerships and Joint Committees as appropriate).

- **Planning Sub-Committee** – established to:
  - Advise and guide the Health Board's planning arrangements and implementation of major change (one year, medium and longer terms plans).
  - Oversee and assure the Transforming Mental Health Implementation Programme and the Transforming Clinical Services Implementation Programme (once established).
  - Provide assurance to the Business Planning & Performance Assurance Committee that the planning cycle is (designed and managed) being taken forward and implemented in accordance with the University Health Board and Welsh Government requirements, guidance and timescales.

- **Finance Sub-Committee** (up until August 2018) – established to:
  - Provide assurance to BPPAC that robust arrangements are in place for financial planning, forecasting and financial performance by providing additional and detailed scrutiny of the Health Board's financial position in view of the current challenges in terms of achieving a balanced financial position.
  - Maintain a robust grip and close scrutiny of the Health Board's financial position with the aim of ensuring the achievement of an end of year balanced financial position.
  - Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation and focus in detail on specific issues where financial performance is showing deterioration or there are issues of concern.

The Business Planning & Performance Assurance Committee Annual Report 2018/19 is intended to outline how the Committee and its Sub-Committees have complied with the duties

delegated by the Board through the Terms of Reference set, and also to identify key actions taken to address developments within the Committee's remit.

Constitution

Until November 2015, membership of the Business Planning & Performance Assurance Committee consisted of six Independent Members, the Chief Executive Officer and all Executive Directors, with an open invitation extended to all Independent Members to attend for an additional level of scrutiny and challenge. All Executive Directors were expected to attend all meetings, with the Chair of the Health Board routinely attending meetings in an ex officio capacity. From the revised Terms of Reference approved on 26th November 2015, the membership was reviewed and agreed as the following:

- Independent Member (Chair)
- Independent Member (Vice-Chair)
- 4 Independent Members

with the following Members identified as "In Attendance" (i.e. Associate Members):

- Chief Executive
- Director of Planning, Performance & Commissioning (Lead Executive)
- Deputy Chief Executive/Director of Operations
- Director of Finance
- Medical Director & Director of Clinical Strategy
- Director of Nursing, Quality & Patient Experience
- Director of Therapies & Health Sciences
- Director of Public Health
- Director of Workforce & Organisational Development
- Director of Primary, Community & Long Term Care
- Director of Partnerships & Corporate Services
- Independent Member (WAST) (not counted for quoracy purposes)
- Hywel Dda Community Health Council Representative (not counted for quoracy purposes)
- Advisory Forum Representatives (Local Partnership Forum/Healthcare Professionals Forum/Stakeholder Reference Group representatives) (not counted for quoracy purposes)
- LMC Representative (not counted for quoracy purposes)

This membership has remained extant during 2018/19.

Meetings

As the Business Planning & Performance Assurance Committee is directly accountable to the Board for its performance, it provides an assurance to the Board through a formal written update report which is received at the subsequent Board meeting. A full set of the papers for each Committee meeting is routinely made publicly available from the Health Board's website.

During 2018/19, the Committee met on 6 occasions and was quorate at all meetings, as follows:

- 24th April 2018
- 26th June 2018
- 28th August 2018
- 30th October 2018
- 18th December 2018
- 26th February 2019

Areas of Responsibility
In discharging its duties, the Business Planning & Performance Assurance Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its business planning & performance assurance agenda:

Governance

- **Draft Annual Report to Board** – at its meeting in April 2018, subject to only minor amendments, the Committee endorsed the BPPAC Annual Report 2017/18 for onward approval to the Board on 30th May 2018.

- **Sub-Committee Terms of Reference** – revisions to the Terms of Reference for BPPAC's Sub-Committees were presented to the Committee during 2018/19 and approved at the following meetings:
  - Capital, Estates and IM&T on 26th February 2019
  - Health & Safety and Emergency Planning on 30th October 2018
  - Information Governance Sub-Committee on 28th August 2018
  - Planning Sub-Committee on 18th December 2018.

- **Committee Self-Assessment of Effectiveness** – at its meeting in April 2018, Members received a composite report on the outcome from the 2017/18 BPPAC self-assessment of effectiveness exercise which provided a level of analysis and clarified a number of themes in common with other Board level Committees. The report also indicated actions to take forward by the Corporate Governance Team as part of their agreed workplan for 2018/19. The themes and outcomes from the self-assessment questionnaire also contributed to the Business Planning & Performance Assurance Committee's on-going development.

  At its meeting in February 2019, the Committee received the BPPAC Self-Assessment of Committee Effectiveness Questionnaire for 2018/19 to consider any amendments or omissions. Members approved the current questionnaire and were advised of the intention to use 'Survey Monkey', an online survey tool, to capture the responses made.

- **BPPAC Revised Terms of Reference** – at its meeting in February 2019, the Committee considered and approved its Terms of Reference with no changes made. These revised Terms of Reference were subsequently ratified by the Board on 28th March 2019.

Performance Assurance

Integrated Performance Assurance Report (IPAR) – the Integrated Performance Assurance Reports presented to the Committee during 2018/19 outlined achievements against targets and actions in place to improve performance. Whilst the Quality, Safety and Experience Assurance Committee are responsible for monitoring patient experience, the correlation between improvements in performance and patient outcomes is acknowledged.

At its meeting in April 2018, the Committee received the Month 12 (2017/18) version of the IPAR, setting out the Health Board's latest performance position. Members acknowledged the challenges faced by Hywel Dda during the winter period, and the effect this had had in terms of sustained periods of poor performance particularly in regard to the 4 and 12 hour A&E targets were shared with the Committee, together with the Health Board's approach to the improvement work required to address these in terms of turnaround cycles, etc. Members were

informed that a comprehensive look back on the previous winter and a look forward to the next would be presented to the Board in July 2018. The Committee was also updated on the Health Board's approach to mandatory training in terms of targeting a particular service area each month which appeared to be paying dividends, together with the work taking place with the services involved to convert training data onto ESR. Members noted the increase in sickness absence in January 2018, due in the main to seasonal absences, with improved performance in February 2018 attributed to the consistency adopted in applying the Health Board's Sickness Absence Policy. PADR compliance also represented an improving position with the Workforce & OD Team updating records centrally on ESR. An update on Patient Safety Notices PSN028, PSN030 and PSN035 was also provided to Members, highlighting the work on-going to address compliance and to demonstrate the progress made. The Health Board's approach to pressure sores was also discussed. Given the number of patients who were admitted with pressure damage either undetected or unreported from the community, Members agreed that the Health Board's approach should be targeted here.

In June 2018, the Committee received the Month 2 (2018/19) version of the IPAR, setting out the Health Board's latest performance position. Members noted that unscheduled care remained the main pressure with cardiology and diagnostics the main challenges. Members' attention was drawn to the latest performance overview in terms of the key deliverable targets set by WG by exception, and noted the variance in clinical coding performance due to capacity issues particularly within Glangwili General Hospital (GGH). It was confirmed that a request had been made through Executive Team for additional clinical coding capacity given its known impact on performance. Members also noted that the metric for the hand hygiene indicator had been changed to a simpler 5% reduction, however expressed concern at the Health Board's decrease in percentage compliance. Members were unassured by the accompanying narrative which suggested staffing issues were having an impact and requested this be referred to the Infection Prevention Sub-Committee of Quality, Safety & Experience Assurance Committee (QSEAC) given the known association between hand hygiene and health care acquired infections. Members also sought an assurance in regard to the new target for Mental Health patients who require to be seen by an Independent Mental Health Advocacy (IMHA) within 5 days which had been outsourced to the West Wales Advocacy Service, and it was agreed to request this assurance from the Health Board's Interim Head of Mental Health & Learning Disabilities. The Committee welcomed the £30m additional funding announced by WG to eradicate all 36 week breaches, and anticipated both in house and outsourcing solutions would need to be considered for a number of specialties e.g. orthopaedics. Members were assured that this additional funding would be tracked intensively. In terms of therapy performance, Members noted the trajectory of increasing waits and suggested this declining performance be monitored at BPPAC, with a comparison of performance to be presented at the next Committee meeting. Members further noted that improvements were not being made from external validation on delayed follow up appointments despite an assurance that this would be the case, and were informed that although extra effort had been put in place as part of year end improvement, this ceased at the end of March 2018. In addition, the high turnover in the internal validation team experienced in April/May 2018 meant activity had to be prioritised on the RTT pathway, however Members were assured that posts are currently being recruited into. Members were also assured that healthcare acquired infections were being addressed through QSEAC and its Sub-Committee structure, with a paper presented to their most recent Committee meeting outlining the measures in place to ensure appropriate and improving performance.

In August 2018, the Committee received the Month 4 (2018/19) version of the IPAR setting out the Health Board's latest performance position. Members acknowledged the Health Board's dependency on outsourcing with a number of recognised risks around this. Members were advised that the Health Board's RTT trajectory for the remainder of the year

would be built into future reports to BPPAC. Members welcomed the assurance provided that Job Planning compliance across all roles had improved from 2017 to 2018, and emphasised the need to maintain monitoring on this as well as on PADRs. The Committee was advised that healthcare acquired infections remained RAG rated red linked predominantly to community acquired infections, and that work on antibiotic prescribing had been undertaken to address this. Recent changes made to C.difficile testing which is contributing to an increase in reporting is expected to improve by the beginning of next year once this becomes embedded. Other than for E.Coli however, Members were pleased to note that performance is an improving position. Members also noted the contributory factors to non Mental Health Delayed Transfers of Care (DTOC) performance, including a combination of staff shortages and inexperienced staff. However, given that the actions identified to remedy poor performance did not necessarily address these issues, the need was agreed to discuss further the content of each locality plan with the County Directors involved who had participated in disaggregating the information, and to bring back to BPPAC for further assurance. Whilst Members were pleased to note that the percentage of patients that had been offered Mental Health advocacy services had improved in June 2018 to over 90%, it was agreed that with appropriate focus the 100% target should be met. Members were further advised that capacity and demand modelling for lymphodema had been undertaken, and a case made for additional funding from RTT. Services involved were in the process of recruiting to gain additional capacity to bring the current 40 week waiting time back to zero by the end of the financial year. Whilst recognising the risks around this, assuming no sudden hike in demand or worsening workforce position, Members were assured that an improvement should be seen from Quarter 3 onwards. Concern was expressed regarding the current long waits for pulmonary rehabilitation, and assurance was provided that a business case had been drafted to develop a hub and spoke model as a more sustainable solution going forward. Members agreed that further indicators around Electric Bio-Medical Engineering (EBME), fire risk assessments and health & safety compliance should be included within Estates KPIs in future iterations of the IPAR.

In October 2018, the Committee received the Month 6 (2018/19) version of the IPAR, setting out the Health Board's latest performance position, and incorporating the improvements made to navigation within the document following a meeting between members of the performance team and Independent Members. Members were informed of a number of areas where improvements were required to meet targets, and acknowledged the significant challenges ahead for the Health Board given the approaching winter and the saving targets expected from turnaround initiatives. Members noted the impact on unscheduled care with delays to discharges and delays to ambulances from Betsi Cadwaladr University Health Board (BCUHB) due to the increasing number being held up at Ysbyty Gwynedd in Bangor, and Members were assured that meetings would take place and the outcome reported to BPPAC. However, Members were pleased to note that the Health Board is currently performing well on three of the stroke targets and on cancer waiting times where Hywel Dda ranks 2nd amongst Health Boards in Wales.

In December 2018, the Committee received the Month 8 (2018/19) version of the IPAR setting out the Health Board's latest performance position and providing a spotlight on unscheduled care and referral to treatment times. Members expressed concern in regard to the rationale behind the delayed transfers of care (DTOC) for non-mental health being split by locality, and requested clarification that solutions to similar issues which are expressed differently by region are being discussed and resolved Health Board wide. Members were assured that the 3 County Directors form part of the Unscheduled Care Directorate and are engaged in issues regarding complex discharges with discussions take place within Multi-disciplinary Teams to ensure triangulation of services. Members were pleased to note that data on community acquired infections demonstrated a continued reduction compared to the previous year. Given

the positive impact of the recent initiative whereby GPs reviewed urology patient notes to reduce delayed follow ups, it was agreed that discussion would be held at ET on the potential to expand this pilot given its cost-effective nature, whilst accepting that initial funding would be required. Members also discussed the uptake of the influenza vaccination, and whilst welcoming the increased uptake for 2-3 year olds, noted the Health Board's overall performance is below target and lower than other Health Boards in Wales. Members were informed of the supply issues experienced at the beginning of the winter period for vaccinations both for patients aged over 65 and under 65, together with cultural barriers preventing patients from presenting for vaccination which are more prevalent within Hywel Dda. In terms of hand hygiene, Members expressed concern at the 17% disparity in compliance between the lowest and highest performing teams involved. Members were informed of a revised social media campaign for staff, with an improvement plan discussed at length previously in QSEAC and a deep dive on infection prevention planned for the Committee in February 2019, whilst recognising that the target of 95% would be a challenge to achieve. Whilst acknowledging the fragility within current therapy services with a reliance on agency and locum cover, Members were assured that provided current staffing levels held, the Health Board would achieve the zero target of 14 week waits for specific therapies by the end of March 2019.

In February 2019, the Committee received the Month 10 (2018/19) version of the IPAR setting out the Health Board's latest performance position, providing a detailed review on unscheduled care pressures where Members noted that performance had declined in January 2019 compared with the previous month. The current status of Referral to Treatment times was discussed, in particular Orthopaedics and Dermatology, with Members advised that the Health Board is working closely with other providers to ensure that the target of zero for patients waiting over 36 weeks would be met by the end of the financial year. Given that the Health Board has made significant progress with reducing the waiting list by 4,000 to close to zero at the end of the financial year, Members were assured that there should be no requirement to outsource from the end of March 2019. Members noted that whilst the uptake in influenza vaccination shows improvement during 2018/19, overall it is below the Health Board's target, and given that vaccine shortages have affected all Health Boards, Members expressed concern that Hywel Dda is under performing whilst recognising this could be due to a number of factors including patients not attending GP arranged sessions. Members were pleased to note that the therapy waiting list had reduced from over 300 in December 2018 to 150 in January 2019, providing an increasing confidence that the Health Board would reach zero 14-week waits by the end of March 2019.

Members recognised that whilst Hywel Dda is heavily reliant on its tertiary centres for the treatment of more specialist conditions, the trajectory for improvement will require the resolution of a number of issues, and whilst there is now a mechanism for this through the Joint Regional Planning & Delivery Committee (JRPDC), the work of this Committee remains longer term focused in the main.

Healthcare Associated Infection (HCAI) Improvement Plan – in April 2018, the Committee received the HCAI Improvement Plan noting that a different risk-based approach was being taken to previous years linked to population needs. Members noted that whilst work currently undertaken in in-patient areas would continue, the focus for 2018/19 would be on population health and working with those in the community to tackle community acquired infection, given that a significant number of reported infections for 2017/18 were not hospital acquired. Whilst confirmation of this year's WG target had not at this point been received, it was anticipated that an infection reduction would remain for 2018/19.

Financial Update & Turnaround Programme Update – at its meeting in April 2018, the Committee noted the Month 12 2017/18 performance demonstrated a £69.413m deficit,

£0.287m less than the revised year end forecast, due to a number of positive movements and an improving position in primary care prescribing, CHC reconciliation and final agreements with Local Authorities. A report on turnaround was shared with Members providing an update on savings at year end of £29m. The Committee welcomed the thematic and co-ordinated approach undertaken, with five major 60 day improvement cycles underway to drive progress against saving plans for 2018/19 and to ensure actions are aligned, which should create savings and deliver benefits for patients.

At its June 2018 meeting, the Committee received an update on the Health Board's financial position and was informed that the Health Board had received £27m additional funding following WG's zero based budgeting review. The Committee acknowledged the particularly challenging 2018/19 Financial Plan outlining a deficit budget of £62.5m which would require the achievement of £30.7m of recurrent savings schemes to be delivered in-year in order to sustain improvement in the underlying financial position. However, Members expressed concern that only £14.9m (49%) of these schemes had been RAG rated as green, with £8.3m rated amber (27%) and £7.5m rated red (24%).Whilst Members were advised that the financial position should be achievable with the current building blocks in place, it was acknowledged that this would require the right focus, the right accountability and the right reporting in place which would be key in terms of moving from process to delivery.

At its August 2018 meeting, the Committee received a further update on the Health Board's financial position, and feedback was also received on the detailed discussions held on the opportunities for financial turnaround on both planned care and RTT. Members expressed concern at the Health Board's deteriorating run rate to be addressed through operational savings which would need to be delivered at pace, although acknowledged that the CEO Holding to Account meetings were helping to build a rhythm and focus for this work. Members were however pleased to note the improvement in Month 4's RAG rating assessment of savings delivery and that focus would be on delivery of the schemes identified.

Following elevation of the Finance Sub-Committee to a statutory Committee of the Board, no further Financial Update & Turnaround Programme Updates were presented to BPPAC.

Flu Vaccine Campaign Performance Update – at its meeting in April 2018, the Committee received a comprehensive update on performance in regard to the 2017/18 Seasonal Influenza Plan, setting out the Health Board's approach to improving vaccination uptake rates over the following 3 year period. The report highlighted the innovative practice that had had an impact on performance in 2017/18, together with a number of initiatives to take into 2018/19. Members were pleased to note the 14% increase in staff uptake rate across the Health Board representing the most improved position across Wales, however expressed disappointment at the entrenched issues remaining within Hywel Dda's population in regard to flu and childhood vaccination uptake, particularly amongst the over 65's, and the 6 months to 64 year olds in clinical risk groups, which highlighted the need for smarter targeting of certain risk groups and the need for further engagement with primary care. Members were assured that some of the more positive work emerging from the 2017/18 programme would be worked upon for 2018/19 in order to turn the learning into practice.

NHS Wales Shared Services Partnership (NWSSP) Summary Performance Report –at its meeting in August 2018, the Committee received an update on performance information in respect of the services received from NHS Wales Shared Services Partnership (NWSSP) for the half year ended 30th June 2018. Members noted that the Health Board's recruitment performance remained an issue for both of the quarters reported, and suggested the Workforce & OD Sub-Committee consider recruitment as a whole. However, Members were pleased to

note that the indicators for management responses to draft Internal Audit reports to be received within 15 days, and report turnaround to draft responses within 10 days, both achieved 100%.

In December 2018, the Committee received a further update on performance for the three months ended 30th September 2018. Members discussed the reasons for the organisation missing the target time to approve vacancies and were informed of the number of factors involved including the tracker not being updated in a timely manner and delays built into vacancy advertisements to comply with departmental budgetary targets. It was proposed that at the next NWSSP meeting in January 2019, an option to allow for this within the KPIs be considered.

In February 2019, the Committee received a further update on performance information for the three months ended 31st December 2018. Members were pleased to note that payroll accuracy was above target with the Health Board achieving the highest performance against this target across Wales, and the Health Board's improved position from Quarter 2 onwards in relation to the time to approve vacancies although not currently meeting the target set. Members queried the reduction in performance for invoice turnaround times during Quarter 3, and whilst recognising that implementation of the 'no purchase number no payment' initiative had had an impact on this, Members were assured that this should improve for future quarters.

Progress Against External Governance Review (EGR) 2017 and Wales Audit Office (WAO) Structured Assessment (SA) 2015 – at its meeting in June 2018, the Committee received an update on the progress made in implementing outstanding recommendations from the External Governance Review 2017 and the Wales Audit Office Structured Assessment 2015, which BPPAC had been requested to monitor. Members accepted that in a number of cases, timing issues had frustrated progress, and it was agreed that Executive leads should draft a short summary to explain why progress could not currently be made for onward reporting to Audit, Risk and Assurance Committee (ARAC) and to highlight this in the BPPAC update report to Board.

Mortality Exception Report – also at its meeting in June 2018, the Committee received the Health Board's mortality indicators, following discussion at the April 2018 QSEAC meeting. Members were assured that following a significant review of the handling of the Health Board's mortality review arrangements, variation in the way in which reviews had been undertaken at GGH and Prince Philip Hospital (PPH) would be addressed and amended to the all Wales process, meaning that more timely reviews could be undertaken and moving the Health Board closer to the WG target. Whilst concern was expressed at the reviews findings, Members were assured that the reasons for increases in mortality had been scrutinised at QSEAC particularly in light of capacity issues relating to internal clinical coding and recent events experienced in Gosport.

Internal Review of the 111 Service – also in June 2018, the Committee received the outcome from the internal review of the 111 service, undertaken to consider the broader impacts of a weakened out of hours service on the unscheduled care pathway. Whilst commending the report which served to demonstrate the challenges involved, Members expressed concern that the initiative appeared to be increasing pressure on GPs when its intent had been to alleviate this. Given assurances could not be provided as to how the service would be improved, it was agreed for an update to be presented to the Committee in October 2018, when a number of the actions proposed to be undertaken should have been put into effect.

In October 2018, the Committee received an update report, addressing in particular concerns regarding the impact of the further expansion of 111 across the Health Board. Members were assured that to address these concerns, robust engagement events had taken place and an

Out of Hours GP Advisory Panel established, together with an Out of Hours Peer Review programme undertaken in August 2018, in readiness for the launch of the 111 service in October 2018.

In December 2018, the Committee received a further update report following the roll out of the 111 service across the Health Board. Members noted that the service had appointed Advanced Paramedic Practitioners (APPs) to supplement the GP workforce, and that with the support of Welsh Ambulance Service Trust (WAST), an additional four APPs would be recruited with the intention to acquire funding to enable these to become permanent roles. Members were presented with highlights from the Out of Hours Peer Review including the positive work undertaken with GPs in Pembrokeshire and Ceredigion who had been interviewed as part of the process. Members recognised that the Health Board would benefit from an improved flow between daytime primary care and OOH services as a key part of the unscheduled care system, and the intention to embed 111 and the new roles within the service over the following 6 months. Whilst acknowledging that Members and Health Board officers understood the operational challenges experienced by the Health Board in achieving national performance targets, it was suggested that the platform of social media be utilised to enable the public to have a better understanding, and for discussions to be held with Hywel Dda CHC on how best to inform the public of the current challenges faced.

Estate Operational Maintenance Performance & Compliance – at its meeting in June 2018, the Committee received the current performance and compliance position within operational estates maintenance, covering operational planned preventative maintenance (PPM) and associated prioritisation process, operational governance including resource gap analysis and associated risk management arrangements. Members commended the comprehensive review noting the key issues affecting performance and compliance were the amount of the estate, the poor state of it and the shortages within its workforce. It was agreed that estates compliance issues should continue to be reported through the H&SEPSC, with performance incorporated within the IPAR.

Primary Care Initiative Pilot - Undertaking Clinical Validation in Primary Care of our Urology Patients Waiting over 100% Delayed for their Follow Up – also at its meeting in June 2018, the Committee received an evaluation of the primary care initiated collaborative pilot for a cohort of patients on the follow up not booked waiting list, which had emanated through risks identified in follow up appointments and the need to address these. Given the pilot's success, Members suggested this initiative be used as a tool for inclusion as part of the Health Board's armoury to address follow ups and to consider areas to target.

Delayed Follow-Up Report Including Plans for 2019/20 – at its meeting in February 2019, the Committee received the Delayed Follow-Up Report including Plans for 2019/20, indicating whilst the Health Board is showing early improvements, significant challenges remain. Members were advised of the three workstreams in place running parallel to each other and with pathway management also in place, which is showing improved outcomes. Members were further advised that gaps in staff knowledge in relation to patient pathways when using Myrddin and/or the Welsh Patient Administration System (WPAS) had identified data being entered incorrectly, resulting in duplication on the delayed follow up list, however the project plan to address the training requirements, due for completion by the end of March 2019, should mean fewer errors over time. Whilst acknowledging the concerns in regard to data accuracy and the current limitations of WPAS, given the planned improvements and increased staff training, Members were assured that all specialities should see a 25% improvement on the overall volume of patients waiting for follow-up outpatient care during 2019/20.

Briefing Note - Outpatient "Follow-Up Not Booked" Reporting – at its meeting in October

2018, the Committee received a briefing note providing an update on the failure of the Health Board to supply the Follow-up Not Booked report to Welsh Government since August 2018 following an upgrade to the Myrddin Patient Administration System. Following the application of a fix on 18th October 2018, the Informatics Team were satisfied that the comparison between July 2018 and September 2018 was within tolerance, therefore the Follow-up Not Booked report was deemed fit for purpose and advised that the statutory return should be submitted to WG. The Chair of BPPAC asked for information to be provided on the nature and extent of testing carried out prior to going live with the Myrddin update.

Business Planning

Work-In-Progress Against the 2019-22 Integrated Medium Term Plan Including the Integrated Planning Assurance Report (IPLAR) – at its meeting in June 2018, the Committee received an update on the development of the draft work in progress on the Integrated Planning Assurance Report (IPLAR) and the proposed next steps. Members noted that the purpose of the IPLAR was to demonstrate to WG the seriousness with which the Health Board is taking the NHS planning framework, incorporating the 'must dos' and 'what good looks like', etc, and looking to maximise integration opportunities. Whilst commending the work involved, Members agreed a more concise version would be required going forward with hyperlinks to appendices to enable Members to consider the detail involved.

In August 2018, the Committee received an update on the development of the draft work in progress on the IPLAR, and were advised of the issues involved in the process of aligning significant work-streams such as Transformation, Turnaround, Performance, Quality Improvement, Organisational Development, IMTP Planning, etc, into one framework. Members noted the intention to have a first cut IMTP drawn from the outputs of all work-streams, for the November 2018 Board meeting, in order to demonstrate a concerted direction of travel. To provide an assurance that planning is being delivered in an integrated way, Members noted the establishment of a Planning Review Panel to check and challenge Triumvirate, Service and Directorate plans and their ongoing alignment through Turnaround and Transformation work programmes, and to support the development of business cases, invest to save and other funding streams which help deliver the Health Board's planning ambitions and objectives and maximise integration opportunities, with the resulting Triumvirate / Service / Directorate plans tracked within the IPLAR. Members recognised that the main thread to demonstrate to WG would be 'value' as a key enabler, and the need was agreed to weave in the quality improvement story to this work.

In October 2018, the Committee received an update on the work in progress against the IMTP including the IPAR and were advised of the process of aligning several significant work-streams into a single plan. Members were informed of the new format for the IMTP, with further discussions on its content to take place with WG prior to the submission date of 31st January 2019, with each chapter of the IMTP containing a detailed plan including evidence. Members accepted that the IPLAR is still work in progress whilst anticipating this will be the proposed governance process supporting the production of the plan, including the document structure going forward.

Following the October 2018 BPPAC meeting, it was proposed that progress of the IPLAR would be presented to the Planning Sub-Committee and reported via the Planning Sub-Committee update report to BPPAC.

Report on the Provision of Residential/Doctors Accommodation – at its meeting in April 2018, the Committee received an interim report in response to concerns raised in a variety of

arenas on the diminishing and sub-standard residential facilities in place across the Health Board. Difficulties in resolving the issues to the standards expected were acknowledged by Members, particularly given the age of the accommodation. The Committee was informed that a Task & Finish Group had been established at the request of CEIM&TSC to address initially the short to medium term issues. The Committee stressed the need to receive an assurance that the sub-standard accommodation's impact on recruitment is minimised as far as possible for both doctors and nurses. In view of the scale of the issues involved, a further report with firm actions was presented to BPPAC in August 2018, where Members were assured that a number of the previously identified housekeeping issues had been resolved, together with better tenancy agreements in place to safeguard the interests of both the Health Board and the tenants involved. Members welcomed the £100K allocated from discretionary capital with the potential for further monies to become available, and were advised that prioritising of this funding would take place for CEIM&TSC' consideration. Members acknowledged that actions over the longer term would need to tie in with the Board's decision on TCS, recognising that different solutions may be required if a new build is proposed. Members sought assurance that the way in which SIFT (Service Increment for Teaching) is to be standardised is progressing with transparency and it was agreed to have a conversation with each hospital site to determine the best way of managing this going forward. It was further agreed to include junior doctor representation on the membership of the Accommodation Task & Finish Group.

The Committee received a further update in December 2018, advising that in order to facilitate improvements, £200,000 had been allocated from discretionary capital and that priority areas for its use had been agreed to address the poorest accommodation in the first instance. Members were informed that the support provided by the Health Board to improve accommodation had been welcomed by students and partner universities alike. Whilst Members were assured that the Accommodation Task & Finish Group would continue to monitor the progress of the work planned, given the further funding required the Committee suggested that junior doctors' accommodation be considered a priority area for the 2019/20 discretionary capital programme, whilst acknowledging that in the longer term, new accommodation would be required through major capital development to meet the expected standards. To provide further assurance to BPPAC on progress, it was agreed that a RAG rated compliance report from the Accommodation Task & Finish Group would be presented to the next CEIM&TSC meeting.

Update on All-Wales Capital Programme 2018/19 Capital Resource Limit and Capital Financial Management – the Committee received update reports on the All Wales Capital Programme 2018/19 Capital Resource Limit and Capital Financial Management up until August 2018 when it was agreed that these would be reported to Finance Committee following its elevation to a formal Committee of the Board in September 2018. At its meeting in June 2018, Members expressed concern at the level of unallocated discretionary capital and the significant weighting of the profile in the final months of the year, which increased the risk of the Health Board being able to deliver the highest risk schemes by 31st March and increased the risk of having to use project/scheme slippage and under-spend on lower risk scored items which are deliverable by 31st March. In August 2018, Members were informed that potential Brexit implications had led to a recommendation from the central procurement team to limit expenditure in March 2019, particularly where there is a reliance on goods from abroad, and to carry stock forward from February 2018 onwards. It was agreed that as much as possible should be fast tracked and brought forward by one quarter where there is the potential for risk.

Update on All Wales Capital Programme & Discretionary Capital Programme incorporating the Capital Governance Update – the Committee received regular updates

throughout 2018/19 on the All Wales Capital Programme & Discretionary Capital Programme incorporating the Capital Governance Update. In June 2018, the Committee agreed the recommendation on how the 2018/19 discretionary capital programme was to be allocated, noting that the development scheme allocations remained budget figures at this stage and subject to tenders, and that any underspends would be reported back to BPPAC with recommendations for its reallocation. The Committee continued to receive updates throughout 2018/19 on the schemes in progress, and in August 2018, acknowledged the need for a holding position until the Medical Devices Inventory Report was complete with a sum of £1million of discretionary capital retained until the extent of the capital required was known. Details of the allocations which the CE&IMTSC had approved were reported to BPPAC and Members were advised that contingency requests were currently higher than in previous years by about £100,000, which would be monitored to establish whether in future years the Health Board should allocate a larger contingency fund. Members noted that the £2.5 million for pre-commitments in association with the 2019/20 Discretionary Capital Programme (DCP) were significantly higher than that which had previously been considered by BPPAC and raised concerns that these pre-commitments could impact on other requests.

In December 2018, the Committee was advised that a further allocation of £1.454m for the DCP had been approved, to be split between the Bronglais General Hospital (BGH) Front of House Scheme due to the reduction in VAT % recovery, and an increase in the contingency budget, with the balance of £1.1m to be prioritised. Members were also provided with an update on the current position with Aseptic Units, and advised that the further options identified by Transforming Access to Medicines (TRAMS) would not be agreed until March 2019. Members were informed of a change in the strategic approach with the proposed option to have 3 regional units across Wales, supported by small local units, and that a Business Justification Case would be produced against this revised position. Given the concerns expressed at the increased risk in the Health Board'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, for the Committee's assurance it was proposed that an update be presented to the next meeting on the actions being taken to manage the risks involved.

In February 2019, the Committee was advised that the balance of £1.1m would be allocated for capital only, and following discussions with WG, a further £800,000 year end funding would be allocated for equipment. Members discussed the pre-commitment of 2019/20 allocations and whilst expressing concern with the agreed level given the advised slippage of projects, accepted that the mitigations put in place should reduce the risk involved. Members were advised that the focus of the CEIM&TSC would be to minimise additional spending in the final quarter of the financial year, in order that the Health Board is in a better position next year.

2018/19 Annual Plan Quarterly Updates – throughout 2018/19, the Committee received regular quarterly updates on the 2018/19 Annual Plan, providing a position on progress against the actions noted in the Health Board's 2018/19 Annual Plan for compliance with Welsh Government requirements, and the expectations for delivery. Whilst accepting the evolving nature of the documentation, the Committee requested a more focused set of actions with more impactful outcomes for future reporting. To facilitate this, it was suggested that each Director should consider their own particular area to reduce the number of objectives, and for the report to only include impactful actions for the remainder of the year with this format to continue into 2019/20. Members welcomed the more succinct reporting and acknowledged the progress made.

Together for Health Delivery Plans – at its meeting in April 2018, the Committee received a comprehensive package of Together for Health Delivery Plans for their subsequent

approval. Members welcomed the wealth of ambition contained within each plan, mapping the work underway to address prevention and population health, and dovetailing together the actions and plans to provide assurance on the linkages in place. The Committee noted that the re-freshed Annual Plans had been based on a consistent corporate approach, with a focus on the prevention agenda. The Committee further noted that Welsh Government had directed Health Boards to concentrate on 11 Delivery Plans with Hywel Dda having currently drafted 7 and in the process of reviewing these to ensure all actions are appropriate. Members were assured that work would continue to have these ready for endorsement by the Planning Sub-Committee in May 2018 in readiness for approval by BPPAC in June 2018, with the 4 outstanding plans following a similar process. Members agreed that sufficient detail had been provided for the Committee to approve the Critical Illness and Liver Disease Annual Reports 2017/18 in April 2018. In June 2018, the Committee received the further progress made in developing the Together for Health Delivery Plans, and Members were assured that whilst all were at different stages of development and would evolve through the 2018/19 planning cycle, all had been the subject of robust discussion at the previous Planning Sub-Committee meeting. Members took an assurance from the mechanisms in place to ensure these had been through a rigorous process and approved the refreshed plans that would be developed and updated through 2018/19.

Monitoring of Welsh Health Circulars (WHCs) – the Committee received regular progress updates in respect of those WHCs falling under the remit of BPPAC and its Sub-Committee structure during 2018/19. Recognising the implications for quality and safety of non-compliance with a number of the circulars, the Committee requested an assurance that these are being addressed, and agreed the need to ensure the quality & safety implications that derive from these were programmed into QSEAC's agenda. It was acknowledged that in number of cases, the Committee could not take an assurance from the exception report as the updates simply involved moving timelines along, and Members directed that firmer updates on progress would be required for monitoring by BPPAC for further assurance in future.

Patient Access Policy – at its meeting in June 2018, the Committee received the revised Patient Access Policy following the July 2017 Board decision to grant authority to implement the policy with the qualification that the Scheduled Care team review the complexity of the document and submit an amended version to BPPAC for consideration and approval. The Committee welcomed the review, commended the inclusion of the patient facing documents, and approved the revised Patient Access Policy.

Fishguard Health Centre Refurbishment and Extension Business Justification Case (BJC) – also at its meeting in June 2018, the Committee received the Fishguard Health Centre Refurbishment and Extension BJC. Members acknowledged the BJC's strategic importance given there is no identified hub in north Pembrokeshire, and recognised the amalgamation of the two practices involved as a short to medium term solution to stabilising GMS in the area until a longer term solution could be found. The Committee approved the BJC for onwards approval via Health Board Chair's Action to WG to ensure submission at the earliest opportunity.

Medicines Transcription and Electronic Discharge (MTED) Evaluation and Option Appraisal – at its meeting in August 2018, the Committee was informed that a business case to support MTED had been presented to ET for consideration. Whilst ET had supported this in principle, the business case had been unable to proceed due to other challenges and priorities for investment, and would now be considered through the Health Board's 2019/20 planning cycle. It was agreed that BPPAC would maintain a watching brief whilst removing MTED as a standing item from its agenda unless the position changed.

In December 2018, the Committee was advised of a further roll out of MTED in BGH to address patient safety concerns on surgical wards. Members expressed concern that evidence had not been received that the benefits outweighed the cost of implementing MTED, and the lack of a formal approach to this roll-out meant there was no learning which was transferrable to other sites, nor was it scalable. Furthermore, ET had previously agreed that given the significant implementation and ongoing revenue costs involved, the system was not a sufficient priority for the Health Board, and had suspended further roll out. Concerns were expressed at the lack of governance that led to the decision to roll out MTED in BGH and it was proposed that ET receive a further report for consideration and for an update to be provided to BPPAC.

In February 2019, the Committee received an update from the discussion at ET and Members were advised that discussions had focused on the innovative way MTED had been introduced whilst avoiding the need for additional resources. The outcome from ET proposed that learning should be shared to establish whether this roll out could be taken forward within other areas of the Health Board. Members suggested that MTED should be a standing agenda item for the Capital, Estates and IM&T Sub-Committee (CEIM&TSC) to monitor progress and for any exceptions to be escalated to BPPAC. Members were further advised that to ensure the correct governance process is followed in future, proposals for further roll outs would be discussed by ET first.

Major Incident Plan – at its meeting in August 2018, the Committee received the updated Major Incident Plan 2018/19, revised to reflect current structures, command and control mechanisms and response processes. As part of its annual review process, Members were assured that the Major Incident Plan had been scrutinised by all relevant groups and was endorsed by the Committee prior to onward submission to the Board for approval in September 2018.

Research & Development Presentation – at its meeting in October 2018, the Committee received a presentation on Research & Development (R&D) from Professor Keir Lewis, highlighting the growth in R&D income over the past 10 years. Members welcomed the Health Board's links to ARCH, including the City Deal and other health and well-being activities. Members were informed of the future vision for R&D, which includes targeting participation in high scoring trials, however acknowledged that whilst WG expect a 10% increase in R&D income year on year, the current lack of clinicians and investigators involved in research within Hywel Dda poses a risk to achieving this. Members welcomed the Health Board's vision to recognise R&D as part of core business, acknowledging that cultural change is required to support teams to deliver this, and that the guiding principle of research should be the ambition to improve everyone's health in the future

Update On the Reporting And Validation Of Delayed Transfers Of Care – also at its meeting in October 2018, the Committee received an update on the reporting and validation of Delayed Transfers of Care across the three counties of Hywel Dda. Members were assured that revised processes had been considered to ensure that these are wholly consistent and compliant with national guidance, and Members acknowledged that the Health Board required a standard process going forward.

Implementation of National ICT Systems Within Hywel Dda University Health Board – at its meeting in December 2018, the Committee received an update on the implementation of National ICT Systems to provide clarity on those systems being implemented by the Health Board and the timescales for when new versions would become available. Members queried the Health Board's ability to influence the priorities for implementing these various systems and were advised that at a National Informatics Management Board level, the focus

is on collating all business cases onto one platform and to prioritise these on an all Wales level. Whilst the Cabinet Secretary has allocated £50m for Information Technology improvements across Health Boards, current business cases exceed this figure and it will therefore be a challenge to determine which projects to prioritise. Members queried the delay in rolling out improvements to the Wales Clinical Portal and were advised of the factors contributing to this including a lack of capacity to make progress and a lack of agreement on which systems should be prioritised. Members agreed that timescales should be included for future reports. The Chair suggested that further assurance could have been derived from the paper were the level of usage of these systems by the Health Board included within the report and it was agreed that a further paper on current levels of adoption and usage would be presented to BPPAC.

Implementation of the Single Cancer Pathway (SCP) – at its meeting in February 2019, the Committee received an update on progress towards implementation of the Single Cancer Pathway (SCP). Members were advised of the changes involved with the introduction of the SCP, the most significant being how the pathway will be tracked. Members acknowledged that the SCP should reduce inequality in the system, however shared the concerns expressed by other Health Boards regarding possible delays with diagnostic testing for other specialities. Members were assured that the Health Board is considering a range of options to increase capacity for the short and medium term, including exploration of opportunities for regional collaboration given the recruitment and capacity challenges currently experienced within Radiology & Pathology services in Hywel Dda.

Delivery of Ophthalmology Implementation Plan – also at its meeting in February 2019, the Committee received an update from the Ophthalmology Service on its compliance with the delivery of improvement plans. Members were pleased to receive confirmation that funding from WG of £605,500, to be spilt over two years, had been confirmed to support the Health Board's Eye Care Sustainability Plan for the community development of Cataract, Glaucoma and Wet Age-Related Macular Degeneration (wAMD) pathways services.

Risk

Corporate Risk Report – the Committee received regular Corporate Risk reports throughout 2018/19, highlighting the corporate risks assigned to BPPAC for consideration. Members noted that each risk had been assigned to an individual Executive Director and that assurance should be received that these are on track. Following detailed discussions on each of the risks, whilst acknowledging some of the identified controls in place, Members expressed concern regarding the number of gaps in controls where no assurance could be taken. It was agreed that continued scrutiny of all corporate risks assigned to BPPAC would be undertaken at each presentation to BPPAC.

Operational Risks Report – the Committee received regular Operational Risks reports throughout 20181/9 outlining the operational risks assigned to BPPAC. These risks were scrutinised in detail and Members received assurance from the relevant controls and mitigating actions in place, with only minor caveats.

Feedback from Sub-Committees
In terms of feedback from Sub-Committees:

- **Capital, Estates & IM&T Sub-Committee** – regular written update reports from the Capital, Estates and IM&T Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:

Capital Schemes during 2018/19

- Aberaeron (Minaeron)
- Aseptic Unit, Glangwili General Hospital
- Bronglais General Hospital, Chemotherapy Day Unit
- Bronglais General Hospital Emergency Fire Lift and Theatre 1 Project
- Bronglais General Hospital Front of House
- Cardigan Integrated Care Centre
- Catering, Health Board wide (not active – to be designated 'on hold' for the next reporting period)
- Cross Hands Health and Wellbeing Centre
- Cylch Caron Integrated Care Project
- Endoscopy and Day Surgery Project, Prince Philip Hospital
- Fishguard Health Centre
- Major Infrastructure and Ward Refurbishments Programme, Health Board wide
- MRI Unit, Bronglais General Hospital
- North Road Clinic,
- Pharmacy Projects, Health Board wide (MTED and Ward Automation)
- Pond Street Clinic/Penal, Carmarthen
- Transforming Mental Health: Acute Inpatient Re-design, Health Board wide
- Ward 10 Refurbishment, Withybush General Hospital
- Welsh Community Care Information Solution (WCCIS) Project
- Women & Children's Phase 2, Glangwili General Hospital

The following projects were placed on hold during 2018/19:

- Cardiology Suite, Glangwili General Hospital – subject to further regional work
- Energy Project, Phase 2, Health Board wide
- IM&T Programme Business Case, Health Board wide

- **Capital – Discretionary Capital Programme (DCP) -** reports received recommending prioritisation and reports monitoring expenditure against the Capital Resource Limit (CRL). Recognising the risk that capital resource remains insufficient to manage all the backlog pressures, three particular pieces of work were taken forward:
  - Development of Estates Major Infrastructure draft Programme Business Case (PBC)
  - Continued dialogue with Welsh Government on the IM&T Programme Business Case
  - Medical Devices Inventory Report

- **Annual Plan 2019/20 – Enabling Plans**
  - Capital Enabling Plan – Infrastructure & Investment
  - Digital Enabling Plan

- **Capital Audit –** updates on progress made with regard to recommendations received from NWSSP Audit and Assurance Services in respect of a number of the audit reports undertaken on capital projects.

- **Risk -** updates received to the risk management process and directorate level risks reviewed that exceeded the UHB agreed risk tolerance, aligned to the Sub-Committee.

- **Other Capital Areas of Responsibility**
  - Integrated Care Fund (ICF)

- Learning Disability provision in Pembrokeshire and Carmarthenshire
- Residential Accommodation
- ISO 14001 Annual Environmental Management Review
- Informatics Operational Plan
- Carmarthen West Development
- Transforming Mental Health – Capital Issues
- Regional Cellular Pathology
- Planning Cycle – Emerging Capital Pressures
- Heavy Fuel Oil
- Water Management Solution
- All Wales E-Nursing Documentation Programme
- LINC Business Case

Where appropriate, key risks and issues/matters of concern and items for approval were escalated to BPPAC during 2018/19.

See Appendix 1 for the full Capital, Estates and IM&T Sub-Committee Annual Report.

- **Health & Safety and Emergency Planning Sub-Committee** (HS&EPSC) – regular written update reports from the Health & Safety and Emergency Planning Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Review of Health and Safety Conditions within Community Premises.
  - Review of COSHH compliance across the Health Board.
  - DSE E-Learning.
  - First Aid Training.
  - Violent and Aggressive Patient Warning Marker Procedure.
  - Violence and Aggression Restrictive Physical Intervention (RPI) Training.
  - Risk Register Review.
  - Access Control & Closed Circuit Television (CCTV).
  - Hospital Lock Down Arrangements.
  - Fire Safety Training, Management Resource and Fire Risk Assessments.
  - Manual Handling Training.
  - Bed Frame Audit.
  - Improve the Process for Bariatric Patient Admission and Discharge.
  - Sharps Injury Audit.

  The HS&EPSC also received updates on the on-going training, exercising and preparedness measures undertaken both internally, and on a multi-agency basis. These included:
  - Business Continuity
  - UK Threat Levels Response Plan
  - Major Incident Plan
  - Mass Casualty Incident Arrangements for NHS Wales
  - Severe Weather Response Protocol

  The following Health and Safety Policies/Procedures were approved by BPPAC during 2018/19:
  - COSHH Policy & Procedure – approved May 2018
  - Violence & Aggression Policy – approved May 2018
  - First Aid at Work Procedure – approved May 2018

- New & Expectant Mothers Procedure – approved November 2018
- Lockdown Policy – approved January 2019
- Health and Safety Policy – approved March 2019

In terms of feedback from the Groups reporting to the HS&EPSC, regular written update reports from the following were received during 2018/19:

- Fire Safety Group (FSG)
- Water Safety Group
- Medical Gases Group
- Health and Safety Advisory Group

Where appropriate, key risks and issues/matters of concern and items for approval were escalated to BPPAC during 2018/19.

See Appendix 2 for the full Health & Safety and Emergency Planning Sub-Committee Annual Report.

- **Information Governance Sub-Committee** – regular written update reports from the Information Governance Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Cyber Security - NHS Wales External Security Assessment
  - IG Activity Report
  - General Data Protection Regulation Update
  - Data Quality / Clinical Coding Update
  - National Intelligent Integrated Audit Solution (NIIAS) Update
  - Annual Review of Information Governance related written control documentation
  - Training and Awareness Development
  - IG Risk Register
  - Data Protection Impact Assessments (DPIA)
  - Welsh Health Circulars
  - C-PIP (Caldicott Out-turn Report)

  See Appendix 3 for the full Information Governance Sub-Committee Annual Report.

- **Planning Sub-Committee** – regular written update reports from the Planning Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Review of the risks aligned to the Planning Risk Register.
  - The Integrated Planning Assurance Report (IPLAR).
  - Digital Health.
  - Mental Health Implementation Group.
  - Transforming Clinical Services Programme (TCS) / A Healthier Mid and West Wales.
  - Together for Health Delivery Plans.
  - All Wales 2018 Summer Planning Event.
  - Welsh Health Circulars.
  - Commissioning Framework.
  - Wellbeing and Future Generations (Wales) Act.
  - Research, Development and Innovation.
  - Regional Partnership Board and the Transformation Fund.
  - Welsh Trauma Network updates.
  - Development of the UHBs End of Life strategy.

- Minutes of the Hywel Dda Community Health Council Service Planning Meetings – for information.
- Updates on collaborative/regional work to ensure/provide assurance that planning implications were understood and joined up as appropriate:
    - Mid Wales Joint Health and Care Collaborative (MWJC).
    - A Regional Collaboration for Health (ARCH)
    - Joint Regional Planning and Delivery Committee (JRPDC)

Where appropriate, key risks and issues/matters of concern and approval items during the reporting period, were escalated to BPPAC.

See Appendix 4 for the full Planning Sub-Committee Annual Report.

- **Finance Sub-Committee** – written update reports from the Finance Sub-Committee have been received by the Business Planning & Performance Assurance Committee up until September 2018 when it became elevated to a formal Committee of the Board, highlighting the key areas of work scrutinised by the Sub-Committee, including:
    - Monthly financial performance and savings position
    - Efficiency opportunities
    - Finance Sub-Committee Annual Report

Following the final meeting of the Finance Sub-Committee on 28th September 2018, the Committee acknowledged the closure of the Sub-Committee following its elevation to a formal Committee of the Board, and that for future BPPAC meetings, finance reporting would be limited to the summary contained within the IPAR.

Collaborative Working/Update Reports:

- **A Regional Collaboration for Health (ARCH) Update** – the Committee received regular feedback from the ARCH Programme Board on the breadth and level of work undertaken during 201/19, including:
    - the Regional Orthopaedic Summit held on 15th March 2018 with the work programme being taken forward by the Chief Operating Officers from both Hywel Dda and ABM UHBs;
    - the Hyper Acute Stroke Unit where work is progressing on the regional stroke specification in anticipation of funding going forward;
    - the ACCELERATE programme, a platform for delivering medical innovation which will afford further opportunities within the innovation field;
    - the Service Transformation Programme which has synergy with a number of the Health Board's imperatives.

  Members were pleased to note that whilst ARCH had commenced as a strong relationship between ABMUHB and Swansea University, given the number of Hywel Dda Executive Directors taking the lead on many of the projects involved, HDdUHB is now considered an equal partner. However, Members expressed concern that the ARCH Programme Board had not met for some months and it was agreed to raise this concern through the ARCH Delivery and Leadership Group.

  Members agreed the need for the work of ARCH and other collaboratives such as the West Wales Partnership Board to be linked together to ensure actions are aligned and duplication avoided.

- **Llanelli Wellness and Life Science Village Update** – regular updates were presented

to the Committee during 2018/19 highlighting the key milestones achieved, including work to develop the Outline Service Specification for the project and the Clinical Delivery Plan for approval by the Health Board's Executive Team, and its closely related Skills and Training Plan. Members acknowledged that the Village would be reliant on inter-related elements in order to gain maximum benefit. Members received an assurance on the Village's alignment to the Health Board's strategic and service plans, and that work would progress to achieve a revenue neutral position in addition to the significant savings proposed through the wider health system. Members acknowledged that the Village supported the direction of travel for ARCH and addressed the Health Board's workforce recruitment and retention issues by providing on-site training, etc, and agreed that it should be ambitious in terms of the services it provides.

- **West Wales Regional Care Partnership Board -** the Committee received regular updates on the work of the West Wales Regional Partnership Board throughout 2018/19, and acknowledged the pace in moving towards an integrated health and social care model. Members were advised that going forward, the Regional Partnership Board (RPB) would represent the fundamental arena where collaborative business will be undertaken, and noted that publication of 'A Healthier Wales' had signalled provision for £100m to be made available through RPB arrangements. In future, it is anticipated that many millions of pounds worth of business will be undertaken through this mechanism, bringing with it a new set of governance arrangements to be addressed which would be reported to the Board.

  The Committee was also presented with the Carer's Annual Report for 2017/18 and the Carers Delivery Plan for 2018/19, demonstrating the ambition of what can be achieved and the better value that can accrue by joint working on this agenda.

- **City Deal Update Report** – at its meeting in August 2018, the Committee received an update on the development of the draft business case for the Health and Life Science Campus for Swansea as part of the City Deal, in a paper previously considered by ABMU Health Board.

- **Strategic Partnership Plans**– at its meeting in April 2018, the Committee received the Public Services Boards (PSBs) Well-Being Plans for each local authority area, and the West Wales Area Plan developed by the West Wales Regional Partnership Board, which had received endorsement at the March 2018 Public Board meeting. These assured the Committee that the Health Board is meeting its obligations under the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014.

- **Wales Major Trauma Network –** the Committee received regular update reports during 2018/19 from the Wales Major Trauma Network report for information. At its meeting in December 2018, Members were advised of a report planned for a subsequent ET meeting to support the designation of a Trauma Unit within Hywel Dda, followed by formal agreement through the Board in January 2019. Members were advised that the availability of a 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS) service had been acknowledged by Health Boards across Wales, and the next stage would be to acquire funding to meet this aspiration.

Key Risks and Issues/Matters of Concern Reported by BPPAC to the Board during 2018/19:

- **Report on the Provision of Residential/Doctors Accommodation** - concerns regarding the scale of the issues involved in relation to the diminishing and sub-standard residential accommodation facilities in place across the Health Board, to be addressed

through funding allocated from discretionary capital and the work of the Accommodation Task & Finish Group reporting to CEIM&TSC.

- **Monitoring of Welsh Health Circulars (WHCs)** – concerns at the lack of assurance that could be taken from the exception report to be addressed by the requirement for firmer updates on progress for monitoring by BPPAC in future.
- **Mortality Exception Report** – concerns in regard to the reviews findings to be mitigated by further scrutiny at QSEAC.
- **Financial & Turnaround Programme Update** - concerns regarding the Health Board's deteriorating financial run rate to be mitigated through operational savings delivering at pace, with the CEO Holding to Account meetings building a rhythm and focus for this work.
- **Integrated Performance Assurance Report** - concerns regarding recruitment performance to be considered further by the Workforce & OD Sub-Committee of QSEAC.
- **Integrated Planning Assurance Report** - concerns regarding the number of objectives within the 2018/19 Annual Plan making it difficult to monitor and provide assurance, to be mitigated by each Director considering their own particular areas to reduce their number and to agree the most 'impactful' actions to report on going forward.
- **H&SEPSC Update Report** - concerns regarding the delay in implementing the Health Boards Lockdown Policy, mitigated by an assurance that this would be presented to the H&SEPSC meeting in January 2019 for approval.
- **Update on All Wales Capital Programme & Discretionary Capital Programme incorporating the Capital Governance Update** - concerns regarding the increased risk in the Health Board's ability to provide aseptic medicines due to having to outsource aseptic unit work, to be mitigated by an update requested for a subsequent BPPAC meeting on the actions taken to manage the risks involved.
- **MTED** - concerns regarding the roll out of MTED in BGH given ET's decision to suspend this, to be mitigated by discussion at ET with a further update to be reported to BPPAC.
- **Information Governance Sub-Committee Update Report –** concerns regarding the significant challenge to meet the clinical coding target, to be addressed by processes put in place to mitigate against this, and funding for additional clinical coders requested through the annual planning process.
- **Report on the Discretionary Capital Programme 2018/19 and 2019/20 and Capital Governance -** concerns regarding the agreed level of pre-commitment of 2019/20 allocations given the slippage on projects identified, to be addressed by mitigating actions put in place to reduce this risk.
- **Implementation of the Single Cancer Pathway (SCP) -** concerns regarding possible delays with diagnostic testing for non-cancer specialities, to be mitigated by the Health Board' consideration of a range of options to increase capacity for the short and medium term, including an exploration of opportunities for regional collaboration given the recruitment and capacity challenges currently experienced within radiology & pathology services.

Matters Requiring Board Level Consideration or Approval

- BPPAC Annual Report 2017/18 for submission to the Board on 30th May 2018.
- Approval of the Fishguard Health Centre Refurbishment and Extension Business Justification Case for submission to WG.
- Major Incident Plan 2018/19.
- BPPAC Revised Terms of Reference 26th September 2018 and 28th March 2019.

Argymhelliad / Recommendation

The Board is asked to endorse the Business Planning & Performance Assurance Committee Annual Report for 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	BPPAC 30th April 2019

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced in the Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.

Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and Committee's Terms of Reference, requires the submission of an Annual Report to the Business Planning & Performance Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	SBAR template in use for all relevant papers and reports

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Draft Business Planning & Performance Assurance Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	David Powell, Chair, Business Planning & Performance Assurance Committee
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Miles, Director of Planning, Performance & Commissioning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the draft Business Planning & Performance Assurance Committee (BPPAC) Annual Report 2018/19 to the Committee for comment, prior to submission to the Board on 29th May 2019 for approval.

The BPPAC Annual Report provides assurances in respect of the work that has been undertaken by the Committee during 2018/19, and outlines the main achievements which have contributed to robust business planning and performance assurance across the Health Board.

Cefndir / Background

Hywel Dda University Health Board's Standing Orders and the Terms of Reference for the Business Planning & Performance Assurance Committee require the submission of an Annual Report to the Board to summarise the work of the Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Committee is to assure the Board on the following:

1. Provide assurance that the planning cycle is being taken forward and implemented in accordance with University Health Board and Welsh Government requirements, guidance and timescales.
2. Provide assurance that all plans put forward for the approval of the Health Board 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.
3. Provide assurance to the Board that, wherever possible, University Health Board plans are aligned with partnership plans developed with Local Authorities, Universities, Collaboratives, Alliances and other key partners.
4. Provide support to the Board in its role of scrutinising performance and assurance on overall performance and delivery against Health Board plans and objectives, including delivery of Tier 1 targets and the financial control total, 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.
5. Assure the Board that the data on which performance is assessed is reliable and of high quality and that any issues relating to data accuracy are addressed.
6. Seek assurance on the management of principal risks within the BAF and CRR allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
7. Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.
8. Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

Asesiad / Assessment

The Business Planning & Performance Assurance Committee has been established under Board delegation with the Health Board initially approving Terms of Reference for the Committee at its Board meeting on 30th July 2015. These were subsequently revised and approved by the Board as part of its annual cycle of review of Committees Terms of Reference at its meetings on 26th November 2015, 26th January 2017, 29th March 2018, 27th September 2018 and 28th March 2019.

The revision to the Committee's Terms of Reference in September 2018 was informed by the decision to elevate the Finance Sub-Committee to a formal Committee of the Board necessitating amendments to BPPACs Terms of Reference to remove roles and responsibilities in relation to financial planning and performance.

In discharging its role, the Committee is required to oversee and monitor the business planning and performance assurance agenda for the Health Board, and in respect of its provision of advice to the Board, ensure the implementation of the business planning and performance assurance agenda against the following areas of responsibility:

Business Planning

- Assure the development of delivery plans within the scope of the Committee, their alignment to the Integrated Medium Term Plan (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 IMTP for sign off by the Board.
- Quality assure and approve all delivery plans required by Welsh Government, ensuring alignment with the University Health Board'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.

Performance Management

- On behalf of the Board, and subject to its direction and approval, 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 and 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.

Governance
- Provide advice and assurance to the University Health Board 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.
- 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 Welsh Government, ensuring alignment with the University Health Board'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 (QSEAC), 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 Business Planning and Performance Assurance Committee, and oversee delivery.
- Agree issues to be escalated to the Board with recommendations for action.

Sub-Committees
The Sub-Committees reporting to Business Planning & Performance Assurance Committee during 2018/19 were as follows:

- **Capital, Estates & IM&T Sub-Committee** – established to:
  - Oversee the development of the estates strategy linked to the Integrated Medium Term Plan for consideration by the Business Planning & Performance Assurance Committee, before approval by the Board.
  - Oversee the development of an innovative strategy for information technology and information analytics (to cover all functions of the University Health Board's services i.e. primary, community, hospital, etc) that supports delivery of the integrated medium term plan for consideration by the Business Planning & Performance Assurance Committee, before approval by the Board.
  - Oversee the development and delivery of implementation plans for the estates and

informatics strategy, agreeing corrective actions where necessary and monitoring its effectiveness.

- **Health & Safety and Emergency Planning Sub-Committee** – established to:
  - Provide assurance around the Health Board's arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities such as patients, members of the public, volunteers, contractors, etc.
  - Provide advice on compliance with all aspects of health and safety, and emergency planning legislation.
  - Oversee the development, maintenance and evaluation of the Health Board's Emergency Management Plan that will be underpinned by policy and protocols, planning and performance targets and strategies to address risks to business continuity.

- **Information Governance Sub-Committee** – established to:
  - Provide assurance to the Business Planning & Performance Assurance Committee on compliance with information governance legislation, guidance and best practice, and to:
  - Provide evidence based and timely advice to assist the Health Board in discharging its functions and meeting its responsibilities with regard to the quality and integrity; safety and security; and appropriate access and use of information (including patient and personal information) to support its provision of high quality healthcare.
  - Provide assurance in relation to the Board's arrangements for creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information in accordance with its stated objectives; legislative responsibilities, e.g. the Data Protection Act and Freedom of Information Act; and any relevant requirements and standards.
  - Provide assurance that risks relating to information governance are being effectively managed across the whole of the Health Board's activities (including for hosted services, through partnerships and Joint Committees as appropriate).

- **Planning Sub-Committee** – established to:
  - Advise and guide the Health Board's planning arrangements and implementation of major change (one year, medium and longer terms plans).
  - Oversee and assure the Transforming Mental Health Implementation Programme and the Transforming Clinical Services Implementation Programme (once established).
  - Provide assurance to the Business Planning & Performance Assurance Committee that the planning cycle is (designed and managed) being taken forward and implemented in accordance with the University Health Board and Welsh Government requirements, guidance and timescales.

- **Finance Sub-Committee** (up until August 2018) – established to:
  - Provide assurance to BPPAC that robust arrangements are in place for financial planning, forecasting and financial performance by providing additional and detailed scrutiny of the Health Board's financial position in view of the current challenges in terms of achieving a balanced financial position.
  - Maintain a robust grip and close scrutiny of the Health Board's financial position with the aim of ensuring the achievement of an end of year balanced financial position.
  - Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation and focus in detail on specific issues where financial performance is showing deterioration or there are issues of concern.

The Business Planning & Performance Assurance Committee Annual Report 2018/19 is

intended to outline how the Committee and its Sub-Committees have complied with the duties delegated by the Board through the Terms of Reference set, and also to identify key actions taken to address developments within the Committee's remit.

Constitution

Until November 2015, membership of the Business Planning & Performance Assurance Committee consisted of six Independent Members, the Chief Executive Officer and all Executive Directors, with an open invitation extended to all Independent Members to attend for an additional level of scrutiny and challenge. All Executive Directors were expected to attend all meetings, with the Chair of the Health Board routinely attending meetings in an ex officio capacity. From the revised Terms of Reference approved on 26th November 2015, the membership was reviewed and agreed as the following:

- Independent Member (Chair)
- Independent Member (Vice-Chair)
- 4 Independent Members

with the following Members identified as "In Attendance" (i.e. Associate Members):

- Chief Executive
- Director of Planning, Performance & Commissioning (Lead Executive)
- Deputy Chief Executive/Director of Operations
- Director of Finance
- Medical Director & Director of Clinical Strategy
- Director of Nursing, Quality & Patient Experience
- Director of Therapies & Health Sciences
- Director of Public Health
- Director of Workforce & Organisational Development
- Director of Primary, Community & Long Term Care
- Director of Partnerships & Corporate Services
- Independent Member (WAST) (not counted for quoracy purposes)
- Hywel Dda Community Health Council Representative (not counted for quoracy purposes)
- Advisory Forum Representatives (Local Partnership Forum/Healthcare Professionals Forum/Stakeholder Reference Group representatives) (not counted for quoracy purposes)
- LMC Representative (not counted for quoracy purposes)

This membership has remained extant during 2018/19.

Meetings

As the Business Planning & Performance Assurance Committee is directly accountable to the Board for its performance, it provides an assurance to the Board through a formal written update report which is received at the subsequent Board meeting. A full set of the papers for each Committee meeting is routinely made publicly available from the Health Board's website.

During 2018/19, the Committee met on 6 occasions and was quorate at all meetings, as follows:

- 24th April 2018
- 26th June 2018
- 28th August 2018
- 30th October 2018
- 18th December 2018
- 26th February 2019

Areas of Responsibility
In discharging its duties, the Business Planning & Performance Assurance Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its business planning & performance assurance agenda:

Governance

- **Draft Annual Report to Board** – at its meeting in April 2018, subject to only minor amendments, the Committee endorsed the BPPAC Annual Report 2017/18 for onward approval to the Board on 30th May 2018.

- **Sub-Committee Terms of Reference** – revisions to the Terms of Reference for BPPAC's Sub-Committees were presented to the Committee during 2018/19 and approved at the following meetings:
  - Capital, Estates and IM&T on 26th February 2019
  - Health & Safety and Emergency Planning on 30th October 2018
  - Information Governance Sub-Committee on 28th August 2018
  - Planning Sub-Committee on 18th December 2018.

- **Committee Self-Assessment of Effectiveness** – at its meeting in April 2018, Members received a composite report on the outcome from the 2017/18 BPPAC self-assessment of effectiveness exercise which provided a level of analysis and clarified a number of themes in common with other Board level Committees. The report also indicated actions to take forward by the Corporate Governance Team as part of their agreed workplan for 2018/19. The themes and outcomes from the self-assessment questionnaire also contributed to the Business Planning & Performance Assurance Committee's on-going development.

  At its meeting in February 2019, the Committee received the BPPAC Self-Assessment of Committee Effectiveness Questionnaire for 2018/19 to consider any amendments or omissions. Members approved the current questionnaire and were advised of the intention to use 'Survey Monkey', an online survey tool, to capture the responses made.

- **BPPAC Revised Terms of Reference** – at its meeting in February 2019, the Committee considered and approved its Terms of Reference with no changes made. These revised Terms of Reference were subsequently ratified by the Board on 28th March 2019.

Performance Assurance

Integrated Performance Assurance Report (IPAR) – the Integrated Performance Assurance Reports presented to the Committee during 2018/19 outlined achievements against targets and actions in place to improve performance. Whilst the Quality, Safety and Experience Assurance Committee are responsible for monitoring patient experience, the correlation between improvements in performance and patient outcomes is acknowledged.

At its meeting in April 2018, the Committee received the Month 12 (2017/18) version of the IPAR, setting out the Health Board's latest performance position. Members acknowledged the challenges faced by Hywel Dda during the winter period, and the effect this had had in terms of sustained periods of poor performance particularly in regard to the 4 and 12 hour A&E targets were shared with the Committee, together with the Health Board's approach to the

improvement work required to address these in terms of turnaround cycles, etc. Members were informed that a comprehensive look back on the previous winter and a look forward to the next would be presented to the Board in July 2018. The Committee was also updated on the Health Board's approach to mandatory training in terms of targeting a particular service area each month which appeared to be paying dividends, together with the work taking place with the services involved to convert training data onto ESR. Members noted the increase in sickness absence in January 2018, due in the main to seasonal absences, with improved performance in February 2018 attributed to the consistency adopted in applying the Health Board's Sickness Absence Policy. PADR compliance also represented an improving position with the Workforce & OD Team updating records centrally on ESR. An update on Patient Safety Notices PSN028, PSN030 and PSN035 was also provided to Members, highlighting the work on-going to address compliance and to demonstrate the progress made. The Health Board's approach to pressure sores was also discussed. Given the number of patients who were admitted with pressure damage either undetected or unreported from the community, Members agreed that the Health Board's approach should be targeted here.

In June 2018, the Committee received the Month 2 (2018/19) version of the IPAR, setting out the Health Board's latest performance position. Members noted that unscheduled care remained the main pressure with cardiology and diagnostics the main challenges. Members' attention was drawn to the latest performance overview in terms of the key deliverable targets set by WG by exception, and noted the variance in clinical coding performance due to capacity issues particularly within Glangwili General Hospital (GGH). It was confirmed that a request had been made through Executive Team for additional clinical coding capacity given its known impact on performance. Members also noted that the metric for the hand hygiene indicator had been changed to a simpler 5% reduction, however expressed concern at the Health Board's decrease in percentage compliance. Members were unassured by the accompanying narrative which suggested staffing issues were having an impact and requested this be referred to the Infection Prevention Sub-Committee of Quality, Safety & Experience Assurance Committee (QSEAC) given the known association between hand hygiene and health care acquired infections. Members also sought an assurance in regard to the new target for Mental Health patients who require to be seen by an Independent Mental Health Advocacy (IMHA) within 5 days which had been outsourced to the West Wales Advocacy Service, and it was agreed to request this assurance from the Health Board's Interim Head of Mental Health & Learning Disabilities. The Committee welcomed the £30m additional funding announced by WG to eradicate all 36 week breaches, and anticipated both in house and outsourcing solutions would need to be considered for a number of specialties e.g. orthopaedics. Members were assured that this additional funding would be tracked intensively. In terms of therapy performance, Members noted the trajectory of increasing waits and suggested this declining performance be monitored at BPPAC, with a comparison of performance to be presented at the next Committee meeting. Members further noted that improvements were not being made from external validation on delayed follow up appointments despite an assurance that this would be the case, and were informed that although extra effort had been put in place as part of year end improvement, this ceased at the end of March 2018. In addition, the high turnover in the internal validation team experienced in April/May 2018 meant activity had to be prioritised on the RTT pathway, however Members were assured that posts are currently being recruited into. Members were also assured that healthcare acquired infections were being addressed through QSEAC and its Sub-Committee structure, with a paper presented to their most recent Committee meeting outlining the measures in place to ensure appropriate and improving performance.

In August 2018, the Committee received the Month 4 (2018/19) version of the IPAR setting out the Health Board's latest performance position. Members acknowledged the Health Board's dependency on outsourcing with a number of recognised risks around this.

Members were advised that the Health Board's RTT trajectory for the remainder of the year would be built into future reports to BPPAC. Members welcomed the assurance provided that Job Planning compliance across all roles had improved from 2017 to 2018, and emphasised the need to maintain monitoring on this as well as on PADRs. The Committee was advised that healthcare acquired infections remained RAG rated red linked predominantly to community acquired infections, and that work on antibiotic prescribing had been undertaken to address this. Recent changes made to C.difficile testing which is contributing to an increase in reporting is expected to improve by the beginning of next year once this becomes embedded. Other than for E.Coli however, Members were pleased to note that performance is an improving position. Members also noted the contributory factors to non Mental Health Delayed Transfers of Care (DTOC) performance, including a combination of staff shortages and inexperienced staff. However, given that the actions identified to remedy poor performance did not necessarily address these issues, the need was agreed to discuss further the content of each locality plan with the County Directors involved who had participated in disaggregating the information, and to bring back to BPPAC for further assurance. Whilst Members were pleased to note that the percentage of patients that had been offered Mental Health advocacy services had improved in June 2018 to over 90%, it was agreed that with appropriate focus the 100% target should be met. Members were further advised that capacity and demand modelling for lymphodema had been undertaken, and a case made for additional funding from RTT. Services involved were in the process of recruiting to gain additional capacity to bring the current 40 week waiting time back to zero by the end of the financial year. Whilst recognising the risks around this, assuming no sudden hike in demand or worsening workforce position, Members were assured that an improvement should be seen from Quarter 3 onwards. Concern was expressed regarding the current long waits for pulmonary rehabilitation, and assurance was provided that a business case had been drafted to develop a hub and spoke model as a more sustainable solution going forward. Members agreed that further indicators around Electric Bio-Medical Engineering (EBME), fire risk assessments and health & safety compliance should be included within Estates KPIs in future iterations of the IPAR.

In October 2018, the Committee received the Month 6 (2018/19) version of the IPAR, setting out the Health Board's latest performance position, and incorporating the improvements made to navigation within the document following a meeting between members of the performance team and Independent Members. Members were informed of a number of areas where improvements were required to meet targets, and acknowledged the significant challenges ahead for the Health Board given the approaching winter and the saving targets expected from turnaround initiatives. Members noted the impact on unscheduled care with delays to discharges and delays to ambulances from Betsi Cadwaladr University Health Board (BCUHB) due to the increasing number being held up at Ysbyty Gwynedd in Bangor, and Members were assured that meetings would take place and the outcome reported to BPPAC. However, Members were pleased to note that the Health Board is currently performing well on three of the stroke targets and on cancer waiting times where Hywel Dda ranks 2nd amongst Health Boards in Wales.

In December 2018, the Committee received the Month 8 (2018/19) version of the IPAR setting out the Health Board's latest performance position and providing a spotlight on unscheduled care and referral to treatment times. Members expressed concern in regard to the rationale behind the delayed transfers of care (DTOC) for non-mental health being split by locality, and requested clarification that solutions to similar issues which are expressed differently by region are being discussed and resolved Health Board wide. Members were assured that the 3 County Directors form part of the Unscheduled Care Directorate and are engaged in issues regarding complex discharges with discussions take place within Multi-disciplinary Teams to ensure triangulation of services. Members were pleased to note that data on community

acquired infections demonstrated a continued reduction compared to the previous year. Given the positive impact of the recent initiative whereby GPs reviewed urology patient notes to reduce delayed follow ups, it was agreed that discussion would be held at ET on the potential to expand this pilot given its cost-effective nature, whilst accepting that initial funding would be required. Members also discussed the uptake of the influenza vaccination, and whilst welcoming the increased uptake for 2-3 year olds, noted the Health Board's overall performance is below target and lower than other Health Boards in Wales. Members were informed of the supply issues experienced at the beginning of the winter period for vaccinations both for patients aged over 65 and under 65, together with cultural barriers preventing patients from presenting for vaccination which are more prevalent within Hywel Dda. In terms of hand hygiene, Members expressed concern at the 17% disparity in compliance between the lowest and highest performing teams involved. Members were informed of a revised social media campaign for staff, with an improvement plan discussed at length previously in QSEAC and a deep dive on infection prevention planned for the Committee in February 2019, whilst recognising that the target of 95% would be a challenge to achieve. Whilst acknowledging the fragility within current therapy services with a reliance on agency and locum cover, Members were assured that provided current staffing levels held, the Health Board would achieve the zero target of 14 week waits for specific therapies by the end of March 2019.

In February 2019, the Committee received the Month 10 (2018/19) version of the IPAR setting out the Health Board's latest performance position, providing a detailed review on unscheduled care pressures where Members noted that performance had declined in January 2019 compared with the previous month. The current status of Referral to Treatment times was discussed, in particular Orthopaedics and Dermatology, with Members advised that the Health Board is working closely with other providers to ensure that the target of zero for patients waiting over 36 weeks would be met by the end of the financial year. Given that the Health Board has made significant progress with reducing the waiting list by 4,000 to close to zero at the end of the financial year, Members were assured that there should be no requirement to outsource from the end of March 2019. Members noted that whilst the uptake in influenza vaccination shows improvement during 2018/19, overall it is below the Health Board's target, and given that vaccine shortages have affected all Health Boards, Members expressed concern that Hywel Dda is under performing whilst recognising this could be due to a number of factors including patients not attending GP arranged sessions. Members were pleased to note that the therapy waiting list had reduced from over 300 in December 2018 to 150 in January 2019, providing an increasing confidence that the Health Board would reach zero 14-week waits by the end of March 2019.

Members recognised that whilst Hywel Dda is heavily reliant on its tertiary centres for the treatment of more specialist conditions, the trajectory for improvement will require the resolution of a number of issues, and whilst there is now a mechanism for this through the Joint Regional Planning & Delivery Committee (JRPDC), the work of this Committee remains longer term focused in the main.

Healthcare Associated Infection (HCAI) Improvement Plan – in April 2018, the Committee received the HCAI Improvement Plan noting that a different risk-based approach was being taken to previous years linked to population needs. Members noted that whilst work currently undertaken in in-patient areas would continue, the focus for 2018/19 would be on population health and working with those in the community to tackle community acquired infection, given that a significant number of reported infections for 2017/18 were not hospital acquired. Whilst confirmation of this year's WG target had not at this point been received, it was anticipated that an infection reduction would remain for 2018/19.

Financial Update & Turnaround Programme Update – at its meeting in April 2018, the

Committee noted the Month 12 2017/18 performance demonstrated a £69.413m deficit, £0.287m less than the revised year end forecast, due to a number of positive movements and an improving position in primary care prescribing, CHC reconciliation and final agreements with Local Authorities. A report on turnaround was shared with Members providing an update on savings at year end of £29m. The Committee welcomed the thematic and co-ordinated approach undertaken, with five major 60 day improvement cycles underway to drive progress against saving plans for 2018/19 and to ensure actions are aligned, which should create savings and deliver benefits for patients.

At its June 2018 meeting, the Committee received an update on the Health Board's financial position and was informed that the Health Board had received £27m additional funding following WG's zero based budgeting review. The Committee acknowledged the particularly challenging 2018/19 Financial Plan outlining a deficit budget of £62.5m which would require the achievement of £30.7m of recurrent savings schemes to be delivered in-year in order to sustain improvement in the underlying financial position. However, Members expressed concern that only £14.9m (49%) of these schemes had been RAG rated as green, with £8.3m rated amber (27%) and £7.5m rated red (24%).Whilst Members were advised that the financial position should be achievable with the current building blocks in place, it was acknowledged that this would require the right focus, the right accountability and the right reporting in place which would be key in terms of moving from process to delivery.

At its August 2018 meeting, the Committee received a further update on the Health Board's financial position, and feedback was also received on the detailed discussions held on the opportunities for financial turnaround on both planned care and RTT. Members expressed concern at the Health Board's deteriorating run rate to be addressed through operational savings which would need to be delivered at pace, although acknowledged that the CEO Holding to Account meetings were helping to build a rhythm and focus for this work. Members were however pleased to note the improvement in Month 4's RAG rating assessment of savings delivery and that focus would be on delivery of the schemes identified.

Following elevation of the Finance Sub-Committee to a statutory Committee of the Board, no further Financial Update & Turnaround Programme Updates were presented to BPPAC.

Flu Vaccine Campaign Performance Update – at its meeting in April 2018, the Committee received a comprehensive update on performance in regard to the 2017/18 Seasonal Influenza Plan, setting out the Health Board's approach to improving vaccination uptake rates over the following 3 year period. The report highlighted the innovative practice that had had an impact on performance in 2017/18, together with a number of initiatives to take into 2018/19. Members were pleased to note the 14% increase in staff uptake rate across the Health Board representing the most improved position across Wales, however expressed disappointment at the entrenched issues remaining within Hywel Dda's population in regard to flu and childhood vaccination uptake, particularly amongst the over 65's, and the 6 months to 64 year olds in clinical risk groups, which highlighted the need for smarter targeting of certain risk groups and the need for further engagement with primary care. Members were assured that some of the more positive work emerging from the 2017/18 programme would be worked upon for 2018/19 in order to turn the learning into practice.

NHS Wales Shared Services Partnership (NWSSP) Summary Performance Report –at its meeting in August 2018, the Committee received an update on performance information in respect of the services received from NHS Wales Shared Services Partnership (NWSSP) for the half year ended 30th June 2018. Members noted that the Health Board's recruitment performance remained an issue for both of the quarters reported, and suggested the Workforce

& OD Sub-Committee consider recruitment as a whole. However, Members were pleased to note that the indicators for management responses to draft Internal Audit reports to be received within 15 days, and report turnaround to draft responses within 10 days, both achieved 100%.

In December 2018, the Committee received a further update on performance for the three months ended 30th September 2018. Members discussed the reasons for the organisation missing the target time to approve vacancies and were informed of the number of factors involved including the tracker not being updated in a timely manner and delays built into vacancy advertisements to comply with departmental budgetary targets. It was proposed that at the next NWSSP meeting in January 2019, an option to allow for this within the KPIs be considered.

In February 2019, the Committee received a further update on performance information for the three months ended 31st December 2018. Members were pleased to note that payroll accuracy was above target with the Health Board achieving the highest performance against this target across Wales, and the Health Board's improved position from Quarter 2 onwards in relation to the time to approve vacancies although not currently meeting the target set. Members queried the reduction in performance for invoice turnaround times during Quarter 3, and whilst recognising that implementation of the 'no purchase number no payment' initiative had had an impact on this, Members were assured that this should improve for future quarters.

Progress Against External Governance Review (EGR) 2017 and Wales Audit Office (WAO) Structured Assessment (SA) 2015 – at its meeting in June 2018, the Committee received an update on the progress made in implementing outstanding recommendations from the External Governance Review 2017 and the Wales Audit Office Structured Assessment 2015, which BPPAC had been requested to monitor. Members accepted that in a number of cases, timing issues had frustrated progress, and it was agreed that Executive leads should draft a short summary to explain why progress could not currently be made for onward reporting to Audit, Risk and Assurance Committee (ARAC) and to highlight this in the BPPAC update report to Board.

Mortality Exception Report – also at its meeting in June 2018, the Committee received the Health Board's mortality indicators, following discussion at the April 2018 QSEAC meeting. Members were assured that following a significant review of the handling of the Health Board's mortality review arrangements, variation in the way in which reviews had been undertaken at GGH and Prince Philip Hospital (PPH) would be addressed and amended to the all Wales process, meaning that more timely reviews could be undertaken and moving the Health Board closer to the WG target. Whilst concern was expressed at the reviews findings, Members were assured that the reasons for increases in mortality had been scrutinised at QSEAC particularly in light of capacity issues relating to internal clinical coding and recent events experienced in Gosport.

Internal Review of the 111 Service – also in June 2018, the Committee received the outcome from the internal review of the 111 service, undertaken to consider the broader impacts of a weakened out of hours service on the unscheduled care pathway. Whilst commending the report which served to demonstrate the challenges involved, Members expressed concern that the initiative appeared to be increasing pressure on GPs when its intent had been to alleviate this. Given assurances could not be provided as to how the service would be improved, it was agreed for an update to be presented to the Committee in October 2018, when a number of the actions proposed to be undertaken should have been put into effect.

In October 2018, the Committee received an update report, addressing in particular concerns regarding the impact of the further expansion of 111 across the Health Board. Members were

assured that to address these concerns, robust engagement events had taken place and an Out of Hours GP Advisory Panel established, together with an Out of Hours Peer Review programme undertaken in August 2018, in readiness for the launch of the 111 service in October 2018.

In December 2018, the Committee received a further update report following the roll out of the 111 service across the Health Board. Members noted that the service had appointed Advanced Paramedic Practitioners (APPs) to supplement the GP workforce, and that with the support of Welsh Ambulance Service Trust (WAST), an additional four APPs would be recruited with the intention to acquire funding to enable these to become permanent roles. Members were presented with highlights from the Out of Hours Peer Review including the positive work undertaken with GPs in Pembrokeshire and Ceredigion who had been interviewed as part of the process. Members recognised that the Health Board would benefit from an improved flow between daytime primary care and OOH services as a key part of the unscheduled care system, and the intention to embed 111 and the new roles within the service over the following 6 months. Whilst acknowledging that Members and Health Board officers understood the operational challenges experienced by the Health Board in achieving national performance targets, it was suggested that the platform of social media be utilised to enable the public to have a better understanding, and for discussions to be held with Hywel Dda CHC on how best to inform the public of the current challenges faced.

Estate Operational Maintenance Performance & Compliance – at its meeting in June 2018, the Committee received the current performance and compliance position within operational estates maintenance, covering operational planned preventative maintenance (PPM) and associated prioritisation process, operational governance including resource gap analysis and associated risk management arrangements. Members commended the comprehensive review noting the key issues affecting performance and compliance were the amount of the estate, the poor state of it and the shortages within its workforce. It was agreed that estates compliance issues should continue to be reported through the H&SEPSC, with performance incorporated within the IPAR.

Primary Care Initiative Pilot - Undertaking Clinical Validation in Primary Care of our Urology Patients Waiting over 100% Delayed for their Follow Up – also at its meeting in June 2018, the Committee received an evaluation of the primary care initiated collaborative pilot for a cohort of patients on the follow up not booked waiting list, which had emanated through risks identified in follow up appointments and the need to address these. Given the pilot's success, Members suggested this initiative be used as a tool for inclusion as part of the Health Board's armoury to address follow ups and to consider areas to target.

Delayed Follow-Up Report Including Plans for 2019/20 – at its meeting in February 2019, the Committee received the Delayed Follow-Up Report including Plans for 2019/20, indicating whilst the Health Board is showing early improvements, significant challenges remain. Members were advised of the three workstreams in place running parallel to each other and with pathway management also in place, which is showing improved outcomes. Members were further advised that gaps in staff knowledge in relation to patient pathways when using Myrddin and/or the Welsh Patient Administration System (WPAS) had identified data being entered incorrectly, resulting in duplication on the delayed follow up list, however the project plan to address the training requirements, due for completion by the end of March 2019, should mean fewer errors over time. Whilst acknowledging the concerns in regard to data accuracy and the current limitations of WPAS, given the planned improvements and increased staff training, Members were assured that all specialities should see a 25% improvement on the overall volume of patients waiting for follow-up outpatient care during 2019/20.

Briefing Note - Outpatient "Follow-Up Not Booked" Reporting – at its meeting in October 2018, the Committee received a briefing note providing an update on the failure of the Health Board to supply the Follow-up Not Booked report to Welsh Government since August 2018 following an upgrade to the Myrddin Patient Administration System. Following the application of a fix on 18th October 2018, the Informatics Team were satisfied that the comparison between July 2018 and September 2018 was within tolerance, therefore the Follow-up Not Booked report was deemed fit for purpose and advised that the statutory return should be submitted to WG. The Chair of BPPAC asked for information to be provided on the nature and extent of testing carried out prior to going live with the Myrddin update.

Business Planning

Work-In-Progress Against the 2019-22 Integrated Medium Term Plan Including the Integrated Planning Assurance Report (IPLAR) – at its meeting in June 2018, the Committee received an update on the development of the draft work in progress on the Integrated Planning Assurance Report (IPLAR) and the proposed next steps. Members noted that the purpose of the IPLAR was to demonstrate to WG the seriousness with which the Health Board is taking the NHS planning framework, incorporating the 'must dos' and 'what good looks like', etc, and looking to maximise integration opportunities. Whilst commending the work involved, Members agreed a more concise version would be required going forward with hyperlinks to appendices to enable Members to consider the detail involved.

In August 2018, the Committee received an update on the development of the draft work in progress on the IPLAR, and were advised of the issues involved in the process of aligning significant work-streams such as Transformation, Turnaround, Performance, Quality Improvement, Organisational Development, IMTP Planning, etc, into one framework. Members noted the intention to have a first cut IMTP drawn from the outputs of all work-streams, for the November 2018 Board meeting, in order to demonstrate a concerted direction of travel. To provide an assurance that planning is being delivered in an integrated way, Members noted the establishment of a Planning Review Panel to check and challenge Triumvirate, Service and Directorate plans and their ongoing alignment through Turnaround and Transformation work programmes, and to support the development of business cases, invest to save and other funding streams which help deliver the Health Board's planning ambitions and objectives and maximise integration opportunities, with the resulting Triumvirate / Service / Directorate plans tracked within the IPLAR. Members recognised that the main thread to demonstrate to WG would be 'value' as a key enabler, and the need was agreed to weave in the quality improvement story to this work.

In October 2018, the Committee received an update on the work in progress against the IMTP including the IPAR and were advised of the process of aligning several significant work-streams into a single plan. Members were informed of the new format for the IMTP, with further discussions on its content to take place with WG prior to the submission date of 31st January 2019, with each chapter of the IMTP containing a detailed plan including evidence. Members accepted that the IPLAR is still work in progress whilst anticipating this will be the proposed governance process supporting the production of the plan, including the document structure going forward.

Following the October 2018 BPPAC meeting, it was proposed that progress of the IPLAR would be presented to the Planning Sub-Committee and reported via the Planning Sub-Committee update report to BPPAC.

Report on the Provision of Residential/Doctors Accommodation – at its meeting in April

2018, the Committee received an interim report in response to concerns raised in a variety of arenas on the diminishing and sub-standard residential facilities in place across the Health Board. Difficulties in resolving the issues to the standards expected were acknowledged by Members, particularly given the age of the accommodation. The Committee was informed that a Task & Finish Group had been established at the request of CEIM&TSC to address initially the short to medium term issues. The Committee stressed the need to receive an assurance that the sub-standard accommodation's impact on recruitment is minimised as far as possible for both doctors and nurses. In view of the scale of the issues involved, a further report with firm actions was presented to BPPAC in August 2018, where Members were assured that a number of the previously identified housekeeping issues had been resolved, together with better tenancy agreements in place to safeguard the interests of both the Health Board and the tenants involved. Members welcomed the £100K allocated from discretionary capital with the potential for further monies to become available, and were advised that prioritising of this funding would take place for CEIM&TSC' consideration. Members acknowledged that actions over the longer term would need to tie in with the Board's decision on TCS, recognising that different solutions may be required if a new build is proposed. Members sought assurance that the way in which SIFT (Service Increment for Teaching) is to be standardised is progressing with transparency and it was agreed to have a conversation with each hospital site to determine the best way of managing this going forward. It was further agreed to include junior doctor representation on the membership of the Accommodation Task & Finish Group.

The Committee received a further update in December 2018, advising that in order to facilitate improvements, £200,000 had been allocated from discretionary capital and that priority areas for its use had been agreed to address the poorest accommodation in the first instance. Members were informed that the support provided by the Health Board to improve accommodation had been welcomed by students and partner universities alike. Whilst Members were assured that the Accommodation Task & Finish Group would continue to monitor the progress of the work planned, given the further funding required the Committee suggested that junior doctors' accommodation be considered a priority area for the 2019/20 discretionary capital programme, whilst acknowledging that in the longer term, new accommodation would be required through major capital development to meet the expected standards. To provide further assurance to BPPAC on progress, it was agreed that a RAG rated compliance report from the Accommodation Task & Finish Group would be presented to the next CEIM&TSC meeting.

Update on All-Wales Capital Programme 2018/19 Capital Resource Limit and Capital Financial Management – the Committee received update reports on the All Wales Capital Programme 2018/19 Capital Resource Limit and Capital Financial Management up until August 2018 when it was agreed that these would be reported to Finance Committee following its elevation to a formal Committee of the Board in September 2018. At its meeting in June 2018, Members expressed concern at the level of unallocated discretionary capital and the significant weighting of the profile in the final months of the year, which increased the risk of the Health Board being able to deliver the highest risk schemes by 31st March and increased the risk of having to use project/scheme slippage and under-spend on lower risk scored items which are deliverable by 31st March. In August 2018, Members were informed that potential Brexit implications had led to a recommendation from the central procurement team to limit expenditure in March 2019, particularly where there is a reliance on goods from abroad, and to carry stock forward from February 2018 onwards. It was agreed that as much as possible should be fast tracked and brought forward by one quarter where there is the potential for risk.

Update on All Wales Capital Programme & Discretionary Capital Programme

incorporating the Capital Governance Update – the Committee received regular updates throughout 2018/19 on the All Wales Capital Programme & Discretionary Capital Programme incorporating the Capital Governance Update. In June 2018, the Committee agreed the recommendation on how the 2018/19 discretionary capital programme was to be allocated, noting that the development scheme allocations remained budget figures at this stage and subject to tenders, and that any underspends would be reported back to BPPAC with recommendations for its reallocation. The Committee continued to receive updates throughout 2018/19 on the schemes in progress, and in August 2018, acknowledged the need for a holding position until the Medical Devices Inventory Report was complete with a sum of £1million of discretionary capital retained until the extent of the capital required was known. Details of the allocations which the CE&IMTSC had approved were reported to BPPAC and Members were advised that contingency requests were currently higher than in previous years by about £100,000, which would be monitored to establish whether in future years the Health Board should allocate a larger contingency fund. Members noted that the £2.5 million for pre-commitments in association with the 2019/20 Discretionary Capital Programme (DCP) were significantly higher than that which had previously been considered by BPPAC and raised concerns that these pre-commitments could impact on other requests.

In December 2018, the Committee was advised that a further allocation of £1.454m for the DCP had been approved, to be split between the Bronglais General Hospital (BGH) Front of House Scheme due to the reduction in VAT % recovery, and an increase in the contingency budget, with the balance of £1.1m to be prioritised. Members were also provided with an update on the current position with Aseptic Units, and advised that the further options identified by Transforming Access to Medicines (TRAMS) would not be agreed until March 2019. Members were informed of a change in the strategic approach with the proposed option to have 3 regional units across Wales, supported by small local units, and that a Business Justification Case would be produced against this revised position. Given the concerns expressed at the increased risk in the Health Board'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, for the Committee's assurance it was proposed that an update be presented to the next meeting on the actions being taken to manage the risks involved.

In February 2019, the Committee was advised that the balance of £1.1m would be allocated for capital only, and following discussions with WG, a further £800,000 year end funding would be allocated for equipment. Members discussed the pre-commitment of 2019/20 allocations and whilst expressing concern with the agreed level given the advised slippage of projects, accepted that the mitigations put in place should reduce the risk involved. Members were advised that the focus of the CEIM&TSC would be to minimise additional spending in the final quarter of the financial year, in order that the Health Board is in a better position next year.

2018/19 Annual Plan Quarterly Updates – throughout 2018/19, the Committee received regular quarterly updates on the 2018/19 Annual Plan, providing a position on progress against the actions noted in the Health Board's 2018/19 Annual Plan for compliance with Welsh Government requirements, and the expectations for delivery. Whilst accepting the evolving nature of the documentation, the Committee requested a more focused set of actions with more impactful outcomes for future reporting. To facilitate this, it was suggested that each Director should consider their own particular area to reduce the number of objectives, and for the report to only include impactful actions for the remainder of the year with this format to continue into 2019/20. Members welcomed the more succinct reporting and acknowledged the progress made.

Together for Health Delivery Plans – at its meeting in April 2018, the Committee received

a comprehensive package of Together for Health Delivery Plans for their subsequent approval. Members welcomed the wealth of ambition contained within each plan, mapping the work underway to address prevention and population health, and dovetailing together the actions and plans to provide assurance on the linkages in place. The Committee noted that the re-freshed Annual Plans had been based on a consistent corporate approach, with a focus on the prevention agenda. The Committee further noted that Welsh Government had directed Health Boards to concentrate on 11 Delivery Plans with Hywel Dda having currently drafted 7 and in the process of reviewing these to ensure all actions are appropriate. Members were assured that work would continue to have these ready for endorsement by the Planning Sub-Committee in May 2018 in readiness for approval by BPPAC in June 2018, with the 4 outstanding plans following a similar process. Members agreed that sufficient detail had been provided for the Committee to approve the Critical Illness and Liver Disease Annual Reports 2017/18 in April 2018. In June 2018, the Committee received the further progress made in developing the Together for Health Delivery Plans, and Members were assured that whilst all were at different stages of development and would evolve through the 2018/19 planning cycle, all had been the subject of robust discussion at the previous Planning Sub-Committee meeting. Members took an assurance from the mechanisms in place to ensure these had been through a rigorous process and approved the refreshed plans that would be developed and updated through 2018/19.

Monitoring of Welsh Health Circulars (WHCs) – the Committee received regular progress updates in respect of those WHCs falling under the remit of BPPAC and its Sub-Committee structure during 2018/19. Recognising the implications for quality and safety of non-compliance with a number of the circulars, the Committee requested an assurance that these are being addressed, and agreed the need to ensure the quality & safety implications that derive from these were programmed into QSEAC's agenda. It was acknowledged that in number of cases, the Committee could not take an assurance from the exception report as the updates simply involved moving timelines along, and Members directed that firmer updates on progress would be required for monitoring by BPPAC for further assurance in future.

Patient Access Policy – at its meeting in June 2018, the Committee received the revised Patient Access Policy following the July 2017 Board decision to grant authority to implement the policy with the qualification that the Scheduled Care team review the complexity of the document and submit an amended version to BPPAC for consideration and approval. The Committee welcomed the review, commended the inclusion of the patient facing documents, and approved the revised Patient Access Policy.

Fishguard Health Centre Refurbishment and Extension Business Justification Case (BJC) – also at its meeting in June 2018, the Committee received the Fishguard Health Centre Refurbishment and Extension BJC. Members acknowledged the BJC's strategic importance given there is no identified hub in north Pembrokeshire, and recognised the amalgamation of the two practices involved as a short to medium term solution to stabilising GMS in the area until a longer term solution could be found. The Committee approved the BJC for onwards approval via Health Board Chair's Action to WG to ensure submission at the earliest opportunity.

Medicines Transcription and Electronic Discharge (MTED) Evaluation and Option Appraisal – at its meeting in August 2018, the Committee was informed that a business case to support MTED had been presented to ET for consideration. Whilst ET had supported this in principle, the business case had been unable to proceed due to other challenges and priorities for investment, and would now be considered through the Health Board's 2019/20 planning cycle. It was agreed that BPPAC would maintain a watching brief whilst removing MTED as a

standing item from its agenda unless the position changed.

In December 2018, the Committee was advised of a further roll out of MTED in BGH to address patient safety concerns on surgical wards. Members expressed concern that evidence had not been received that the benefits outweighed the cost of implementing MTED, and the lack of a formal approach to this roll-out meant there was no learning which was transferrable to other sites, nor was it scalable. Furthermore, ET had previously agreed that given the significant implementation and ongoing revenue costs involved, the system was not a sufficient priority for the Health Board, and had suspended further roll out. Concerns were expressed at the lack of governance that led to the decision to roll out MTED in BGH and it was proposed that ET receive a further report for consideration and for an update to be provided to BPPAC.

In February 2019, the Committee received an update from the discussion at ET and Members were advised that discussions had focused on the innovative way MTED had been introduced whilst avoiding the need for additional resources. The outcome from ET proposed that learning should be shared to establish whether this roll out could be taken forward within other areas of the Health Board. Members suggested that MTED should be a standing agenda item for the Capital, Estates and IM&T Sub-Committee (CEIM&TSC) to monitor progress and for any exceptions to be escalated to BPPAC. Members were further advised that to ensure the correct governance process is followed in future, proposals for further roll outs would be discussed by ET first.

Major Incident Plan – at its meeting in August 2018, the Committee received the updated Major Incident Plan 2018/19, revised to reflect current structures, command and control mechanisms and response processes. As part of its annual review process, Members were assured that the Major Incident Plan had been scrutinised by all relevant groups and was endorsed by the Committee prior to onward submission to the Board for approval in September 2018.

Research & Development Presentation – at its meeting in October 2018, the Committee received a presentation on Research & Development (R&D) from Professor Keir Lewis, highlighting the growth in R&D income over the past 10 years. Members welcomed the Health Board's links to ARCH, including the City Deal and other health and well-being activities. Members were informed of the future vision for R&D, which includes targeting participation in high scoring trials, however acknowledged that whilst WG expect a 10% increase in R&D income year on year, the current lack of clinicians and investigators involved in research within Hywel Dda poses a risk to achieving this. Members welcomed the Health Board's vision to recognise R&D as part of core business, acknowledging that cultural change is required to support teams to deliver this, and that the guiding principle of research should be the ambition to improve everyone's health in the future

Update On the Reporting And Validation Of Delayed Transfers Of Care – also at its meeting in October 2018, the Committee received an update on the reporting and validation of Delayed Transfers of Care across the three counties of Hywel Dda. Members were assured that revised processes had been considered to ensure that these are wholly consistent and compliant with national guidance, and Members acknowledged that the Health Board required a standard process going forward.

Implementation of National ICT Systems Within Hywel Dda University Health Board – at its meeting in December 2018, the Committee received an update on the implementation of National ICT Systems to provide clarity on those systems being implemented by the Health Board and the timescales for when new versions would become available. Members queried the Health Board's ability to influence the priorities for implementing these various

systems and were advised that at a National Informatics Management Board level, the focus is on collating all business cases onto one platform and to prioritise these on an all Wales level. Whilst the Cabinet Secretary has allocated £50m for Information Technology improvements across Health Boards, current business cases exceed this figure and it will therefore be a challenge to determine which projects to prioritise. Members queried the delay in rolling out improvements to the Wales Clinical Portal and were advised of the factors contributing to this including a lack of capacity to make progress and a lack of agreement on which systems should be prioritised. Members agreed that timescales should be included for future reports. The Chair suggested that further assurance could have been derived from the paper were the level of usage of these systems by the Health Board included within the report and it was agreed that a further paper on current levels of adoption and usage would be presented to BPPAC.

Implementation of the Single Cancer Pathway (SCP) – at its meeting in February 2019, the Committee received an update on progress towards implementation of the Single Cancer Pathway (SCP). Members were advised of the changes involved with the introduction of the SCP, the most significant being how the pathway will be tracked. Members acknowledged that the SCP should reduce inequality in the system, however shared the concerns expressed by other Health Boards regarding possible delays with diagnostic testing for other specialities. Members were assured that the Health Board is considering a range of options to increase capacity for the short and medium term, including exploration of opportunities for regional collaboration given the recruitment and capacity challenges currently experienced within Radiology & Pathology services in Hywel Dda.

Delivery of Ophthalmology Implementation Plan – also at its meeting in February 2019, the Committee received an update from the Ophthalmology Service on its compliance with the delivery of improvement plans. Members were pleased to receive confirmation that funding from WG of £605,500, to be spilt over two years, had been confirmed to support the Health Board's Eye Care Sustainability Plan for the community development of Cataract, Glaucoma and Wet Age-Related Macular Degeneration (wAMD) pathways services.

Risk

Corporate Risk Report – the Committee received regular Corporate Risk reports throughout 2018/19, highlighting the corporate risks assigned to BPPAC for consideration. Members noted that each risk had been assigned to an individual Executive Director and that assurance should be received that these are on track. Following detailed discussions on each of the risks, whilst acknowledging some of the identified controls in place, Members expressed concern regarding the number of gaps in controls where no assurance could be taken. It was agreed that continued scrutiny of all corporate risks assigned to BPPAC would be undertaken at each presentation to BPPAC.

Operational Risks Report – the Committee received regular Operational Risks reports throughout 20181/9 outlining the operational risks assigned to BPPAC. These risks were scrutinised in detail and Members received assurance from the relevant controls and mitigating actions in place, with only minor caveats.

Feedback from Sub-Committees
In terms of feedback from Sub-Committees:

- **Capital, Estates & IM&T Sub-Committee** – regular written update reports from the Capital, Estates and IM&T Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:

Capital Schemes during 2018/19

- Aberaeron (Minaeron)
- Aseptic Unit, Glangwili General Hospital
- Bronglais General Hospital, Chemotherapy Day Unit
- Bronglais General Hospital Emergency Fire Lift and Theatre 1 Project
- Bronglais General Hospital Front of House
- Cardigan Integrated Care Centre
- Catering, Health Board wide (not active – to be designated 'on hold' for the next reporting period)
- Cross Hands Health and Wellbeing Centre
- Cylch Caron Integrated Care Project
- Endoscopy and Day Surgery Project, Prince Philip Hospital
- Fishguard Health Centre
- Major Infrastructure and Ward Refurbishments Programme, Health Board wide
- MRI Unit, Bronglais General Hospital
- North Road Clinic,
- Pharmacy Projects, Health Board wide (MTED and Ward Automation)
- Pond Street Clinic/Penal, Carmarthen
- Transforming Mental Health: Acute Inpatient Re-design, Health Board wide
- Ward 10 Refurbishment, Withybush General Hospital
- Welsh Community Care Information Solution (WCCIS) Project
- Women & Children's Phase 2, Glangwili General Hospital

The following projects were placed on hold during 2018/19:

- Cardiology Suite, Glangwili General Hospital – subject to further regional work
- Energy Project, Phase 2, Health Board wide
- IM&T Programme Business Case, Health Board wide

- **Capital – Discretionary Capital Programme (DCP) -** reports received recommending prioritisation and reports monitoring expenditure against the Capital Resource Limit (CRL). Recognising the risk that capital resource remains insufficient to manage all the backlog pressures, three particular pieces of work were taken forward:
  - Development of Estates Major Infrastructure draft Programme Business Case (PBC)
  - Continued dialogue with Welsh Government on the IM&T Programme Business Case
  - Medical Devices Inventory Report

- **Annual Plan 2019/20 – Enabling Plans**
  - Capital Enabling Plan – Infrastructure & Investment
  - Digital Enabling Plan

- **Capital Audit –** updates on progress made with regard to recommendations received from NWSSP Audit and Assurance Services in respect of a number of the audit reports undertaken on capital projects.

- **Risk -** updates received to the risk management process and directorate level risks reviewed that exceeded the UHB agreed risk tolerance, aligned to the Sub-Committee.

- **Other Capital Areas of Responsibility**

- Integrated Care Fund (ICF)
- Learning Disability provision in Pembrokeshire and Carmarthenshire
- Residential Accommodation
- ISO 14001 Annual Environmental Management Review
- Informatics Operational Plan
- Carmarthen West Development
- Transforming Mental Health – Capital Issues
- Regional Cellular Pathology
- Planning Cycle – Emerging Capital Pressures
- Heavy Fuel Oil
- Water Management Solution
- All Wales E-Nursing Documentation Programme
- LINC Business Case

Where appropriate, key risks and issues/matters of concern and items for approval were escalated to BPPAC during 2018/19.

See Appendix 1 for the full Capital, Estates and IM&T Sub-Committee Annual Report.

- **Health & Safety and Emergency Planning Sub-Committee** (HS&EPSC) – regular written update reports from the Health & Safety and Emergency Planning Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Review of Health and Safety Conditions within Community Premises.
  - Review of COSHH compliance across the Health Board.
  - DSE E-Learning.
  - First Aid Training.
  - Violent and Aggressive Patient Warning Marker Procedure.
  - Violence and Aggression Restrictive Physical Intervention (RPI) Training.
  - Risk Register Review.
  - Access Control & Closed Circuit Television (CCTV).
  - Hospital Lock Down Arrangements.
  - Fire Safety Training, Management Resource and Fire Risk Assessments.
  - Manual Handling Training.
  - Bed Frame Audit.
  - Improve the Process for Bariatric Patient Admission and Discharge.
  - Sharps Injury Audit.

  The HS&EPSC also received updates on the on-going training, exercising and preparedness measures undertaken both internally, and on a multi-agency basis. These included:
  - Business Continuity
  - UK Threat Levels Response Plan
  - Major Incident Plan
  - Mass Casualty Incident Arrangements for NHS Wales
  - Severe Weather Response Protocol

  The following Health and Safety Policies/Procedures were approved by BPPAC during 2018/19:
  - COSHH Policy & Procedure – approved May 2018
  - Violence & Aggression Policy – approved May 2018

- First Aid at Work Procedure – approved May 2018
- New & Expectant Mothers Procedure – approved November 2018
- Lockdown Policy – approved January 2019
- Health and Safety Policy – approved March 2019

In terms of feedback from the Groups reporting to the HS&EPSC, regular written update reports from the following were received during 2018/19:

- Fire Safety Group (FSG)
- Water Safety Group
- Medical Gases Group
- Health and Safety Advisory Group

Where appropriate, key risks and issues/matters of concern and items for approval were escalated to BPPAC during 2018/19.

See Appendix 2 for the full Health & Safety and Emergency Planning Sub-Committee Annual Report.

- **Information Governance Sub-Committee** – regular written update reports from the Information Governance Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Cyber Security - NHS Wales External Security Assessment
  - IG Activity Report
  - General Data Protection Regulation Update
  - Data Quality / Clinical Coding Update
  - National Intelligent Integrated Audit Solution (NIIAS) Update
  - Annual Review of Information Governance related written control documentation
  - Training and Awareness Development
  - IG Risk Register
  - Data Protection Impact Assessments (DPIA)
  - Welsh Health Circulars
  - C-PIP (Caldicott Out-turn Report)

  See Appendix 3 for the full Information Governance Sub-Committee Annual Report.

- **Planning Sub-Committee** – regular written update reports from the Planning Sub-Committee have been received by BPPAC during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee, including:
  - Review of the risks aligned to the Planning Risk Register.
  - The Integrated Planning Assurance Report (IPLAR).
  - Digital Health.
  - Mental Health Implementation Group.
  - Transforming Clinical Services Programme (TCS) / A Healthier Mid and West Wales.
  - Together for Health Delivery Plans.
  - All Wales 2018 Summer Planning Event.
  - Welsh Health Circulars.
  - Commissioning Framework.
  - Wellbeing and Future Generations (Wales) Act.
  - Research, Development and Innovation.
  - Regional Partnership Board and the Transformation Fund.
  - Welsh Trauma Network updates.

- Development of the UHBs End of Life strategy.
- Minutes of the Hywel Dda Community Health Council Service Planning Meetings – for information.
- Updates on collaborative/regional work to ensure/provide assurance that planning implications were understood and joined up as appropriate:
    - Mid Wales Joint Health and Care Collaborative (MWJC).
    - A Regional Collaboration for Health (ARCH)
    - Joint Regional Planning and Delivery Committee (JRPDC)

Where appropriate, key risks and issues/matters of concern and approval items during the reporting period, were escalated to BPPAC.

See Appendix 4 for the full Planning Sub-Committee Annual Report.

- **Finance Sub-Committee** – written update reports from the Finance Sub-Committee have been received by the Business Planning & Performance Assurance Committee up until September 2018 when it became elevated to a formal Committee of the Board, highlighting the key areas of work scrutinised by the Sub-Committee, including:
    - Monthly financial performance and savings position
    - Efficiency opportunities
    - Finance Sub-Committee Annual Report

Following the final meeting of the Finance Sub-Committee on 28th September 2018, the Committee acknowledged the closure of the Sub-Committee following its elevation to a formal Committee of the Board, and that for future BPPAC meetings, finance reporting would be limited to the summary contained within the IPAR.

Collaborative Working/Update Reports:

- **A Regional Collaboration for Health (ARCH) Update** – the Committee received regular feedback from the ARCH Programme Board on the breadth and level of work undertaken during 201/19, including:
    - the Regional Orthopaedic Summit held on 15th March 2018 with the work programme being taken forward by the Chief Operating Officers from both Hywel Dda and ABM UHBs;
    - the Hyper Acute Stroke Unit where work is progressing on the regional stroke specification in anticipation of funding going forward;
    - the ACCELERATE programme, a platform for delivering medical innovation which will afford further opportunities within the innovation field;
    - the Service Transformation Programme which has synergy with a number of the Health Board's imperatives.

Members were pleased to note that whilst ARCH had commenced as a strong relationship between ABMUHB and Swansea University, given the number of Hywel Dda Executive Directors taking the lead on many of the projects involved, HDdUHB is now considered an equal partner. However, Members expressed concern that the ARCH Programme Board had not met for some months and it was agreed to raise this concern through the ARCH Delivery and Leadership Group.

Members agreed the need for the work of ARCH and other collaboratives such as the West Wales Partnership Board to be linked together to ensure actions are aligned and duplication avoided.

- **Llanelli Wellness and Life Science Village Update** – regular updates were presented to the Committee during 2018/19 highlighting the key milestones achieved, including work to develop the Outline Service Specification for the project and the Clinical Delivery Plan for approval by the Health Board's Executive Team, and its closely related Skills and Training Plan. Members acknowledged that the Village would be reliant on inter-related elements in order to gain maximum benefit. Members received an assurance on the Village's alignment to the Health Board's strategic and service plans, and that work would progress to achieve a revenue neutral position in addition to the significant savings proposed through the wider health system. Members acknowledged that the Village supported the direction of travel for ARCH and addressed the Health Board's workforce recruitment and retention issues by providing on-site training, etc, and agreed that it should be ambitious in terms of the services it provides.

- **West Wales Regional Care Partnership Board -** the Committee received regular updates on the work of the West Wales Regional Partnership Board throughout 2018/19, and acknowledged the pace in moving towards an integrated health and social care model. Members were advised that going forward, the Regional Partnership Board (RPB) would represent the fundamental arena where collaborative business will be undertaken, and noted that publication of 'A Healthier Wales' had signalled provision for £100m to be made available through RPB arrangements. In future, it is anticipated that many millions of pounds worth of business will be undertaken through this mechanism, bringing with it a new set of governance arrangements to be addressed which would be reported to the Board.

  The Committee was also presented with the Carer's Annual Report for 2017/18 and the Carers Delivery Plan for 2018/19, demonstrating the ambition of what can be achieved and the better value that can accrue by joint working on this agenda.

- **City Deal Update Report** – at its meeting in August 2018, the Committee received an update on the development of the draft business case for the Health and Life Science Campus for Swansea as part of the City Deal, in a paper previously considered by ABMU Health Board.

- **Strategic Partnership Plans**– at its meeting in April 2018, the Committee received the Public Services Boards (PSBs) Well-Being Plans for each local authority area, and the West Wales Area Plan developed by the West Wales Regional Partnership Board, which had received endorsement at the March 2018 Public Board meeting. These assured the Committee that the Health Board is meeting its obligations under the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014.

- **Wales Major Trauma Network –** the Committee received regular update reports during 2018/19 from the Wales Major Trauma Network report for information. At its meeting in December 2018, Members were advised of a report planned for a subsequent ET meeting to support the designation of a Trauma Unit within Hywel Dda, followed by formal agreement through the Board in January 2019. Members were advised that the availability of a 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS) service had been acknowledged by Health Boards across Wales, and the next stage would be to acquire funding to meet this aspiration.

Key Risks and Issues/Matters of Concern Reported by BPPAC to the Board during 2018/19:

- **Report on the Provision of Residential/Doctors Accommodation** - concerns regarding the scale of the issues involved in relation to the diminishing and sub-standard

residential accommodation facilities in place across the Health Board, to be addressed through funding allocated from discretionary capital and the work of the Accommodation Task & Finish Group reporting to CEIM&TSC.

- **Monitoring of Welsh Health Circulars (WHCs)** – concerns at the lack of assurance that could be taken from the exception report to be addressed by the requirement for firmer updates on progress for monitoring by BPPAC in future.
- **Mortality Exception Report** – concerns in regard to the reviews findings to be mitigated by further scrutiny at QSEAC.
- **Financial & Turnaround Programme Update** - concerns regarding the Health Board's deteriorating financial run rate to be mitigated through operational savings delivering at pace, with the CEO Holding to Account meetings building a rhythm and focus for this work.
- **Integrated Performance Assurance Report** - concerns regarding recruitment performance to be considered further by the Workforce & OD Sub-Committee of QSEAC.
- **Integrated Planning Assurance Report** - concerns regarding the number of objectives within the 2018/19 Annual Plan making it difficult to monitor and provide assurance, to be mitigated by each Director considering their own particular areas to reduce their number and to agree the most 'impactful' actions to report on going forward.
- **H&SEPSC Update Report** - concerns regarding the delay in implementing the Health Boards Lockdown Policy, mitigated by an assurance that this would be presented to the H&SEPSC meeting in January 2019 for approval.
- **Update on All Wales Capital Programme & Discretionary Capital Programme incorporating the Capital Governance Update** - concerns regarding the increased risk in the Health Board's ability to provide aseptic medicines due to having to outsource aseptic unit work, to be mitigated by an update requested for a subsequent BPPAC meeting on the actions taken to manage the risks involved.
- **MTED** - concerns regarding the roll out of MTED in BGH given ET's decision to suspend this, to be mitigated by discussion at ET with a further update to be reported to BPPAC.
- **Information Governance Sub-Committee Update Report –** concerns regarding the significant challenge to meet the clinical coding target, to be addressed by processes put in place to mitigate against this, and funding for additional clinical coders requested through the annual planning process.
- **Report on the Discretionary Capital Programme 2018/19 and 2019/20 and Capital Governance -** concerns regarding the agreed level of pre-commitment of 2019/20 allocations given the slippage on projects identified, to be addressed by mitigating actions put in place to reduce this risk.
- **Implementation of the Single Cancer Pathway (SCP) -** concerns regarding possible delays with diagnostic testing for non-cancer specialities, to be mitigated by the Health Board' consideration of a range of options to increase capacity for the short and medium term, including an exploration of opportunities for regional collaboration given the recruitment and capacity challenges currently experienced within radiology & pathology services.

Matters Requiring Board Level Consideration or Approval

- BPPAC Annual Report 2017/18 for submission to the Board on 30th May 2018.
- Approval of the Fishguard Health Centre Refurbishment and Extension Business Justification Case for submission to WG.
- Major Incident Plan 2018/19.
- BPPAC Revised Terms of Reference 26th September 2018 and 28th March 2019.

Argymhelliad / Recommendation

The Board is asked to endorse the Business Planning & Performance Assurance Committee Annual Report for 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	BPPAC 30th April 2019

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced in the Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.

Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and Committee's Terms of Reference, requires the submission of an Annual Report to the Business Planning & Performance Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	SBAR template in use for all relevant papers and reports

PWYLLGOR CYNLLUNIO BUSNES A SICRHAU PERFFORMIAD
BUSINESS PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Capital, Estates, Information Management & Technology (CEIM&T) Sub Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Karen Miles, Director of Planning, Performance & Commissioning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Paul Williams, Assistant Director of Strategic Planning & Development

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Capital, Estates, Information Management & Technology (CEIM&T) Sub-Committee Annual Report 2018/19 to the Business Planning & Performance Assurance Committee (BPPAC). The CEIM&T Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

The Capital, Estates, Information Management & Technology (CEIM&T) Sub-Committee can assure the Business Planning & Performance Assurance Committee that it has operated within its Terms of Reference and meetings have all been quorate. The Sub-Committee provides detailed assurance reports to BPPAC following each of these meetings and these can be found on the Committee webpage.

The Business Planning & Performance Assurance Committee is asked to endorse the Capital, Estates, Information Management & Technology Sub-Committee Annual Report 2018/19.

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the CEIM&T Sub-Committee require the submission of an Annual Report to the Business Planning & Performance Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to:

- Oversee delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term).
- Recommend to the Board, via the Business Planning and Performance Assurance Committee (BPPAC), for the use of the Health Board's Capital Resource Limit (CRL).
- Oversee the development of the Estates Strategy aligned to the Clinical Services Strategy for consideration by BPPAC, prior to Board approval.

- Oversee the development of an innovative IM&T and Digital Health Strategy for IM&T (to cover all functions of the UHB's services i.e. primary, community, acute, etc) aligned to the Clinical Services Strategy for consideration by BPPAC, prior to Board approval.
- Oversee the development and delivery of implementation plans for the Estates and, IM&T and Digital Health Strategy agreeing corrective actions where necessary and monitoring its effectiveness.

The Annual Report 2018/19 specifically comments on the key issues considered by the Sub-Committee in terms of capital strategy, planning and monitoring and the adequacy of the governance and control measures in place.

Asesiad / Assessment

The CEIM&T Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Business Planning & Performance Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the CEIM&T Sub-Committee were subsequently approved at its meeting on 29th September 2017 and revised at its meeting on 29th January 2019 prior to approval by the Business Planning & Performance Assurance Committee at its meeting on 26th February 2019.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Business Planning & Performance Assurance Committee around the organisation's Capital Strategy, ensuring that there is an accurate reflection of planning, governance, and monitoring to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the Capital Planning agenda for the Business Planning & Performance Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the Capital agenda against the following areas of responsibility:

- Develop recommendations to the Board, via the Business Planning and Performance Assurance Committee (BPPAC), for the use of the Health Board's Capital Resource Limit (CRL).
- Develop prioritised recommendations for discretionary capital sums and All Wales Capital Schemes and investment proposals, in response to an assessment of the organisation's risks, and to support the Health Board's Clinical Services Strategy (including delivery plans) and vision for healthcare and its strategic objectives, including performance and financial improvement.
- Provide a co-ordinated approach to overseeing delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term) enabling the Health Board to understand the overall delivery commitments and risks, and proposing changes as appropriate.
- Provide assurance that capital projects are managed and governed in accordance with mandatory requirements, best practice and the latest Welsh Government Capital guidance, ensuring that revenue consequences associated with capital projects are explicit at project scoping stage.
- Provide assurance around the effective management of the Health Board's CRL, ensuring expenditure is in line with Standing Orders and within the agreed programme.
- Scrutinise and quality assure major capital business cases prior to submission to BPPAC including those developed in partnership with other organisations.
- Ensure that there is a robust disposal policy for redundant estate.
- Consider options for the acquisition or disposal of estate and agree recommendations for the Board, via BPPAC.

- Review and recommend the appropriate delegated limits for capital expenditure authorisation and authorisation for other funding sources.
- Make recommendations on appropriate capital expenditure on IM&T assets.
- Ensure arrangements are in place to assess and deliver benefits of the capital received for innovative information technology, and information services to benefit patients, clinicians and the public.
- Provide assurance to BPPAC that all risks associated with capital investment for estates and IM&T services are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
- Agree the Annual Capital Audit Plan and monitor action against recommendations contained within audit reports issued by Capital Audit.
- Agree issues to be escalated to BPPAC with recommendations for action.
- Agree an annual work plan for the Sub Committee for review and approval by BPPAC.
- Agree and submit an Annual Report for BPPAC's review.

CEIM&T Sub-Committee Groups
The Groups reporting to the CEIM&T Sub-Committee during 2018/19from which the Sub-Committee received an update were as follows:

Capital Planning Group – established to:

- Provide assurance to the Capital, Estates and IM&T Sub Committee around the development of the Discretionary Capital Programme.
- Ensure robust processes are in place for the prioritisation of capital bids in line with the Health Board's risk management processes and strategic objectives.
- Receive and review the monthly Dashboard reports linked to AWCP funded projects approved by Project Directors and submitted to Welsh Government (these also form part of the CRM agenda).

Capital Monitoring Forum – established to:

- Provide assurance to the Capital, Estates and IM&T Sub Committee around the management and monitoring of the delivery of the capital investment programme and Capital Resource Limit.
- Keep the Capital Planning Group informed of progress on the delivery of the Capital Programmes and variances on expenditure/timescales which require attention.

In addition to the above, the work undertaken by the following groups is received in the form of update reports and minutes presented to the CEIM&T Sub-Committee. In January 2019, the Sub-Committee recommended the establishment of a Capital Governance Forum (CGF) to tighten governance processes. This was approved by BPPAC within revised Terms of Reference at its meeting on 26th February 2019.

Capital Review Meetings - Monthly meetings are held between the Health Board and Welsh Government's Capital Division to discuss all capital related issues. The minutes of these meetings are circulated to the CEIM&T Sub-Committee.

The CEIM&T Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Business Planning & Performance Assurance Sub-Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Capital Project Groups - Each capital project is managed by a Project Group led by an appointed Executive Lead (Senior Responsible Officer) and Service Lead (Project Director). Bi-

monthly project highlight reports are received by the CEIM&T Sub-Committee which report on project risks and progress and escalated to the Business Planning & Performance Assurance Committee. The report provides a RAG rating for each project; BPPAC receive a summary position on all red RAG rated projects and those which report an amber RAG rating for two consecutive months or more.

Where appropriate for the scheme value/programme, a Sub Group will meet prior to the Project Group to go through the detail of the financial status of the project chaired by the Finance Lead. This Sub Group will then present a highlight report to the main Project Group. For All Wales Capital Planning, dashboards are submitted to Welsh Government as well as to the CEIM&T Sub-Committee.

Constitution

From the terms of reference approved at the Business Planning & Performance Assurance Committee meeting in February 2019, the membership of the Sub-Committee was agreed as the following (or deputies as appropriate):

- Director of Planning, Performance and Commissioning (Chair)
- Assistant Director of Strategic Planning and Development (Vice-Chair/Sub Committee Lead)
- Independent Member
- Director of Finance
- Director of Estates, Facilities and Capital Management
- Assistant Director of Nursing, Professional Standards & Workforce
- Senior Finance Business Partner
- Head of Facilities Information and Capital Management
- Deputy Chief Executive & Director of Operations
- Medical Director & Director of Clinical Strategy
- Assistant Director of Informatics
- Head of Primary Care
- Head of Risk & Assurance
- Head of Procurement
- Deputy Assistant Director of Mental Health and Learning Disabilities
- County Director and Commissioner – Carmarthenshire
- County Director and Commissioner – Ceredigion
- County Director and Commissioner – Pembrokeshire
- Radiology Services Manager
- General Manager, Women & Children's Directorate
- Head of Pathology (added per the revised January 2019 Terms of Reference)
- Assistant Director of Therapies & Health Sciences (added per the revised January 2019 Terms of Reference)

In Attendance

- Committee Support/Secretary
- Head of Capital Audit (Quarterly)

Meetings

CEIM&T Sub-Committee meetings have been held on a bi-monthly basis as follows;

- 29th May 2018
- 24th July 2018
- 25th September 2018
- 27th November 2018
- 29th January 2019

- 27th March 2019

As the CEIM&T Sub-Committee is directly accountable to the Business Planning & Performance Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on 6 occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the CEIM&T Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

Capital Schemes
The Sub-Committee has and continues to oversee and report on the delivery and continued progression of a significant number of capital projects which have been subject to risk based highlight reporting to the Sub-Committee during the year:

- Aberaeron (Minaeron)
- Aseptic Unit, Glangwili General Hospital
- Bronglais General Hospital, Chemotherapy Day Unit
- Bronglais General Hospital Emergency Fire Lift and Theatre 1 Project
- Bronglais General Hospital Front of House
- Cardigan Integrated Care Centre
- Catering, Health Board wide (not active – to be designated 'on hold' for the next reporting period)
- Cross Hands Health and Wellbeing Centre
- Cylch Caron Integrated Care Project
- Endoscopy and Day Surgery Project, Prince Philip Hospital
- Fishguard Health Centre
- Major Infrastructure and Ward Refurbishments Programme, Health Board wide
- MRI Unit, Bronglais General Hospital
- North Road Clinic,
- Pharmacy Projects, Health Board wide (MTeD and Ward Automation)
- Pond Street Clinic/Penlan, Carmarthen
- Transforming Mental Health: Acute Inpatient Re-design, Health Board wide
- Ward 10 Refurbishment, Withybush General Hospital
- Welsh Community Care Information Solution (WCCIS) Project
- Women & Children's Phase 2, Glangwili General Hospital

The following projects have been placed on hold during 2018/19:
- Cardiology Suite, Glangwili General Hospital – subject to further regional work
- Energy Project, Phase 2, Health Board wide
- IM&T Programme Business Case, Health Board wide

Capital – Discretionary Capital Programme (DCP)
Reports recommending prioritisation have been submitted to BPPAC as well as reports monitoring expenditure against the Capital Resource Limit (CRL). The year started with a DCP of £7.421m, with an additional allocation bringing it up to £8.875m for the year.

The Sub-Committee has placed greater emphasis to focus on the need to spend a smaller percentage of capital in the final months of the year.

The Sub-Committee has also received numerous update reports from the Residential Accommodation Task & Finish Group given the £200,000 which was prioritised from this year's DCP allocation to urgently address and improve doctors' accommodation across the Health Board's estate.

It is acknowledged that capital resource remains insufficient to manage all the backlog pressures. To help address this, there have been three particular pieces of work:

- Development of Estates Major Infrastructure draft Programme Business Case (PBC)
- Continued dialogue with Welsh Government on the IM&T Programme Business Case
- Medical Devices Inventory Report

Annual Plan 2019/20 – Enabling Plans

As part of the planning cycle, the CEIM&T Sub-Committee has discharged its duty to oversee the development of enabling plans as follows:

- Capital Enabling Plan – Infrastructure & Investment
- Digital Enabling Plan

Capital Audit

A quarterly report is presented to the Capital, Estates and IM&T Sub Committee to provide an update on progress made with regard to recommendations received from NHS Wales Shared Services Partnership, Audit and Assurance Services (NWSSP) in respect of a number of the audit reports undertaken on capital projects. A capital audit tracker has been developed to ensure that the Sub-Committee oversees the capital audit process in terms of the monitoring of actions against recommendations included in each audit report.

Risk

The Terms of Reference state the Sub-Committee will 'provide assurance to BPPAC that estates and IM&T services are safe and sustainable and that all risks associated with capital investment are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate)'. In 2018/19, the Sub-Committee received updates to the risk management process and reviewed directorate level risks that exceeded the UHB agreed risk tolerance, aligned to the Sub-Committee.

The Sub-Committee also received themed risk registers for 'capital', estates/environment' and 'IM&T' which captured all risks where there were planned actions related to current or future capital requirements. Further work is being undertaken to review these to validate these against the capital bid process and the prioritisation lists for DCP allocation. No significant unknown risks have been identified to date.

Other Areas of Responsibility - Capital

- Integrated Care Fund (ICF)
- Learning Disability provision in Pembrokeshire and Carmarthenshire
- Residential Accommodation
- ISO 14001 Annual Environmental Management Review
- Informatics Operational Plan
- Carmarthen West Development
- Transforming Mental Health – Capital Issues
- Regional Cellular Pathology
- Planning Cycle – Emerging Capital Pressures
- Heavy Fuel Oil
- Water Management Solution

- All Wales E-Nursing Documentation Programme
- LINC Business Case

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to the Business Planning & Performance Assurance Committee:

- **Capital Resource Limit and Discretionary Capital Allocations 2018/19 -** despite notification of a non-recurring uplift to the Discretionary Capital allocation in 2018/19, the capital allocation will remain insufficient to provide the Business Planning & Performance Assurance Committee with full assurance on the management of infrastructure and backlog risks.

- **Capital Projects** – to note those capital projects reporting a high risk assessment guideline status and the work underway to mitigate risks. As at February 2019, the red risk projects were Cylch Caron and Bronglais General Hospital Front of House, which are both the subject of further monitoring by the CEIM&T Sub-Committee.

Matters Escalated to Business Planning & Performance Assurance Committee
During 2018/19, the following matters requiring Business Planning & Performance Assurance Committee level consideration or approval were raised:

- Recommended actions, approvals for capital allocations and expenditure have been included in an update report submitted to the Business Planning & Performance Assurance Committee on a bi monthly basis.
- In addition to Capital Project Highlight Report summaries, reports have been presented to the Business Planning & Performance Assurance Committee for a number of projects during 2018/19 for example, Cross Hands Health & Wellbeing Centre, Women & Children's Phase 2, Pond Street/Penlan, Major Infrastructure and Cardigan Integrated Care Centre Scheme.
- Recommendation for approval of policies.
- Approval of the CEIM&TSC revised Terms of Reference.

Capital, Estates and IM&T Sub-Committee Developments for 2019/20
The following developments are planned for the Capital, Estates and IM&T Sub-Committee during 2019/20:

- Further improvements to the capital prioritisation process for allocation of DCP and All Wales Capital to ensure alignment to risk registers and strategic and business objectives.
- Further improve the capital planning cycle to ensure timely scheme planning, procurement and expenditure strategic and business objectives.
- Further development of risk registers for IM&T, Estates and Planning, ensuring close working with the Operational Team to ensure capital bids are aligned to departmental risk registers; the implementation of Datix for risk management will support the capital prioritisation process.
- Progression of priority business cases and capital projects noted in this paper and development of new projects as agreed, including those aligned to 'A Healthier Mid & West Wales'.
- Further professional development for project/programme management.

Argymhelliad / Recommendation

The Business Planning & Performance Assurance Committee is asked to endorse the Capital, Estates and Information Management & Technology Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Capital Estates Information Management & Technology Sub-Committee. Sub-Committee Update reports for Business Planning and Performance Assurance Committee
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad: Parties / Committees consulted prior to Business Planning and Performance Assurance Committee:	Capital Estates Information Management & Technology Sub-Committee.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced within the CEIM&T Sub-Committee's Annual report, will assist with ensuring financial control, and the safeguard of public funds
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Capital, Estates, Information Management & Technology Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Capital, Estates, Information Management & Technology Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Business Planning & Performance Assurance Committee
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	SBAR template in use for all relevant papers and reports.

PWYLLGOR CYNLLUNIO BUSNES A SICRHAU PERFFORMIAD
BUSINESS PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health & Safety and Emergency Planning Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations/Deputy Chief Executive/Ros Jervis Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joe Teape, Director of Operations/Deputy Chief Executive/Ros Jervis Director of Public Health

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Health & Safety and Emergency Planning Sub-Committee Annual Report 2018/19 to the Business Planning & Performance Assurance Committee. The Health & Safety and Emergency Planning Sub-Committee Annual Report provide assurances in respect of the work that has been undertaken by the Sub-Committee during the previous financial year, primarily against the targets and aims set out in the Sub-Committee's Annual Work Plan.

Cefndir / Background

The UHB's Standing Orders and terms of reference for the Health & Safety and Emergency Planning Sub-Committee require submission of an Annual Report to the Business Planning & Performance Assurance Committee with the intention of outlining the work of the Sub-Committee and identifying how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance around the UHB's arrangements for ensuring the health, safety, welfare, security together with emergency planning arrangements of the Health Board's business operations, as they affect employees and patients and others who may be affected by work-related activities.

The Annual Report specifically comments on key issues considered by the Sub-Committee in terms of health & safety, security and emergency planning and the adequacy of policies and plans in place.

Asesiad / Assessment

During 2018/19 the Health and Safety and Emergency Planning Sub-Committee met on the following occasions:

Date	Did meeting take place	Quorate
17th May 2018	✓	✓
Terms of reference changed to reflect meeting every two months		
10th September 2018	✓	✓
15th November 2018	✓	✓

17th January 2019	✓	✓
6th March 2019	✓	✓

During the reporting period, groups reporting to the Health and Safety and Emergency Planning Sub-Committee included:

- Fire Safety Group
- Water Safety Group
- Medical Gases Group

Constitution

From the terms of reference amended and approved on 10th September 2018, the membership of the Sub-Committee was agreed as the following:

- Deputy Chief Executive/Director of Operations (Co-Chair)
- Director of Public Health (Co-Chair)
- County Director
- Independent Member
- Director of Operational Nursing and Quality – Acute Services
- Director of Estates, Facilities and Capital Management
- General Manager – Scheduled Care
- General Manager – Unscheduled Care
- General Manager – Women's' and Children's Services
- General Manager – Community
- General Manager – Mental Health and Learning Disabilities
- Primary Care representative
- Therapy and Out of Hours representative
- Site General Managers; Carmarthenshire, Ceredigion, Pembrokeshire
- Workforce and OD – HR representative
- Health and Safety Manager
- Head of Health, Safety and Security
- Head of Occupational Health Service
- Security and Case Manager
- Moving and Handling Co-ordinator
- Head of PAMOVA
- Head of Health Emergency Planning
- Union Safety Representatives – RCN, RCM, Unite, UNISON, BMA, SOR etc.

As the Health & Safety and Emergency Planning Sub-Committee is directly accountable to the Business Planning & Performance Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

Work Undertaken in 2018/19

The Annual Work Plan includes sections relating to six specific specialties including the following:

- Health and Safety
- Security
- Health Emergency Planning
- Occupational Health
- Manual Handling
- Violence and Aggression

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Health and Safety and Emergency Planning Sub-Committee has undertaken work during 2018/19 against the above areas of responsibility and the following demonstrates compliance and progress with the Sub-Committee's Work Plan.

Health, Safety & Security

Review of Health and Safety Conditions within Community Premises

During 2018/19, 25 community premises received a health and safety inspection with findings reported back to Estates and local management teams. The 2 premises not visited (Winch Lane/Yorke Street Health Centres) have been forward planned for the 2019/20 programme of inspections. These outstanding premises will be completed within the first quarter of 2019.

Review of COSHH compliance across the Health Board
The Annual Work Plan identified the following actions:

- Produce the COSHH Policy and seek approval at Health and Safety & Emergency Planning Sub-Committee. This was achieved with the COSHH Policy approved by the Health and Safety & Emergency Planning Sub-Committee in May 2018.
- Undertake visits to assess whether COSHH risk assessments are in place for each department where high volumes of harmful substances are used. This action has only been partially achieved as due to competing demands placed on the Health and Safety Manager, not all identified departments have been visited. This will be rectified during the latter part of 2019 when a Health and Safety Adviser will be appointed which will enable to department to focus on this area of responsibility more proactively.
- Review the current arrangements for chemical exposure monitoring. This has also not been undertaken and will be progressed once the Health and Safety Adviser has been appointed.

Display Screen Equipment (DSE) E-Learning
The roll-out of mandatory DSE E-learning module has been completed. The next stage is for the team to liaise with Leaning & Development to identify 'Users' via ESR for the module to be assigned to all identified display screen users.

Policies / Procedures
The following Health and Safety Policies/Procedures were written/reviewed during 2018/19:

- COSHH Policy & Procedure – approved May 2018
- Violence & Aggression Policy – approved May 2018
- First Aid at Work Procedure – approved May 2018
- New & Expectant Mothers Procedure – approved November 2018
- Lockdown Policy – approved January 2019
- Health and Safety Policy – approved March 2019

First Aid Training
A business case and options appraisal for the provision of Emergency First Aid at Work training within HDdUHB was completed in August 2018, approved by the Health and Safety & Emergency Planning Sub-Committee in May 2018 and submitted to the Learning & Development to appoint the Health Board's First Aid trainer.

Violent and Aggressive Patient Warning Marker Procedure
The draft procedure has been transcribed to reflect the Hywel Dda Management structure and requires the various management teams to take ownership of this procedure. It is currently out

for Global consultation and is expected to be approved at the Health and Safety & Emergency Planning Sub-Committee in May 2019.

Risk Register Review
The Annual Work Plan identified the following actions:

1. Review the 'Health and Safety' Risks entered onto the Datix Risk System.
2. Undertake visits to the priority areas and provide assistance/support in identifying and implementing control measures to reduce the identified risks.

These actions have not been fully achieved during 2018/19. The Health, Safety & Security Team has focused on high risks during the reporting period, where support has been provided to certain departments however this has been limited. The benefit of expertise from the Health and Safety Team, in particular, will enable control measures to be explored and practical risk reduction measures to be considered. With the appointment of the Health and Safety Adviser, proactive work should be achievable.

Security Management

Access Control & Closed Circuit Television (CCTV)
A number of actions have been identified to improve the way in which access control and CCTV is managed. This has culminated in a draft access control procedure being written which identifies the Facilities Management Department as being primarily responsible for managing the above. The procedure requires departmental managers to also undertake specific tasks and therefore needs to be promoted once finalised.

Hospital Lock Down Arrangements
During 2017 a detailed site security survey was completed for each of the four acute hospital sites. The priority was to review existing external doors and identify strengths and weaknesses to current arrangements. The review has identified a number of recommendations for each site, including improved electronic lock down capabilities.

A discretionary capital bid has been completed and submitted in order to improve the integrity and installation of electronic locks to certain external doors. The funding for this work is awaited from the 2019/20 capital allocation.

Lock Down Policy
The Health Board's Lock Down Policy was approved in January 2019 and individual Hospital Lock Down Plans are being written to reflect the management arrangements for each site. The Hospital Lockdown plans will be completed by September 2019.

Fire Safety Management

The 2018/19 Annual Work Plan did not include a specific section for Fire Safety Management. This will be addressed in the 2019/20 Annual Work Plan. However, the Committee can take assurance from the fact that Fire Safety is a standing agenda item at Sub-Committee meetings. The following is a summary of items routinely discussed.

Fire Safety Training
The Fire Safety Team continues to provide training to staff and improvements to the way this is recorded on the Electronic Staff Record are being addressed. Additional resources are now in place to support the team in order to further improve training compliance as well as the required fire risk assessments. In addition to this, a revised training needs analysis has been developed by the fire safety team, combining the previous L1 and L2 content into one general fire safety

training component. This has been undertaken to offer a clearer pathway for staff and to maximise throughput. Improvements to the Learning & Development fire safety prospectus pages have also been completed, clarifying the courses, who should attend and when the courses are scheduled.

Fire Safety Management Resource

Following a funding application to increase its workforce resource, the Fire Safety Management team will now have a dedicated Head of Fire Management together with an additional 1.8 Fire Safety Advisors (one x 5 days per week and one x 4 days per week). The restructure of the Fire Safety section enables there to be a dedicated Fire Safety Advisor to be present on each of the acute hospital sites.

Fire Risk Assessments.

The Health Board has a significant backlog of fire risk assessments, particularly in the Glangwili General Hospital (GGH) and Prince Philip Hospital (PPH) sites. There are currently (as at April 2019) 64 overdue fire risk assessments outstanding, with a focus on completing all High Risk assessments (circa 15) by the end of May 2019 and all remaining assessments by the end of August 2019. The increase in resources as described above will allow fire safety to be managed more efficiently, will provide resilience where necessary and will enable the Health Board to reduce the fire risk assessment backlog significantly.

A new timeframe sets out that a concentrated effort would be made to reduce the backlog in terms of higher risk areas by the end of May 2019 and a significantly improved situation overall would be evident by the end of August 2019.

Health Emergency Planning

The Health & Safety and Emergency Planning Sub Committee received updates on the on-going training, exercising and preparedness measures undertaken both internally, and on a multi-agency basis. These included:

- Business Continuity
- UK Threat Levels Response Plan
- Major Incident Plan
- Mass Casualty Incident Arrangements for NHS Wales
- Severe Weather Response Protocol

Major Incident Plan

The Health Board Major Incident Plan was reviewed during 2018 with the assistance of each of the County Emergency Planning Groups. The Plan was submitted to the Health and Safety & Emergency Planning Sub-Committee for agreement prior to onward submission to BPPAC and subsequently to the Board for final ratification on 27 September 2018.

Business Continuity

Following a previous audit in 2013 which provided ‘limited assurance’, the outcome from an audit carried out in 2018 showed considerable improvement with a much improved rating. In relation to the seven audit objectives, five received a substantial assurance rating and two a reasonable assurance rating. The audit made three recommendations with its initial focus being on Pembrokeshire services, all of which have been progressed. Engagement and action associated with Business Continuity Management (BCM) is much improved across the Health Board with a more positive approach being observed across county-based and organisation-wide services.

Business Continuity Themed Risk Register Review

The Emergency Planning Team are required to:

1. Review all the risks entered onto the Datix Risk System associated with service/business interruption/disruption theme, and
2. Provide advice and assistance in confirming the risks to business continuity and supporting the identification of control measures to reduce the identified risks.

The team has completed this work and provided advice for all current service/business interruption/disruption themed risks.

Severe Weather Protocol

An action following the adverse weather interruptions during 2017/18 and a goal within the Annual Work plan was to produce a Severe Weather Protocol incorporating recommendations of the Severe Weather Debrief held in March 2018. . A protocol was developed and presented to the Sub-Committee on 15th November 2018 detailing procedures for preparedness and response to severe weather incidents to facilitate business continuity.

Moving and Handling

Manual Handling training

During 2018/19, the Moving and Handling Team continued with the workplace assessor model to improve training compliance rates and to provide improved support and supervision to the workplace assessors and clinical staff. This has involved reducing the number of classroom updates with trainers spending one day per week in the workplace with the ward based assessors. This improved level of support has increased the number of workplace assessments being undertaken and in turn reduced the need for the projected number of classroom updates to be provided. There has also been feedback from clinical staff that the increased presence of the manual handling trainers in the ward environments have reduced the incidence of poor manual handling practices that were previously being reported and has also significantly reduced the loss of hours that staff are away from the clinical area to attend classroom training.

The Annual Work plan included a target to achieve 85% compliance in both level 1 and level 2 manual handling training and to provide classroom manual handling training to staff groups who do not have access to a workplace assessor. At the start of 2018, level 2 manual handling training compliance stood at 36%. This figure has risen each month until March 2019 where it has now reached 47%. There have been a number of reasons for not meeting the planned target, most significantly the number of agency staff working in clinical areas which has made carrying out workplace assessments with substantive staff more challenging than anticipated; a vacancy and long-term sickness within the team has also compounded the situation. The Moving and Handling Team are working closely with senior nurses and ward managers to ensure that access to workplace assessments for substantive staff is increased. The annual work plan for 2019/20 identifies the areas to be targeted to improve compliance to achieve the 85% compliance in both level 1 and level 2.

The Moving and Handling team will continue to provide updates to the HS&EP Sub-Committee and continue to implement and monitor the workplace assessment strategy.

Bed frame audit

A Health Board wide bed frame audit was completed in November 2018. The findings informed the replacement programme for existing bed frames and also identified a number of electrical safety issues with the existing bed frames. These electrical concerns were raised with the Estates Department and all known faults rectified. However this did identify the need for staff to

be vigilant and to report any damage seen. The audit findings were formally reported to the Sub-Committee in January 2019.

Improve process for bariatric patient admission and discharge
As described in the Annual Work plan, a Health Board wide bariatric service provision group was established in September 2018. The aim of this group is to decrease the risk of injury to staff providing care to bariatric patients. The group's remit also includes advising the Furniture and Equipment Group on the most appropriate furniture and equipment to purchase or hire for this specialist group of patients.

Prevention and Management of Violence and Aggression (PAMOVA)

Violence and Aggression Restrictive Physical Intervention (RPI) Training
The Sub-Committee acknowledged the need for a 'behaviours that challenge' training course to be delivered to clinical staff to improve their skills with regard to equipping them with the necessary skills to try and prevent violent an aggressive incidents.

Improvements in RPI Training for Portering staff have been undertaken and the Health & Safety and Emergency Planning Sub-Committee has monitored compliance with this area of work over the past 12 months.

The Annual Work Plan identified the need to undertake a scoping exercise to identify high-risk areas which has been completed. Meetings have taken place with senior staff within these areas. Content has been clarified as well as the aims and objectives of the managing behaviours that challenge course.

Approximately 500 staff have been identified as requiring training. The first courses have been arranged and the team are working closely with the ward managers to improve attendance. The PAMOVA team have also included support from Deprivation of Liberty staff and as a consequence of their work, the promotion of this new training model is being undertaken. The May 2019 course is now fully booked.

Occupational Health

Sharps Injury Audit
At the request of the Health and Safety & Emergency Planning Sub Committee and the Infection Prevention Sub Committee, sharps injuries sustained by staff members and reported to the Occupational Health Service have been reviewed.

The report obtained was based on the records from 1st July to 31st December 2018 of injuries reported to the service either by staff members or via other means such as Datix or Emergency Unit reports.

The total number of incidents, across the Health Board was eighty, with reports received from Primary Care as the Occupational Health Service provides services via a Service Level Agreement to general practitioners and dental services in the Hywel Dda University Hospital area.

Sharps or needle-stick incidents are one of the most common causes of injury to staff in healthcare and carry the potential of serious harm due to the risk of transmission of a blood borne infection.

The Sub-Committee has requested further collaborative work with other departments and users of sharps during 2019/20 in order to identify control measures that will improve this position.

Feedback from Groups
The salient and emergent themes from Groups during 2018/19 were as follows:

- **Fire Safety Group (FSG) Update** - the Sub-Committee was informed of the ongoing work by the Fire Safety Group (FSG) during 2018/19. The FSG covered a variety of issues and a range of positive evidence was presented by the work managed and controlled through the community and acute hospital sub-groups, such as:
    - Improved management mechanisms have now been embedded to monitor and address fire risk assessment actions via risk owners.
    - Improvements to Ward 10 fire escape at Withybush General Hospital (WGH).
    - Regular global communications on "Fire Safety within our Estate" campaign.
    - Establishment of Fire Safety Wardens across the Health Board.

- **Water Safety Group** – written update reports from the Water Safety Group highlighting key areas of work particularly in relation to the Health Board's compliance with legionella management were received during 2018/19. The Water Safety Group scrutinised and identified key risks which have been received by the Health & Safety and Emergency Planning Sub-Committee during 2018/19.The Water Safety Group now reports directly to the Infection Prevention Sub-Committee.

- **Medical Gases Group** – written update reports from the Medical Gases Group highlighting key areas of work that have been scrutinised and key risks that have been identified have been received by the Sub-Committee during 2018/19, including the following:
    - There have been a number of key actions that have either now been addressed or have firm committed arrangements set against them since the submission of the medical gas audits. These relate to improvements to medical gas infrastructure, staff training and appointments and the establishment of a Medical Gas Group.
    - The Facilities Directorate is fully aware that there are a small number of items currently outstanding that require addressing by the various operational teams, these relate to medium and low risk items. The Facilities Directorate has confirmed that these are being carefully planned and prioritised by risk by the compliance team and the operational site leads at the main acute hospital sites.

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were escalated to the Business Planning & Performance Assurance Committee:

1. **Cellular Pathology Laboratory - Environmental Conditions at GGH**
   Concerns with the lack of space and environmental conditions of the Cellular Pathology Laboratory at GGH.

   What is being done to address this?
   A discretionary capital bid has been formally submitted to the Capital Planning Group and is now with the Capital Planning Team who will identify this as a pre-commitment in the 2019/20 discretionary capital programme.

2. **Violent Patient Marker Process**

The risk of not providing staff with accurate/up to date information on patients who may pose a violence and aggression risk to staff has been identified as considerable.

There remains a risk of patient complaints if patient records continue to be marked with a violent and aggressive warning without any criteria or process being followed.

What is being done to address this?
A Violent Patient Marker Procedure has been written and is currently out for consultation. Approval is expected at the Health and Safety & Emergency Planning Sub-Committee in May 2019.

3. **Improved Training Strategy Required for Restrictive Physical Intervention (RPI) Training**
   The risk of injury to both staff and patients if staff are not adequately trained in recognised RPI techniques.

   What is being done to address this?
   The Prevention and Management of Violence and Aggression (PAMOVA) training team have started training clinical staff using the two day training course model.

4. **Lock Down Plans**
   The risk of not having adequate emergency lockdown procedures in place in the event of a serious incident taking place at any of the acute hospital sites.

   What is being done to address this?
   Lock Down Policy approved. The Health, Safety Team will work with Hospital Site Management and Facilities Team to develop bespoke hospital lock down plans to be completed by September 2019.

5. **Fire Safety Compliance**
   There is an ongoing risk of Fire Authority enforcement action being taken if fire risk assessment and training compliance is not adequate.

   What is being done to address this?
   With the additional resource to support the team further, improved training compliance will be achieved during 2019/20 as well as improved performance with the required fire risk assessments.

Matters Escalated to Business Planning & Performance Assurance Committee
During 2018/19, the following matters requiring Business Planning & Performance Assurance Committee level consideration or approval were raised:

- **Obligatory Response to Violence in Healthcare Agreement**
  The agreement was reported to BPPAC to inform the Committee of the new agreement between the four Police forces, Crown Prosecution Service and NHS Wales. Entitled 'The Obligatory Responses to Violence in Healthcare' was launched on 21 November 2018. The agreement has been signed by the Director General of Health & Social Services on behalf of NHS Wales as well as the four Chief Constables and Chief Prosecutor for the Crown Prosecution Service. The agreement sets out clear expectations on all NHS providers that they implement the principles set out within this multi-agency approach to responding to violence and aggression.

  The signed agreement aims to bring;

- Effective and efficient communication across partners, including the exchange of information at all levels.
- Clear understanding of the respective roles, responsibilities, processes and legal constraints.
- Clear statement on prosecution policy which will help NHS staff to understand the criminal justice system, and have confidence in it.

The revised Obligatory Responses to Violence in Healthcare sets out the responsibilities of the partners when dealing with violent or aggressive incidents relating to NHS staff.

- **Restraint Physical Intervention (RPI) training**
  Pursue the concept of training other professional groups of staff in RPI techniques. The Sub-Committee agreed that using restraint should not be limited to the porters' remit, but should fall within the care area concerned. BPPAC expected to see improvements in the way staff are trained in relation to equipping them with the appropriate skills to deal with behaviours that challenge.

- **Major Incident Plan**
  Updated Major Incident Plan submitted for consideration prior to gaining final Board ratification. This was endorsed by BPPAC.

Argymhelliad / Recommendation

To endorse the Health & Safety and Emergency Planning Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety 1.1 Health Promotion, Protection and Improvement 2.9 Medical Devices, Equipment and Diagnostic Systems
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Support people to live active, happy and healthy lives Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Health & Safety and Emergency Planning Sub-Committee meetings 2017/18
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad: Parties / Committees consulted prior to Business Planning and Performance Assurance Committee:	Health & Safety and Emergency Planning Sub-Committee Chair/Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Health & Safety and Emergency Planning Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	Delivery of a robust and effective Health, Safety and Emergency Planning provision for the HDUHB has a direct impact on the quality of services provided by the UHB.
Gweithlu: Workforce:	Delivery of a robust and effective Health, Safety and Emergency Planning provision for the HDUHB has a direct impact on the welfare and safety of its staff.
Risg: Risk:	Wherever possible mitigation plans are developed to minimise risk. Failure to manage these challenges effectively will impact on staff and patient safety and possibly lead to enforcement action.
Cyfreithiol: Legal:	The UHB has a responsibility to comply with the Health and Safety at Work Act, Fire Regulatory Reform Order.

Enw Da: **Reputational:**	The outcome of the above has a direct bearing on the reputational status of the HDUHB.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	At this stage no formal EqIA has been undertaken

PWYLLGOR CYNLLUNIO BUSNES A SICRHAU PERFFORMIAD
BUSINESS PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Information Governance Sub-Committee (IGSC) Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Karen Miles, Director of Planning, Performance, Informatics and Commissioning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Anthony Tracey, Assistant Director of Informatics

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Information Governance Sub-Committee (IGSC) Annual Report 2018/19 to the Business Planning & Performance Assurance Committee. The Information Governance Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated information governance across the University UHB (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Information Governance Sub-Committee require the submission of an Annual Report to the Business Planning & Performance Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance to the Business Planning & Performance Assurance Committee on the Health Board's information governance assurance frameworks, including risk assurance, and compliance with information governance legislation, guidance and best practice.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of the information governance and security framework, statutory compliance, and the adequacy of the policies, procedures and action plans in place.

Asesiad / Assessment

The Information Governance Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Business Planning & Performance Assurance Committee at its Board meeting on 26th January 2010. The terms of reference of the Information Governance Sub-Committee were subsequently approved at its meeting on 27th November 2010.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Business Planning & Performance Assurance Committee around the organisation's information governance framework, ensuring that there is an accurate reflection of Sub-Committee activity, work programmes, action plans, and policies and procedures to deliver against gaps in assurance.

The Information Governance Sub Committee (IGSC) terms of reference have been reviewed and updated at its meeting on 30th July 2019 to reflect the changes to the membership, the outcome of a review of the function of the IGSC, a change to the reporting groups in order to align with the updated information governance work plan and to include more specific detail on Cyber Security.

In discharging this role, the Sub-Committee is required to oversee and monitor the information governance agenda for the Business Planning & Performance Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the information governance agenda against the following areas of responsibility:

Governance

- Promote and develop a robust information governance and security framework within the Health Board;
- Encourage a culture of information governance and information security across the Health Board.
- In conjunction with key Committees/sub-committees/groups develop appropriate systems, policies, procedures, work plans and action plans including (but not restricted to) the following areas:
    - Information and Cyber Security (including SIRO related issues)
    - Information Sharing Protocols
    - Contracts, partnership and third party and supplier agreements
    - Confidentiality and Data Protection
    - Freedom of Information
    - Subject Access Requests
    - Records Management
    - Information Quality Assurance
    - Risk Management and Incident Management
    - Data Protection Impact Assessments
    - Patient records

Assurance

- Ensure the Health Board is compliant with the new Data Protection Legislation (the Data Protection Act 2018 and Regulation (EU) 2016/679 (General Data Protection Regulation) - together referred to as the Data Protection Legislation).
- Ensure quality and statutory compliance in relation to all information processed by the Health Board;
- Ensure that new projects, processes and the development of systems are compliant with statutory requirements in relation to information governance;
- Ensure that there is a process of Privacy Impact Assessment in accordance with Information Commissioner's guidance.
- Ensure that information sharing and transfer with third party organisations are compliant with statutory requirements in relation to information governance;
- Ensure that the Health Board is following the Caldicott Principles when processing patient information;
- Caldicott Principles into Practice (C-PIP);
- Information Governance (IG) toolkit;
- Internal and External Audit reviews;
- Information Commissioners Officer (ICO) standards;
- Any other relevant National or Welsh requirements/assessments.

Policies and Procedures

- Recommending policies and procedures to the Business Planning & Performance Assurance Committee for approval that link with or assist in delivering the information governance agenda.

Training and Awareness Development

- Ensure that employees across the Health Board are given the information and training required to ensure good information governance principles are followed by all staff.
- Developing a programme of information governance training that meets the needs of different staff members wherever possible.

Information Governance Sub-Committee Groups

The Groups reporting to the Information Governance Sub-Committee during 2018/19 were as follows:

- **General Data Protection Regulations (GDPR) /Information Asset Owners (IAO) Group** – established to:
    - Agree and oversee the GDPR compliance project work plan.
    - Develop and oversee a programme of information asset audits and asset mapping.
    - Ensure that Information Asset Owners are in place across the organisation and are fully briefed in relation to their role.
    - Agree a process for identifying, recording and mitigating any information risk identified through the information asset audit programme.
    - Develop and agree a communication and engagement programme for staff around the GDPR and information governance, including information security.

- Progress the implementation of Data Protection Impact Assessments (DPIAs) across the Health Board.

- **Information Governance Incident Group** – established to:
  - Receive updates on new Information Security Incidents reported including the presentation of any Information Security Incident Investigation Reports.
  - Agree recommendations and actions in relation to any new Information Security Incidents reported.
  - Receive updates on the Information Security Incident Action Plan.
  - Reach agreement to close any completed Information Security Incidents.
  - Agree any further recommendations/work required around managing Information Security Incidents within the Health Board.
  - Develop and Information Security Incident reporting procedure.

- **The Health Records Group**
  A Health Records Group has been established and reported to the IGSC as a Sub-Committee from April 2018. Terms of reference and key activities for the group have been approved by the IGSC. There have been some challenges in designating a Chair for the group.

  The principal duties of the Health Records Group are to undertake the following:
  - To operate as a task & finish group resolving risks and issues affecting the health record and its users
  - To provide a multidisciplinary forum for the discussion of issues relating to and affecting the health record and its users.
  - To provide clear leadership in the promotion of effective health records management.
  - To be responsible for assuring that health records arrangements within the Health Board provide the patient and service users with effective treatment and care that is compliant with best practice.
  - To support the development of a Health Board wide integrated records management system, including storage, security arrangements and the move towards an electronic patient record (EPR), providing expert advice and guidance.

The Information Governance Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Business Planning & Performance Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution
From the updated terms of reference approved in July 2018, the membership of the Sub-Committee was agreed as the following:

- Director of Planning, Performance, Informatics and Commissioning (SIRO) (Chair)

- Assistant Director of Informatics (Deputy SIRO) (Vice Chair)
- Independent Member
- Medical Director/Director of Clinical Strategy (Caldicott Guardian)
- Associate Medical Director for Information and Research/Deputy Caldicott Guardian
- Information Asset Owners delegate from each service area or appropriate delegate
- Head of Information Governance
- Head of Information Services
- Head of Health Records
- Information Governance Managers
- Assistant Director of Workforce and OD
- ICT Security Manager
- Mental Health Representative
- Nursing Representative
- Therapies & Health Sciences Representative
- County/Community Representative
- Primary Care Representative
- Head of ICT
- Head of Systems and Informatics Projects

Meetings
Since 1st April 2018, Information Governance Sub-Committee meetings have been held on a quarterly basis as follows:

- 25th May 2018
- 7th July 2018
- 24th September 2018
- 26th November 2018
- 6th February 2019

During 2018/19, the Sub-Committee met on five occasions and was quorate at all of those meetings. The review of the meeting attendance has been presented to IGSC on 15 February 2019, where low attendance was discussed as an issue.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Information Governance Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

Governance
Reporting Groups Update:

- **GDPR/IAO Group** - established to implement the General Data Protection Regulation 2016 and the Data Protection Act 2018 meets regularly and provides updates to IGSC meetings on a regular basis.

- **Information Governance Incident Group** – this only met once in 2018-19, on 5th April 2018, due to the IG team not being complete. The group will restart during 2019 – 20, with the next meeting arranged for 15th May 2019.

- **The Health Records Group** - only met once during 2018-19. Unfortunately setting up meetings proves to be challenging due to availability of the Clinical lead.

The IGSC work plan for 2019/2020 will be presented to the sub-committee for approval at its meeting on 17th May 2019. The main emphasis for the workplan will be:

- Complete the Information Governance (IG) toolkit, and implementation of any associated recommendations.
- Continue the development of the Information Asset Owners Group and Information Asset register
- Continue the improvements in Cyber Security, and implementation of the Stratia Report.
- Work with the ICT Team to remove the need for fax machines within the Health Board.

Cyber Security - NHS Wales External Security Assessment

A security assessment has been carried out on behalf of NHS Wales by Stratia Consulting, and provides a proposed work plan to address the recommendations highlighted during the assessment. In 2017, NHS Wales Informatics Service (NWIS) outlined their Welsh Cyber Assurance Process (WCAP). The intended outcome of this All Wales funded initiative is to provide assurance to the Welsh Government, Wales Audit Office, and to external suppliers, that connection to the NHS Wales network and the services it provides is secure, and also to enable the creation of locally focussed action plans to improve security.

The first stage of WCAP was the completion of a self-assessment questionnaire, by all NHS Wales health boards. Information requested included :

- Security Policies
- Physical Environments
- Access Controls
- Logging and Monitoring
- Network Controls
- Incident Response
- User Education
- Mobile / Home Working
- Business Continuity

The next stage was to hold an independent assessment to provide consistency checking across all health boards, and guidance on any potential national solutions. An external company (Stratia Consulting) were invited to spend time at each Health Board in Wales to independently assess current process and procedure. Stratia conducted their investigation around 5 areas :

- a Cyber Essentials Plus standards assessment
- a gap analysis against ISO 27001
- a General Data Protection Regulation (GDPR) readiness assessment
- a National Cyber Security Centre internet vulnerability check
- a Networks and Information Systems (NIS) readiness assessment

The assessment for Hywel Dda took place during 4 days in January 2018. The outcome of this assessment was the publication of a local Hywel Dda summary report (NHS Wales External Security Assessment - Hywel Dda UHB Report and Improvement Plan).

The report detailed the findings of the Stratia consultant, highlighting where the Health Board is compliant, and where shortfalls exist, and included a 'Security Improvement Plan' giving recommendations to address any issues. Feedback from Stratia was on the whole positive. The report showed that as a Health Board, there were improvements which could be implemented, but in the majority of cases the Health Board had passed their assessments:

- E-mail system passed the security tests
- Desktop pc's had very good protection status and all tests were passed
- Internet link and MobileIron passed all the security tests

Concerns were raised around :-

- a lack of vulnerability scanning tools
- a lack of resources from a software and staffing perspective to undertake patching
- the existence of legacy software which no longer receive security patches or software updates

Stratia presented their National report giving an overall view and recommendations at an All Wales level.

- The national Infrastructure Management Board has created a 'Task and Finish' group to review the recommendations of the National report and address any shortfalls identified.
- Hywel Dda ICT have produced a work plan to address the shortfalls identified in the local 'Hywel Dda UHB Report and Improvement Plan'.

To deal with the current Health Board environment, NHS Digital and the National Cyber Security Centre are promoting a more proactive and adaptive approach to cyber security. In order for the Health Board to be more proactive in its approach to cyber security, the Health Board should look to invest in the required resources. In addition, the NHS Wales Infrastructure Management Board under the direction of the National Service Management Board (attended by the Health Board's Assistant Directors of Informatics and NWIS Directors) is coordinating a national set of activities in the spirit of "Once for Wales".

The Information Governance Sub-Committee (IGSC) has recognised the requirements to strengthen the organisation's approach to ICT and Cyber Security following the recent cyber-attack, and as such significant risks on the organisation's risk register have been logged. The recent cyber security attacks that have taken place within the NHS have been assessed and heightened the risk associated with these threats.

IGSC wishes to undertake a review of its Information Security Management System (ISMS) to ensure that it is robust, fit for purposes and provides a framework to mitigate risk and to ensure information is protected to the highest standards possible. This work will include a review of where the organisation currently stands in relation to the ISO27001 and Cyber Essentials standards and recommendations for improvement where gaps in practice are identified.

The action plan is being reviewed and a detailed update will be presented to IGSC on 17th May 2019, and is a standard agenda item for the Sub-Committee.

Assurance:

The IG Activity Report is presented at every IGSC meeting:

- Update on Enquiries received by IG Team :

Mar - Apr 2018	May - Jun 2018	Jul - Aug 2018	Sep - Oct 2018	Nov - Dec 2018	Jan - March 2019	TOTAL
19	25	42	96	81	96	359

- Update on Health Subject Access Requests received by the Medical Records Team

Applicable Target / Data Requirement	**Target**	**Apr-2018**	**May-2018**	**Jun-2018**	**Jul-2018**	**Aug-2018**	**Sep-2018**	**Oct-2018**	**Nov-2018**	**Dec-2018**	**Jan-2019**	**Feb-2019**
Subject Access Requests												
Number of requests received		165	159	193	233	249	234	307	234	157	252	243
Number of requests completed within agreed timescale		164	157	162	191	223	209	269	206	128	220	190
40/28 Day Compliance	**100%**	**99.4 %**	**98.7 %**	**83.9 %**	**82.0 %**	**89.6 %**	**89.3 %**	**87.6 %**	**88.0%**	**81.5 %**	**87.3 %**	**78.2 %**

- Update on corporate Subject Access Requests received by the Information Governance Team in 2018/19.

Date 2018/19	**Total number received**	**Compliance rate (% of requests responded to within agreed time-scale).**
Q1 (April – June)	1	100%
Q2 (July – Sep)	4	25%
Q3 (Oct – Dec)	8	63% - new SAR procedure implemented in this quarter
Q4 (Jan – March)	10	100%

*One Internal SAR Review was requested and completed with no further contact has been made by the applicant since.

**One complaint was made to the Information Commissioner around the handling of a corporate Subject Access Request during 2018/19 – a new *SAR procedure was implemented to improve the process, which was accepted by the ICO.*

- Update on Freedom of Information Requests received by the Corporate Office.

	Qtr1 Activity 01/04/18 to 30/06/18	Qtr2 Activity 01/07/18 to 30/09/18	Qtr3 Activity 01/10/18 to 31/12/18	Qtr4 Activity 01/01/19 to 31/03/19
Total number of FOI requests	167	144	116	104
Total number of responses issued outside the 20 working day period	14	7	4	9
Total number of review requests	0	2	2	0
Total number of exemptions applied	51	43	36	16
% Increase/decrease of number of requests received from previous quarter	41.5% increase	23% increase	5% decrease	21% decrease

General Data Protection Regulation Update

The General Data Protection Regulations (GDPR) came into force on 25th May 2018. The GDPR both update and strengthen current data protection legislation with more emphasis on accountability and the individual's information rights.

In addition to the risk to the organisation of increased fines for non-compliance, because of the highly sensitive nature of the information we hold about individuals, the organisation has an ethical and moral duty to protect the information it is responsible for. An invasion of a person's privacy whether by an accidental loss of their data, a security attack on our systems or by the dishonest actions of a staff member will all have a major impact upon our patients and the trust they put in the organisation to deliver safe and effective care.

The report is being submitted to every IGSC meeting on the progress to date in meeting key areas of the GDPR requirements to improve systems and processes to better safeguard personal data.

The Information Governance Team has made significant progress in moving the organisation towards GDPR compliance against an agreed work plan. A recent Internal Audit Report sought to provide assurance to the Health Board that arrangements are in place and managed appropriately within its directorates to ensure compliance with the requirements of the GDPR.

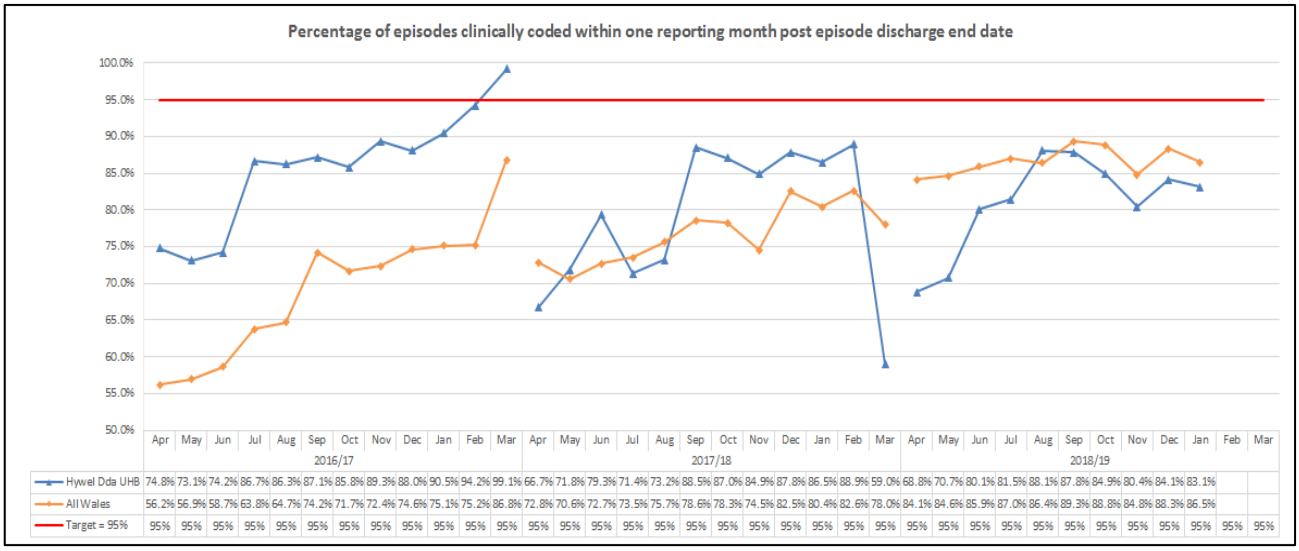
The report commented that there has been a great deal of work carried out at a senior level within the organisation to prepare for the regulation. This review sought to establish how these arrangements have been embedded within the organisation and to provide assurance that the arrangements at the operational level are extant and thus that the organisation is compliant or on a path to achieve compliance with GDPR.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with GDPR compliance is 'Substantial assurance'.

Data Quality / Clinical Coding Update

Data quality and clinical coding continues to be a standing item for the Sub-Committee. The purpose of the summaries is to provide an update on the Data Quality work within the Health Board. The quality of data collected and recorded is an important factor in ensuring the care offered to patients is of the highest standard possible. There will be a separate report to the Business Planning and Performance Assurance Committee on Data Quality in June 2019.

In summary, Hywel Dda University Health Board's (HDdUHB's) performance declined by 1% in January 2019 with 83.1% of episodes coded within one month, compared to 84.1% in December 2018. The Health Board is below the All Wales average of 86.5% for January 2019.



Please note that the figures above for March 2018 are the 'submitted' figures to NWIS but there was an oversight in not submitting the correct information on the 17th May by the Data Standards Team. April 17 activity only was submitted, therefore this did not take into account the huge amount of work put in by the Clinical Coding Team to achieve 87.2% for March activity (not 59.0%)

The 2018/19 NWIS audit showed that that the clinical coding staff at Hywel Dda UHB exceeded the recommended accuracy rate in 3 of the 4 areas of assigned codes: secondary diagnosis (≥80%), primary procedure (≥90%) and secondary procedure (≥80%), whilst narrowly missing the primary diagnosis (≥90%). The Health Board has again achieved the WG target, in the 18/19 audit, to show improvement with 89.72% compared to 89.55% the previous year.

A breakdown of the error rates is provided below:

Code type	Total number of codes reviewed	Total number of correct codes	Percentage correct	Target
Primary Diagnosis	420	370	88.10%	90%
Secondary Diagnosis	1,578	1,397	88.53%	80%

Primary Procedure	309	292	94.50%	90%
Secondary Procedure	747	681	91.16%	80%

The Welsh Government Clinical Coding Accuracy Measure score has been produced from the figures above as follows:

	Total number of codes reviewed	Total number of correct codes	Percentage correct
2018/19 Audit	3,054	2,740	89.72%
2017/18 Audit	2,640	2,364	89.55%

The target is to show an improvement from the previous audit and the Health Board has seen an improvement of 0.17% compared to the previous audit, thus achieving the Welsh Government target.

The Sub-Committee, have been made aware of the implications of having a large number of uncoded episodes and the impact upon a number of performance measures such as:

- The rate of emergency hospital admissions for basket of 8 chronic conditions per 100,000 of the health board population
- The rate of emergency hospital multiple re-admissions (within a year) for basket of 8 chronic conditions per 100,000 of the health board population
- Rate of hospital admissions with any mention of intentional self-harm for children and young people (age 10-24 years), rate per 100,000 population
- Number of procedures that do not comply with selected NICE 'Do Not Do' guidance for procedure of limited effectiveness (selected from a list agreed by the Planned Care Board)
- RAMI and all other CHKS benchmarking measures
- National Joint Registry Hips and Knees Extract
- Public Health Wales Hips and Knees Extract

As well as the above performance measures clinically coded data is used for a variety of other uses and it impacts on a number of areas including, but not exhaustive:

- Healthcare planning (including service reconfiguration);
- Clinical coding data is central to a range of national information initiatives, such as the annual financial costing process and patient-level costing
- Consultant information which promotes further engagement/discussion
- Health needs assessment
- National and local clinical audits
- Evaluation of treatment and outcome analysis
- Benchmarking
- Chronic disease management (and the linkage of datasets)
- Provision of information for research
- The production of official statistics and ad-hoc requests
- Ad hoc requests (be they Ministerial, FOI's, media/public and so on)

The Sub-Committee, request that updates are supplied at every meeting to ensure that the importance of clinically coded data is accurate, consistent, complete and coded in a timely fashion. Clinical data must be accurately and consistently recorded to well defined national standards to enable it to be used for statistical analysis. Information drawn from accurate clinical coding better reflects the pattern of practice of clinicians and provides a sound basis for the decision making process. The use of tools such as Clinical Indictors pushes forward the need for accurately and consistently recorded clinical information. Steps to ensure that this is the case should include audit of clinical coded data and the comprehensive training of those responsible for the classification of such information. Healthcare information at local and national level is crucial to support management, planning and monitoring of health services.

The aforementioned codes are used to support many functions within the Health Board, both clinically and statistically. These functions include:

- Clinically – Clinical Governance, Clinical Audit, and Outcome and Effectiveness of Patient's Care and Treatment.
- Statistically – Value Based Healthcare, Cost Analysis, Commissioning, Aetiology Studies, Health Trends, Epidemiology Studies, Clinical Indicators and Casemix Planning.

Much can be done to help clinical coders achieve accurate coding. The involvement of physicians in the coding process may result in better understanding of medical terminology and surgical procedures by coding staff. Clinicians have a responsibility to ensure that the information recorded in medical notes is clear and complete. An increased awareness of the role of clinical coders can only help facilitate their work. The Wales Audit Office has recommended regular clinical coding audit. As part of this process coders and clinicians should collaborate to identify ways in which coding can be improved.

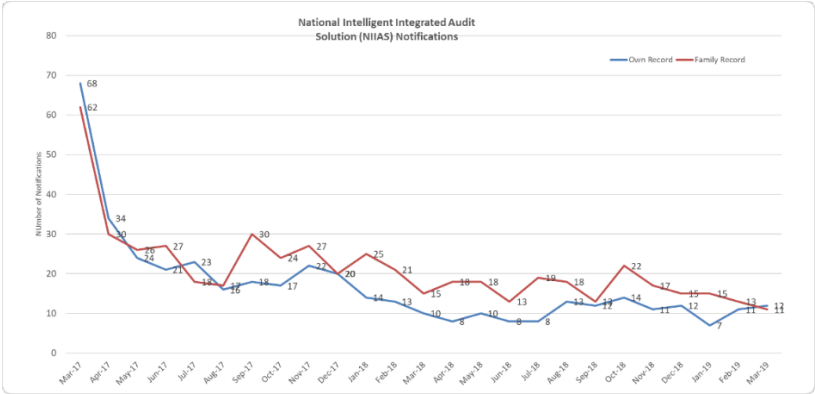
Due to the requirement to achieve 98% of episodes clinical coding by June 2019 and the importance of clinical coded activity, the Health Board agreed to tender for contract clinical coders to reduce the backlog. GSA Techsource were successful in the bidding process to address the estimated 20,000 finished consultant episode (FCE) in time for the final finance costing return due in early June 2019. GSA Techsource are looking to provide 20 weekend shifts (10 Saturday and 10 Sunday) and approximately the same amount as week day coders (4-5 shifts per week day). A maximum space for 10 coders per day was requested for the full 7 days. This would amass to 400 shifts by 9th June 209, with a total of 50 FCEs per coder per day totalling the 20,000 FCE backlog. This would in turn allow our established coding resource to continue on the in-month work, putting the Health Board in a better position to start the next financial year.

National Intelligent Integrated Audit Solution (NIIAS) Update

The NIIAS reporting tool has been active across the Health Board since January 2016 and monitoring of staff access to systems has taken place since this date. The Information Governance (IG) Team are now actively enforcing access to "Own Record" since March 1st 2017 and have been actively enforcing access to "Family Record".

The procedure developed between the former Head of IG and the Assistant Director of Workforce and agreed by the Executive Team takes a risk based approach to managing the backlog of staff identified by NIIAS and any new accesses. The table and graph below provide a rolling analysis of breaches within the Health Board;

Month	Own Record	Family Record
Mar-18	10	15
Apr-18	8	18
May-18	10	18
Jun-18	8	13
Jul-18	8	19
Aug-18	13	18
Sep-18	12	13
Oct-18	14	22
Nov-18	11	17
Dec-18	12	15
Jan-19	7	15
Feb-19	11	13
Mar-19	12	11



In summary;

- **Own Record** - Inappropriate access to own records has shown an overall increase of 17% over the rolling 12 months, however the average number of data breaches has risen since the last reporting period to 12 breaches within the month, and is below the agreed target of 8 per month.

- **Family Record** - The number of inappropriate accesses by staff to family records has shown a 36% reduction over a rolling 12 month period. Notwithstanding this reduction, the Health Board is still seeing an average of 16 breaches over the reporting period

During 2018/19, 83 NIIAS training awareness sessions have been held across Health Board sites and key messages re-iterated to staff, including the escalation process if any further breaches are reported against a staff member.

Annual Review of Information Governance related written control documentation

The IGSC is the 'owning' Sub-Committee identified for 27 approved corporate written control documents The overview below provides an outline of the current status of the relevant written control documentation including review dates and details of those control documents approved during 2018/19 in line with the UHB's 190 - Written Control Document Policy, as well as highlighting where relevant written control documents are out of date or due for review

During 2018/19 the following information governance documents were reviewed and approved. The table below provides the assurance of the documents approved:

Policy Ref	Policy Title	Approval / Revision Date
320	Acceptable Use of IT Policy	25 May 2018
318	Screensaver Policy (no longer required incorporated into other policies)	-
319	Disposal of Information/IT Assets Policy	25 May 2018
250	Information Quality Assurance Within Hywel Dda Local UHB Strategy	30 July 2018
238	Information Governance Framework	30 July 2018
279	Third Party Information Assurance Policy	25 May 2018
174	Reuse Of Public Sector Information Procedure	31 March 2018
347	Corporate Records Management Policy	30 June 2018
346	Corporate Records Management Strategy	30 June 2018
172	Confidentiality Policy	25 May 2018
422	Consumer Device Policy (Smartphones/Tablets)	30 July 2018
225	Data Protection Policy	To be discussed at the next IGSC on 26 April 2019
173	Freedom Of Information Policy	25 May 2018
183	Information Security Policy	30 July 2018
192	Health Records Management Policy	25 May 2018
191	Health Records Management Strategy	25 May 2018
193	Retention and Destruction of Records Policy (including Health Records)	25 May 2018
249	Access To Health Records Policy	To be discussed at the next IGSC on 26 April 2019
301	User Account Management Policy	25 May 2018
495	All Wales Internet Usage Policy	30 July 2018
494	All Wales Email Use Policy	30 July 2018
281	Mobile Working Policy	29 March 2019
282	Network Security Policy	29 March 2019
190	Written Control Document Policy	24 May 2019
240	Informatics Procurement & Requests Procedure	26 Feb 2020
275	Secure Transfer Of Personal Information Policy	22 Aug 2020
224	Information Classification Policy	24 Aug 2020

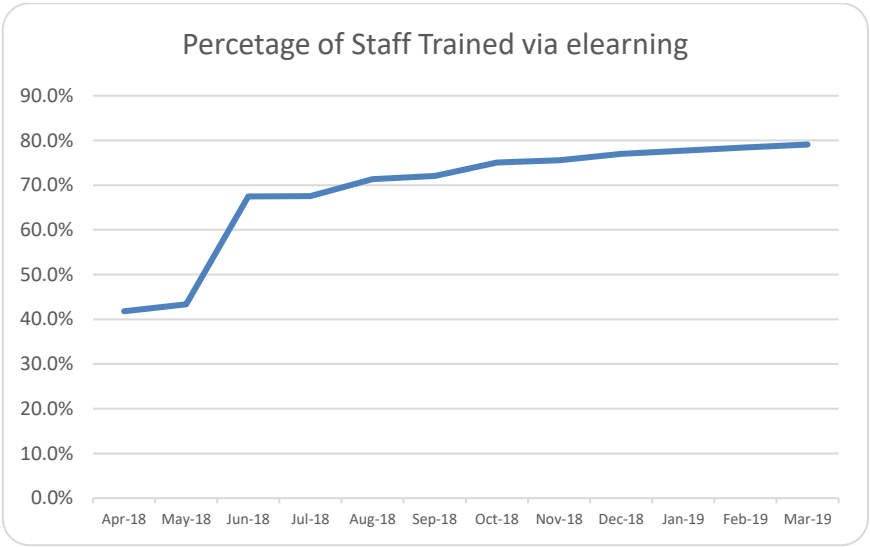
Training and Awareness Development

Staff training around Information Governance is vital to ensure that all staff are aware of and are applying the principles of good information governance and confidentiality to their every-day working practice and the Health Board is meeting its requirements under the General Data Protection Regulations 2016, the Common Law Duty of Confidentiality and the Caldicott principles:

- GDPR training undertaken for the Information Asset Owners Group, Primary Care, Operations Group, Information Asset Owners and other key service areas.
- A significant amount of work has been undertaken by IG and Workforce to improve the mandatory Information Governance training compliance rate as the Health Board had been one of the worst performing organisations in Wales. Ensuring staff have undertaken this training is also a key mitigating factor considered by the Information Commissioner's Office (ICO) in the event of a data breach of security incident.
- IG Code (proposed graphic) has been developed across all Health Board
- Information Governance visibility has been improved at corporate induction and general awareness with staff has been improved.
- All Wales e-learning Cyber Security module is currently available to employees, however due to licences limitation it cannot be made mandatory.
- Information Governance Training Strategy.
  The Caldicott standards on IG Training and Awareness were assessed as being of 'amber status' (*further work is required to fully meet the standards*) by the Health Board in August 2017. Work has been carried out in the past 12 months to move these actions forward, however, this work does not ensure full compliance for the Health Board and there are areas of work that require further development.
- Improvement rates for Information Governance mandatory e-learning module are as follows (medical and dental staff groups will need to be addressed to raise the percentage):

The table and graph below illustrate the progress throughout 2018/19;

Month	% Trained
Apr-18	*41.8%*
May-18	*43.4%*
Jun-18	*67.4%*
Jul-18	*67.6%*
Aug-18	*71.3%*
Sep-18	*72.0%*
Oct-18	*75.0%*
Nov-18	*75.6%*
Dec-18	*77.0%*
Jan-19	*77.7%*
Feb-19	*78.4%*
Mar-19	*79.1%*



IG Risk Register

The Information Governance Sub-Committee Terms of Reference state that it will:

- Provide assurance that risks relating to information governance are being effectively managed across the whole of the UHB's activities (including for hosted and contracted services, through shared services, partnerships, independent contractors and Joint Committees as appropriate).

There 4 risks contained in the Information Governance Sub Committee Risk Register have been extracted from Datix Risk Module on 11th March 2019 based on the following criteria :

- The Information Governance Sub Committee has been selected by the risk lead as the 'Assuring Committee' on Datix Risk Module
- Risks are above the proposed tolerance level that were discussed and agreed by the Board on 27th September 2018
- Risks that have been approved at Directorate level on Datix
- Risks have not been escalated to the Corporate Risk Register.

The risks have scored against the following 'impact' domains':

- Statutory duty/inspections (2 risk)
- Service/Business interruption/disruption (2 risks)

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Rationale for the current risk score	Target Risk Score
356	11/01/17	Cyber Security measures	Planning, Performance & Commissioning (PP&C)	20 ⇔	Currently under national review and awaiting outcome	10
371	01/03/17	Clinical Coding Resource (Staff Numbers)	Planning, Performance & Commissioning (PP&C)	16 ⇔	Overtime is being implemented to address some of the short fall in the completeness factor.	12
343	05/12/16	Meeting the requirements of the General Data Protection Regulations (GDPR)	Planning, Performance & Commissioning (PP&C)	16 ⇔	Changeover of staff within the IG team Project plan in place and monitored by IGSC	8
234	01/11/11	Data protection breach in Health Records due to staff non-compliance with IG training affects whole Health Board.	Central Operations Health Records	9 ⇔	There have been very few breaches of patient confidentiality and staff are very aware of their roles and responsibilities working in conjunction with the GDPR and Data Protection Act. The risk has increased due to the implementation of the GDPR in 2018 and with a	3

					reduction in the legal timescales for providing information it certainly increases the possibility of inappropriately releasing information or releasing information that could cause harm to a 3rd party.	

The Sub-Committee continues to monitor not only the risks outlined above, but also the wider themed Risk Register. The monitoring of the Risk Register is a standing agenda item for consideration by the Sub-Committee.

Data Protection Impact Assessments (DPIA)

IGSC has approved the following Data Protection Privacy Impact Assessments which have been developed or consulted upon by the Information Governance Team. The following DPIA were presented to IGSC:

- **Text reminder service utilising Healthcare Communications** [APPROVED] (The key objective of the text reminder service is to improve DNA rates of the Health Board and to improve how HDdUHB communicates with patients as well as bringing efficiencies to the central contact centre located at Prince Philip Hospital. A reduction in the DNA rate can improve capacity management of OPD clinics.
- **Patient Knows Best** [APPROVED] (A citizen centred portal to allow patients control / access to their information to be better informed and assist in their healthcare delivery)
- **Standard Operating Procedure for putting an Alert Risk of Child Sexual Exploitation (CSE) on Children's Medical Electronic Records** (The initiative has been presented to IGSC and a Privacy Impact Assessment will be required, before final sign-off)
  The Procedure for putting an Alert of Risk of Child Sexual Exploitation (CSE) on Children's Medical Electronic Records will be further discussed with IGSC.

Welsh Health Circulars

Since their reintroduction in October 2014, compliance with Welsh Health Circulars (WHCs) has been regularly reported to the Board via the Chief Executive's Report. At its meeting on 27th July 2017, the Board requested that WHCs which have not been implemented by the stated timescales should be closely monitored by its sub-committee structure, in order that assurance could be gained on the compliance and delivery of the outstanding WHC, as well as an understanding of the impacts resulting from late/non-delivery.

This summary includes progress reports on WHCs which come under the remit of the Committee and its sub-structure. The Committee is asked to gain assurance from the lead Executives/Directors or Supporting Officer on the management of WHCs within their area or

responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

WHCs which have not been implemented within stated timescales (Red RAG status).

WHC Ref	Name of WHC	Date Issued	Update Overview
053_15	Introduction of SNOMED CT as an Information Standard in NHS Wales	12/12/2015	The National SNOMED Team have met the UHB to provide an initial early awareness session to key informatics teams including the Chief Clinical Informatics Officer. The SNOMED team have visited almost all Health Boards as part of the initial awareness plan; there will be further sessions for wider audiences when further work has been developed. The responsibility for the introduction of SNOMED CT into all Welsh National Products is the responsibility of the NHS Wales Informatics Service (NWIS) and the UHB are still awaiting a confirm action plan for implementation into national systems. The SNOMED service have been requested by Work stream 3 to set up a new SNOMED reference group where progress to date can be shared and for reviewing documentation, principles and guidelines. The group are currently waiting for the Welsh Technical Standards Board (WTSB) to be fully established before they submit the SNOMED CT Data Entry and Storage guidelines for approval. These guidelines and the approvals process are still being developed.

WHCs which have not been implemented but are on schedule (Amber RAG status).

WHC Ref	Name of WHC	Date Issued	Update Overview
007_15	Update on the All Wales position of the EDCIMS (Emergency Department Clinical Information	30/03/2015	There has been a delay in the implementation of the Welsh Emergency Departments System (WEDS) nationally. Following legal consultation, NWIS on behalf of NHS Wales, issued EMIS Health Two Non-Conformance Reports, against the Master Service Agreements for WEDS.

	Management System)		There is significant risk that EMIS Health will not be able to deliver a robust solution in line with contractual specifications. All relevant parties expecting to implement the solution (NWIS along with ABMU, Aneurin Bevan and BCU Health Boards) have formally requested assurance from EMIS Health on resolution of outstanding issues preventing User Acceptance Testing sign off. No timelines have been provided and so confidence is low with regards the delivery of the product. EMIS, have supplied a test version of WEDS for implementation in Aneurin Bevan, with a proposed implementation date of August 2019. Following this implementation a national roll-out plan will be discussed and agreed.
049_15	Operational Standards for Use of the NHS Number	06/11/2015	NHS number compliance is being monitored on all the identified systems and reported regularly to IGSC. The 6 major NHS systems referenced in the DSCN now comply with the DSCN specification around uses and availability of the NHS number. Some gaps do exist as part of the system functionality, these are being addressed through the national development programmes for each of the systems where appropriate. Local work has begun to address the other systems (not specifically referenced in the DSCN) as part of the Phase 3 work to ensure those systems also use the NHS number in all ways laid out by the DSCN

C-PIP (Caldicott Out-turn Report)

The Foundation Manual for Caldicott Guardians, Caldicott Leads and Information Governance Leads sets the requirements that organisations should endeavour to achieve. This manual provides all involved with protecting and using patient identifiable information with a knowledge framework containing what they need to know, why they need to do it and how to do it. It also includes an online Self-Assessment tool the C-PIP Assessment which enables organisations to evaluate where they are with compliance and plan appropriate improvements.

The out-turn report provides a summary of the completed assessment and the improvement plan for 2019/20. While staff shortages have had an impact on the number of achieved

improvements, a significant number of the outstanding issues from the previous Caldicott Improvement Plans have needed to be transferred into 2019/20's plan. In spite of this, the assessment shows an improvement on the previous year's assessment with:

- 28 standards being fully compliant,
- 9 being partially compliant, and
- 4 being non-compliant.

The previous report had 25 areas of full compliance, 9 areas of partial compliance and 7 areas of non-compliance.

However 4 areas remain intransigent due in part to the assessment tools inflexibility, where partial compliance scores zero. Systems and processes cannot record these requirements therefore these elements have been put on hold due to staff shortages.
They are:

- G6. *Do mechanisms and guidelines exist to ensure that any decision taken by a patient or service user to restrict the disclosure of their personal information are appropriately respected*? (currently some systems do not have the ability to record this information)
- M7. *Does the organisation have an up to date Business Continuity and Disaster Recovery Plan*? (not for all areas)
- CA4. *What controls are in place to restrict staff access to patient/service user identifiable information*? (the Health Board's current practice, staff vigilance and an honour system, is not considered adequate)
- CA5. *Are there physical access controls in place for relevant buildings?* (physical controls are not in place for all relevant buildings)

Hywel Dda University Health Board's current score is 76-90% 'Your responses to the assessment demonstrate a good level of assurance of information governance risks; but there is still work to be done.'

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to the Business Planning & Performance Assurance Committee:

- Thirteen areas of the Caldicott Principles into Practice framework have failed to reach an adequate score and therefore require significant resources for future improvement. An action plan will be presented to the May 2019 IGSC meeting outlining how these areas can be improved.
- An appropriate Chair requires identifying for the Health Records Group as the current Chair will have to step down due to other work commitments
- Longer timescales will be needed to undertake all actions required to ensure the Health Board is compliant with the GDPR. Completing the Information Asset Register will require more time than anticipated. There are still areas that have not responded to emails in regard to identifying the initial workload.

Information Governance Sub-Committee Developments for 2019/20
The following developments are planned for the Information Governance Sub-Committee during 2019/20:

- Continue with GDPR compliance work and associated work plan.
- Complete asset mapping process for the organisation.
- Approve and monitor action plan for moving towards ISO 27001 and Cyber Essentials compliance. Continue to review IT security progress.
- Reintroduce Health Records Group and review progress in addressing key issues relating to the paper record.
- Reintroduce Information Governance Incident Group and review progress in addressing key issues when investigating security breaches.
- Monitor IG risks and mitigating actions.
- Continue to monitor the reporting of IG incidents, general patterns and issues arising and agree any organisational wide action required.
- Continue to roll out the NIIAS programme.
- Monitor progress against the C-PIP action plan.
- Monitor progress against WAO/internal audit recommendations.
- Complete policy reviews for policies that require updates.

Argymhelliad / Recommendation

The Committee is requested to

- **ENDORSE** the Information Governance Sub-Committee Annual Report 2018/19

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.5 Record Keeping 3.4 Information Governance and Communications Technology
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Information Governance Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad: Parties / Committees consulted prior to Business Planning & Performance Assurance Committee:	Information Governance Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Information Governance Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	SBAR template in use for all relevant papers and reports.
Cyfreithiol: Legal:	A sound system of internal control, as evidenced in the Information Governance Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Information Governance Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Business Planning & Performance Assurance Committee
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	SBAR template in use for all relevant papers and reports

PWYLLGOR CYNLLUNIO BUSNES A SICRHAU PERFFORMIAD
BUSINESS PLANNING AND PERFORMANCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Planning Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Karen Miles, Director of Planning, Performance, Informatics and Commissioning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Daniel Warm, Strategic Planning Manager Paul Williams, Assistant Director of Strategic Planning and Development

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Planning Sub-Committee Annual Report 2018/19 to the Business Planning & Performance Assurance Committee. The Planning Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

The Business Planning & Performance Assurance Committee should note that this is the first full year of the constitution of the Planning Sub-Committee.

The Planning Sub-Committee can assure the Business Planning & Performance Assurance Committee that it has operated within its Terms of Reference; and meetings have all been quorate. The Sub-Committee provides detailed assurance reports to the Business Planning & Performance Assurance Committee following each of these meetings, and these can be found on the Committee webpage.

The Business Planning & Performance Assurance Committee is asked to endorse the Planning Sub-Committee Annual Report 2018/19.

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Planning Sub-Committee require the submission of an Annual Report to the Business Planning & Performance Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Planning Sub-Committee according to its Terms of Reference is to:

- Advise and guide the University Health Board's planning arrangements and implementation of major change (one year, medium and longer terms plans).
- Oversee and assure the Transforming Mental Health Implementation Programme.

- Oversee and assure the Transforming Clinical Services Implementation Programme (once established).

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of planning, and the adequacy of the governance and control measures in place.

Asesiad / Assessment

The Planning Sub-Committee has been established under Board delegation, with the University Health Board approving terms of reference for the Business Planning & Performance Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the Planning Sub-Committee were subsequently approved at its meeting on 16th January 2018 and revised at its meeting on 22nd November 2018.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Business Planning & Performance Assurance Committee around the organisation's governance, ensuring that there is an accurate reflection of the Planning Sub-Committees work programme and to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the planning agenda for the Business Planning & Performance Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the planning agenda against the following areas of responsibility:

- Provide assurance to the Business Planning & Performance Assurance Committee that the planning cycle is (*designed and managed*) being taken forward and implemented in accordance with the University Health Board and Welsh Government requirements, guidance and timescales.
- Ensure the development of, and quality assure, all Together For Health delivery plans, ensuring their alignment with the University Health Board's strategy and priorities, and also ensuring their alignment to the planning cycle.
- Have an overview of on-going regional planning work and the impact on local planning, including strengthening of the commissioning of these services, determining local targets, and repatriation opportunities.
- Ensure that risks relating to planning are being effectively managed across the whole of the University Health Board's activities.
- Receive updates from Hywel Dda Community Health Council (CHC) Service Planning Committee.
- Agree issues to be escalated to the Business Planning & Performance Assurance Committee with recommendations for action.

Planning Sub-Committee Groups

The Groups reporting to the Planning Sub-Committee during 2018/19 were as follows:

- **Mental Health Implementation Group** (Senior Responsible Officer – Deputy Chief Executive/Chief Operating Officer) – established to:
    - Provide overall direction and management of the Mental Health Implementation Sub-Groups.
    - Take major decisions and make recommendations for approval in accordance with the governance structure.
    - Identify and manage risks to delivery, escalating issues to the Planning Sub-Committee.
    - Provide progress reports to the Planning Sub-Committee, the Mental Health Legislation Assurance Committee, the Mental Health Power of Discharge Sub-Committee, the Mental Health & Learning Disabilities Business, Planning and

Performance Assurance Group, the Local Mental Health Partnership Board and Hywel Dda Community Health Council Strategy Planning Committee.

The Planning Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Business Planning & Performance Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution of the Planning Sub-Committee

From the revised terms of reference approved in November 2018, the membership of the Sub-Committee was agreed as the following (or deputies as appropriate):

- Director of Planning, Performance, Informatics and Commissioning (Chair)
- Assistant Director of Planning (Vice-Chair)
- Assistant Director of Informatics
- Director of Operations
- Director of Primary & Community Care
- Director of Workforce & OD
- Executive Director of Therapies & Health Science
- Independent Member
- Medical Director
- Strategic Planning Manager
- Transformation Director
- Director of Finance (added per the revised November 2018 Terms of Reference)
- Director of Public Health (added per the revised November 2018 Terms of Reference)
- Director of Nursing, Quality and Patient Experience (added per the revised November 2018 Terms of Reference)

With respect to the Independent Member, the revised Terms of Reference clarified that their role was that 'an Independent Member shall attend the meeting in a scrutiny capacity'. The scrutiny role of Independent Members in Sub-Committees is to ensure their effectiveness in terms of processes and outcomes, and in particular that their work is organised and undertaken in accordance with their terms of reference, that they have clarity about the limits of their delegated powers and responsibilities, and that they understand fully their relationship with and reporting responsibilities to their parent Committee

Meetings

Planning Sub-Committee meetings have been held on a bi-monthly basis as follows:

- 29th May 2018
- 20th July 2018
- 28th September 2018
- 22nd November 2018
- 29th March 2019

The Sub-Committee was quorate at all meetings, and a register of attendance is maintained.

A further meeting was scheduled for 25th January 2019 however was stood down by the Chair of the Sub-Committee due to changes in the expectation of the work being undertaken at the time in relation to the Annual Plan and following ongoing discussions with Welsh Government.

As the Planning Sub-Committee is directly accountable to the Business Planning & Performance Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Planning Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

- **Terms of Reference**

The Sub-Committee reviewed the Terms of Reference with respect to membership and quoracy in November 2018, noting that the Terms of Reference were formally endorsed at the December 2018 Business Planning & Performance Assurance Committee (BPPAC) meeting.

- **Planning Sub-Committee Risk Register**

The Sub-Committee reviewed the risks pertinent to the Planning Sub Committee extracted from the wider Planning, Performance and Informatics risk register.

The Sub-Committee noted the risks included on the Planning Risk Register and agreed to monitor progress on a quarterly basis in line with submission to the Risk Management Team. At the end of 2018/19 the risks on the risk register were:

- Planning Cycle, Products – Plans: There is a risk of the organisation being unable to deliver an approvable IMTP 2019/22 (Datix reference 705).
- Planning Cycle, Processes – Delivery: There is a risk of the organisation being be unable to deliver an approvable IMTP 2019/22 (Datix reference 706).
- Resources: There is a risk of insufficient capacity within the existing Planning Team to deliver Health Board objectives with regard to plans (Datix reference 704).
- Regional Planning: There is a risk of key services not being planned on a regional basis which is a requirement of Welsh Government (Datix reference 337). Note that on review of the risk register this was transferred from the Capital, Estates and IM&T Sub-Committee to the Planning Sub-Committee.

- **Annual Plan 2019/20**

The Sub-Committee has been leading on the delivery of the draft Annual Plan submitted to Welsh Government in in March 2019. This included:

- Draft planning cycle including timelines and products
- Product expectation
- Draft plans - key actions
- Draft enabling plans with particular reference to workforce planning, infrastructure investment and digital health
- Planning templates
- Changes to submission timelines as specified by Welsh Government

Up until the November 2018 meeting of the Sub Committee, there was an expectation that the UHB would be submitting an Integrated Medium Term Plan (IMTP) to Welsh Government rather than an Annual Plan. Therefore, much of the work of the Sub-Committee was in relation to the products and processes relating to the IMTP, and thus the Sub-Committee has had to be flexible enough to adapt to changes in both timelines and final planning products.

- **Planning Sub-Committee Reporting Mechanisms - Integrated Planning Assurance Report**

The Sub-Committee was presented at each meeting with the Integrated Planning Assurance Report (IPLAR) which has been developed based on the Integrated Performance Assurance Report. The aim of the report is to support the monitoring of the progress in the development of future Integrated Medium Term Plans (IMTP)/Annual Plans, starting with the Planning Cycle for the 2019/20 Annual Plan, and is based on the requirements of the NHS Wales Planning Framework which sets out the principles that underpins the content of IMTPs.

- **Digital Health**

It was agreed that Digital Health would be a standing agenda item, in order to assure the progress with respect to the 2018/19 Informatics Operational Plan, and the development of a revised Digital Plan in line with the Annual Plan and the Transforming Clinical Services Programme. As part of this ongoing work programme, the Sub-Committee was provided with an end of year report for 2017/18.

A proposal for a Digital Delivery Group (with two sub-groups – Clinical Informatics Sub-Group and Programme Assurance Sub-Group) to sit under the Planning Sub-Committee was presented to the March 2019 meeting. The Planning Sub Committee noted the intention to establish the Digital Delivery Group (and its two sub-groups) and the requirement for further discussion regarding the remit; format; and governance were required with other key stakeholders and governance forums, before Terms of Reference could finally be approved.

Mental Health Implementation Group – written update reports were routinely received from the Mental Health Implementation Group highlighting the key areas of work and identifying key risks and issues and matters of concern, have been regularly scrutinised by the Planning Sub-Committee during 2018/19, including the following:

- A draft implementation plan
- Draft documents to be submitted to Board for approval of the consultation outcomes and proposals.

- **Transforming Clinical Services Programme (TCS) / A Healthier Mid and West Wales**

The Sub-Committee has received updates on the progress of the TCS programme and the subsequent A Healthier Mid and West Wales Strategy.

- **Together for Health Delivery Plans**

As requested at the April 2018 meeting of BPPAC, the Planning Sub Committee reviewed the 11 mandatory Together for Health Delivery Plans (cancer; critical illness; diabetes; end of life care; heart disease; liver disease; neurological conditions; organ donation and transplantation; rare diseases; respiratory; and stroke) from the perspective of drafting status; whether the plans currently address Welsh Government and National Implementation Group priorities; whether actions were dependent on investment (revenue and/or capital); and whether they had Executive Leadership sign-off. This review was to provide assurance of the plans prior to submission for approval at BPPAC in June 2018, which was granted.

- **Collaboratives**

The Sub-Committee received updates on collaborative/regional work to ensure/provide assurance that planning implications were understood and joined up as appropriate:

- Mid Wales Joint Committee for Health and Care (MWJC).
- A Regional Collaboration for Health (ARCH).
- Joint Regional Planning and Delivery Committee (JRPDC).

- **All Wales Summer Planning Event**

The Planning Sub-Committee received updates on the development of the programme for the All Wales 2018 Summer Planning event, the responsibility for which lay with the University Health Board to plan and discharge. The event successfully took place on 11th July 2018 in Parc-Y-Scarlets, Llanelli. The Hywel Dda UHB Chief Executive opened the event with key speakers including the Director General of NHS Wales; the Wellbeing and Future Generations Commissioner for Wales; the Chief Executive of Health Education and Improvement Wales, and the Directors of Planning for Hywel Dda and Abertawe Bro Morgannwg UHBs.

- **Welsh Health Circulars**

During 2018/19. the following Welsh Health Circulars were presented and considered by the Planning Sub-Committee:

  - 047-2017: NHS Planning Framework 2018/21
  - 025-2018: Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery
  - 040-2018: Issue of the NHS Planning Framework 2019/22

- **Key presentations and verbal items included:**
  - Commissioning Framework
  - Wellbeing and Future Generations Act
  - Research, Development and Innovation
  - Regional Partnership Board and the Transformation Fund
  - Welsh Trauma Network updates
  - The development of the UHBs End of Life strategy
  - Hywel Dda Community Health Council Service Planning Meetings – in accordance with the terms of reference of the Sub Committee, minutes of the meetings were presented for information

- **Key Risks and Issues/Matters of Concern**

During 2018/19, the following key risks and issues/matters of concern were raised to BPPAC:

  - The Planning Sub-Committee will need to assess the risks associated with the 2018/19 Planning Cycle for the 2019/22 Integrated Medium Term Plan, noting that this is currently based on the 2017 NHS Wales Planning Framework (May 2018).

- **Matters Escalated to Business Planning & Performance Assurance Committee for Consideration or Approval**
  - Revised Planning Sub Committee Terms of Reference (November 2018).

- **Planning Sub-Committee Developments for 2019/20**

The following developments are planned for the Planning Sub-Committee during 2019/20:

  - Further development, and monitoring, of the Integrated Planning Assurance Report.
  - Development of the 2019/20 Planning Cycle and consequently the Integrated Medium Term Plan.
  - Further review of the Terms of Reference to ensure they reflect any changes to its remit with respect to the establishment of the Digital Delivery Group (and its two Sub-Groups)
  - Continuing to advise and guide the Health Board's planning arrangements and implementation of major change (one year, medium and longer terms plans).
  - Continue to oversee and assure the Transforming Mental Health Implementation Programme.
  - Assure alignment of planning deliverables with the Transforming Clinical Services Implementation Programme.

Argymhelliad / Recommendation

The Business Planning & Performance Assurance Committee is asked to endorse the Planning Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Risk Register Reference:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Planning Sub-Committee meetings 2018/19 Update reports for Business Planning and Performance Assurance Committee from the Planning Sub-Committee
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad: Parties / Committees consulted prior to Business Planning and Performance Assurance Committee:	Planning Sub-Committee (at the March 2019 meeting)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced in the Planning Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.

Cyfreithiol: Legal:	A sound system of internal control, as evidenced in the Planning Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Planning Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Business Planning & Performance Assurance Committee.
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	SBAR template in use for all relevant papers and reports

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality, Safety & Experience Assurance Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor John Gammon, Chair, Quality, Safety & Experience Assurance Committee
SWYDDOG ADRODD: REPORTING OFFICER:	Mandy Rayani, Director of Nursing Quality and Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Quality, Safety & Experience Assurance Committee (QSEAC) Annual Report 2018/19 to the Board.

The QSEAC Annual Report provides assurances in respect of the work that has been undertaken by the Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the QSEAC require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Committee and to identify how it has fulfilled the duties required of it.

The QSEAC Annual Report provides assurances in respect of the work that has been undertaken by the Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Asesiad / Assessment

The Health Board established QSEAC, under the Board's Scheme of Delegation in 2015. The terms of reference for the QSEAC approved by the Board on 26th November 2015, reviewed by the QSEAC during 2016 and approved by the Board at its meeting on 26th January 2017. These have been subject to a further review and most recently approved by the Board at its meeting on 28th March 2019.

These terms of reference clearly detail that the Committee's purpose is to provide assurance to the Board that the organisation's strategy and delivery plans for quality and safety are appropriate and that it can provide evidence based and timely advice to the Board to assist it in discharging its responsibilities.

The Committee provides leadership and ensures that the appropriate enablers are in place to promote a positive culture of quality improvement based on best evidence. During

2018, there was a review of the Sub-Committees reporting to QSEAC. As a result, there was an agreement that both Medicines Management and Infection Prevention Committees would report directly to QSEAC as Sub-Committees.

There, was a further recognition that the QSEAC were dealing with a number of quality and safety operational issues. As a result the Operational Quality Safety Experience (OQSEAC) Sub Committee was formed with the first meeting being held in July 2018.
In summary the Sub-Committees of QSEAC are:

- Operational Quality Safety Experience Sub Committee (OQSEAC)
- Mental Health & Learning Disabilities Quality, Safety & Experience Sub-Committee
- Infection Prevention Sub-Committee (New Sub-Committee 2018)
- Improving Experience Sub-Committee
- Medicines Management Sub-Committee (New Sub-Committee 2018)
- Strategic Safeguarding Sub-Committee
- Workforce & Organisational Development Sub-Committee
- Effective Clinical Practice Sub-Committee

The Terms of reference for the above Sub-Committees were reviewed and approved during 2018/2019.

CONSTITUTION

From the terms of reference approved by the Board in November 2015, and those revised and approved in March 2018, the membership of the Committee has been agreed as the following:

- Independent Member as the Chair
- 6 x Independent Members (including the Audit and Risk Assurance Committee Chair and t the Business Planning & Performance Assurance Committee Chair)

In attendance Members:

- Chief Executive
- Deputy Chief Executive/Director of Operations
- Medical Director & Director of Clinical Strategy
- Director of Nursing, Quality & Patient Experience (Lead Executive)
- Director of Planning, Performance and Commissioning
- Director of Workforce & Organisational Development (and Chair of Workforce and OD
- Sub-Committee)
- Director of Therapies & Health Science (and Chair of Operational Quality, Safety &
- Experience Sub-Committee)
- Director of Public Health
- Director of Partnerships and Corporate Governance
- Assistant Director of Assurance, Quality Safeguarding and Professional Regulation
- Assistant Director of Quality and Improvement
- Head of Medicine Management
- Chair of Mental Health Learning Disability Services and Quality Safety and Experience
- Chair of Improving Experience Sub-Committee
- Chair of Strategic Safeguarding Sub-Committee
- Chair of Effective Clinical Practice Sub-Committee
- Chair of Medicines Management Sub-Committee
- Chair of Infection Prevention Sub-Committee
- Hywel Dda Community Health Council (CHC) Representative (not counted for quoracy purposes)

MEETINGS
QSEAC meetings have been held on a bi-monthly basis throughout the year and were all quorate as follows:

- 10th April 2018
- 12th June 2018
- 14th August 2018
- 16th October 2018
- 4th December 2018
- 5th February 2019

In-committee sessions were held after each committee meeting during 2018/19, to discuss either potentially sensitive matter or identifiable data such as serious incidents (prior to the final report being shared with the patient and/or their family). The items discussed included:

- Update on Medical devices
- Trans-catheter Aortic Valve Implantation (TAVI) Waiting List
- Serious incidents:
- Ultrasound scan
- Cardiology
- Infection Control Outbreak
- Orthopaedics

As QSEAC is directly accountable to the Board for its performance, the Chair of QSEAC has provided assurance or escalated matters to Board through a formal written update report.

QSEAC WORKING ARRANGEMENTS
The Committee working arrangements and expectations of members was considered at the beginning of the financial year and there was an agreement for:

- Necessity of membership attendance,
- Executive Director Attendance
- Reports to focus on quality, safety matters and assurance.
- The implementation of the OQSEAC, to support scrutiny at an operational level, allowing QSEAC to deal with high risk quality and safety matters.

The role of the Sub-Committees was reinforced, with the Chair emphasising the importance of quality and safety agenda and the focus on outcomes rather than process. It was agreed that QSEAC would review the higher-level quality and safety risks and issues as opposed to the operational detail. The OQSEAC chaired by the Director of Therapies would consider the operational quality and safety risks in more detail.

It is recognised that further work is required to get to a position where this report is outcome focused and this will be a priority for 2019/20.

Monitoring of Performance against patient safety and incidents, complaints and claims and Management of Serious Incidents (SI's). Welsh Government has a target of 60 days to close serious incidents, with a compliance target of 90%. The compliance over the past year has been variable between 38% and 94%. Although the overall average for the year has seen an increase from the previous years, it is recognised that further work is to continue in 2019/20 to ensure there is a sustainable level of improvement.

During the year, the quality of investigation reports and the closure forms have improved, which has been recognised by Welsh Government.

The Committee were advised on the number of initiatives that have been implemented throughout the year to support the ongoing improvement. These haves included, implementation of weekly serious incident meetings chaired by the Executive Director of Nursing. The Medical Director and the Executive Director of Therapies attend. Where poor compliance at Directorate level is noted, the triumvirate teams are asked to attend a specific Panel meeting to discuss the improvement plans, these meetings run alongside the weekly SI meetings. There will be a continued focus on the timeless of SI closure forms through 2019/20.

The top two incidents reported to Welsh Government are Pressure Damage and Patient Falls. QSEAC have received assurance that a range of improvement activities has been progressed during the year.

Pressure damage improvement initiatives reported to QSEAC have included:
The continuation of pressure damage workshops, during 2018. The workshops were based on themes arising from investigation of the pressure damage incidents, case studies were used to support the workshops. Further initiatives have been taken forward these have included:

- Scrutiny meetings implemented across all of the acute sites, chaired by the Heads of Nursing, with attendance from sisters, safeguarding and tissue viability nurses.
- Multi-professional steering Board established, chaired by the Assistant Director for Quality Improvement. Membership includes, Welsh Ambulance, Local Authority and University Partners.
- Focused heal pressure damage training at Bronglais General Hospital; this has seen positive outcomes and further roll out is proposed at Glangwili General Hospital in 2019/20.
- New pressure damage patient information leaflet is being developed to highlight prevention techniques.
- Community are in the process of rolling out scrutiny meetings, this will be progressed during 2019/20.

Falls Quality Improvement:
Quality improvement teams have focused on ward in-patient falls. There has been positive outcomes from this focused work, with a reduction in falls noted as a result at Prince Philip Hospital. Although further monitoring of this work is required to understand if this is a sustainable improvement. Falls improvement initiatives have included:

- The ‘Bay’ watch principles adopted on a number of wards. This ensures that the patients that are at risk of falls in one bay with an increase of staff.
- Implementation of scrutiny meetings. These meetings will review all falls to understand how they occurred and learn lessons.
- Falls workshops to raise awareness of staff.
- Falling stars implemented across acute wards.

The quality improvement team will continue to work with operational services, undertaking ‘deep dives’ and to identify hot spot areas and provide focus work throughout 2019/20. This will be further enhanced by the implementation of the quality improvement strategic framework endorsed by the Board.

Quality Improvement Strategic Framework
QSEAC received regular updates on the progress of the Quality Improvement Strategic Framework during 2018/19. The Board endorsed this framework in December 2018. With a formal launch 21st March 2019. There are 5 Quality Improvement Goals

- No avoidable deaths
- Protect Patients from avoidable harm
- Reduce duplication and eliminate waste
- Reduce unwarranted variation and increase reliability
- Focus on what matters to patients, service users, their families and carers, and our staff

During 2019/20, there will be a focus on training staff to undertake quality initiatives using the quality improvement methodologies. The intention will be to support a mindset change in relation to quality and quality improvement, supporting outcome focused works. These will be reported through assurance and quality improvement reports during 2019/20.

Never Events
Never events are serious largely preventable patient safety incidents. Two never events were reported during 2018/19, with action plans completed for both.

Retained Swab - key areas for action included:

- Staff training competencies
- Record keeping improvement
- Findings shared at a Multi-disciplinary learning from events

Incorrect route for administering medication - key areas for action included:

- Update of Central venous catheter policy
- Staff training and competencies
- Improvement in documentation relating to recording of line pressures.

All actions were completed in a timely manner in relation to both never events.

Complaints Management
A Scrutiny Panel was established by the Improving Experience Sub-Committee in May 2017. The Panel is chaired by the Board's Independent Member with responsibility for Putting Things Right. Its primary purpose is to provide assurance to the Improving Experience Sub-Committee that the organisation is properly implementing the NHS (Concerns, Complaints and Redress) Regulations 2011 and that the delivery of the process is consistent with the Principles of the Review of Concerns Handling in Wales in 2014 – 'Using the Gift of Complaints'.

The overall aim of the Panel is to drive quality and improvement in the management of concerns by ensuring the patient is at the heart of the process and that the Health Board is learning effectively from patients' experiences, in facilitating organisational learning, the Panel seeks to gain assurance that outcomes from lessons learnt are being implemented in practice. It is recognised that the scrutiny panels are a relatively new concept and are evolving; learning from the scrutiny panel will be a focus for 2019/20.

Patient Safety Alerts (PSA) /Patient Safety Notices (PSN)
The Committee monitored compliance against patient safety alerts and notices throughout the year. During 2018/19 focused work was undertaken to close outstanding PSN and PSA, with particular emphasis given to overdue PSA's and PSN's. As a result, one PSA (PSA008) and five PSNs were closed; some of these had been open for some years.

There are 6 PSNs that remain open. All are allocated to Sub-Committees or Groups within the Health Board and regular updates will be provided to QSEAC.

Annual Reports
The Committee received and approved the following Annual reports in 2018/19:

- QSEAC Annual Report 2017/18
- Draft Annual Quality Statement 2018/2019
- All Sub-Committees to QSEAC Annual Reports 2017/18

Discussions were held during QSEAC in April 2018 and it was agreed that the report formats did not necessarily provide an accurate reflection on outcomes. As many of the reports this year are of a similar format to previous years, further discussions have commenced between the Board Secretary and the Executive Nurse Director to identify a more appropriate template to support outcome focused reports for 2019/20.

External Reports
Healthcare Inspectorate Wales (HIW) Annual Report 2017/18 & 3 Year Strategy
The Committee received the report, which considered reviews across Wales. The Committee recognised that this was an important report as it provided a standard for the Health Board to benchmark itself against other Health Boards. The HIW Strategic Plan 'Making a Difference' was presented at a Board Seminar.

In relation to findings from HIW reports, Committee received assurance that the level of scrutiny in relation to implementation plans had greatly improved and the Executive Nurse Director signs off all action plans and will attend feedback sessions whenever possible. This provides leadership and support for the operational teams.

External Reviews
Community Health Council (CHC) Visits and Healthcare Inspectorate Wales (HIW).
During 2018/19 QSEAC received regular updates in relation to activity undertaken by HIW and the Community Health Council (CHC). Whilst there are no clear consistent themes that have emerged from the visits across the various wards and departments, there were clearly areas for improvement. Matters which were site and/or ward specific have been addressed through local responsiveness, whilst issues that have been flagged which may have a broader reach are being taken up for action by the relevant corporate teams. This approach will continue during 2019/20. Overall, the findings within the reports were helpful in providing a constructive and objective view of care and services as perceived by local members of the public whilst acting in their capacity as CHC representatives. There was an agreement at QSEAC, during the year, to delegate the monitoring of actions that have been identified as a result of the visits to the relevant QSEAC Sub-Committees, or Directorate governance committee meetings and any exceptions identified would be reported to QSEAC via the Sub Committee's exception reports during 2019/20.

Operational and Strategic Delivery Reports
During the year, the Committee received numerous presentations, reports and updates in relation to operational services delivery and performance issues. Examples of which are:

Dementia Care Progress Report – the report advised that a Dementia Steering Group had been established, and National actions identified would be progressed; one key action was to improve patient access to services. The Steering Group would undertake a scoping exercise to understand the extent of this work. It was recognised that further work would be required in relation to outcomes from this work and would be reported through QSEAC in 2019/20.

Vascular Clinical Service Clinical Progress Report & Action Plan - Members were presented with an update on the Vascular Service Clinical Progress Report and Action Plan, although assurance was obtained that actions were being taken forward it was agreed that further consideration would be given to patient access and data on patient outcomes should be presented to QSEAC in April 2019.

Nurse Staffing levels (WALES) Act – Phased Implementation Plan - Members were advised that significant work has been undertaken within the Health Board and at the All Wales Nurse Staffing Group, and advised that Ministers have acknowledged the requirement for a phased implementation of the Act. Regular reports would continue through QSEAC in 2019/20.

Hywel Dda Inpatient Cardiac Treatment Waits at ABMUHB - concerns were raised in relation to waits for treatment for cardiac patients at Morriston Hospital, and any impact this could have on patients. The Committee were advised that regional work is being undertaken to increase capacity, for examples included, regional testing for certain conditions, whilst it was acknowledged that funding was required to support this project. This would be in collaboration with Swansea Bay UHB (formally known as Abertawe Bro Morgannwg UHB). It was agreed at QSEAC that this would be taken forward through Business Planning and Performance Assurance Committee (BPPAC).

Welsh Audit Office (WAO) Out-Patients Appointments Follow Up Report - Members were advised that Wales Audit Office (WAO) undertook a review of follow-up outpatients across all Health Boards in Wales. A further review was undertaken in 2017 to assess progress achieved since 2015, following which the Board received new recommendations. The report was presented to Audit and Risk Assurance Committee (ARAC), where it was agreed that the ongoing actions would be monitored through QSEAC. A number of the recommendations were discussed and actions to address these were noted. It was agreed that to provide assurance on patient impact, a further report would be required to be presented to QSEAC during 2019/20.

Breaking The Cycle - Quality Impact & Risk Management - the Committee noted that, since October 2017, there has there been improvement and learning from targeted work in Glangwili General Hospital (GGH) led by the Turnaround Director, and that similar work will be progressed in Withybush General Hospital (WGH).

Update Reports from Sub-Committees
The Committee received update reports from the Sub-Committees at each meeting during 2018/19. The full annual reports from each Sub-Committee will be presented alongside QSEAC annual report, (Appendices 1-8) as such only key areas are reported below.

Assurance Reports of the Sub-Committees
Operational Quality, Safety & Experience Sub Committee (OQSESC) - the Sub-Committee had its inaugural meeting on 10th July 2018, where the format of the Sub-Committee was agreed

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to QSEAC:

- Lack of a RRAILS monitoring group in Bronglais General Hospital (BGH) – now resolved
- Challenges for the OQSESC to adequately monitor the number of operational risks to the level required to provide assurance

- Environmental risks in the North Road facility, Ceredigion
- Lack of medical input to the Nutrition and Hydration Group – now resolved
- Risks 654 and 303 relating to risk of harm to patients in hospital due to malnutrition
- The Regulation 28 Report relating to the nutritional management of an inpatient in GGH
- A list of laboratory equipment for inclusion onto the RAM 5000 system still outstanding
- Risk 684 in relation to the risk of interruption to radiology service provision from a breakdown of ageing imaging equipment

Matters Escalated to QSEAC
- During 2018/19, the following matters requiring QSEAC level consideration or approval were raised:
- Medical workforce challenges in dermatology, resulting in a paper being received by QSEAC.
- Approval of the Operational Quality, Safety and Experience Sub-Committee revised terms of reference.

The Sub-Committee is still developing and continues to review its effectiveness on a regular basis. Members continue to discuss and refresh the mechanism for monitoring and providing assurance to QSEAC in relation to operational risks with a potential quality or safety impact on patient care.

Improving Experience Sub-Committee (IESC)
This Sub-Committee is key to supporting patient experience and learning. There is a real focus in 2019/20 to developing and implementation of a Patient Experience Charter & Delivery Plan. This will help influence some of the operational and strategic reports relating to quality of services that are presented to QSEAC.

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to QSEAC:
- Attitude/communication/assault – highlighted as a new emerging theme impacting on both staff and patient experience and it was proposed that a detailed analysis would be presented for review at the next Sub-Committee meeting.
- Communication and information – between teams and professionals highlighted as the most significant area for improvement following a review of feedback. This will form part of a new quality improvement collaborative programme.

Mental Health and Learning Disabilities (MHLD) Services Quality, Safety and Experience Sub-Committee
Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to QSEAC:
- Inpatient capacity and high levels of bed occupancy in adult mental health services continued to be robustly scrutinised to monitor demand across the service areas. The Sub-Committee continues to report to the QSEAC and escalate as required.
- Recruitment challenges across the Directorate in a number of key areas such as medical and nursing remained a concern and was closely monitored, although assurances have been received due to a number of positive recruitment campaigns. However, medical recruitment remains an area of significant challenge.
- Learning Disabilities registered nurses are also an area of potential recruitment challenges due to the high numbers of staff who are nearing or at the eligible age of

retirement. The Directorate has a number of plans in place to mitigate the impact of this.
- A report on the Fragility of Mental Health services updated QSEAC on the current risks the Directorate encounters in order to provide assurance that escalation processes are in place to manage those risks.

Vagal Nerve Stimulation (VNS) Device Monitoring: The Sub-Committee received the VNS device monitoring report, noting that VNS monitoring had previously been undertaken within Hywel Dda UHB by an Epilepsy Clinical Nurse Specialist, however, since their departure in 2017, there has been a gap in service provision pending recruitment into the post. This has resulted in a lack of monitoring for some clients. An agreement has been received from ABMUHB regarding the establishment of a Service Level Agreement to deliver VNS follow-ups for individuals

Matters Escalated to QSEAC
During 2018/19, the following matters requiring QSEAC level consideration or approval were raised:
- Sustained pressures within adult mental health inpatient services.
- Recognition and endorsement of the MHLD Written Control Documentation Group (WCDG).

Workforce and OD Sub-Committee
Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to QSEAC:
- Surgery at F2 level was escalated to Targeted visit. It is also anticipated that Obstetrics and Gynaecology will escalate to Targeted visit.

Matters Escalated to Quality, Safety & Experience Assurance Committee
During 2018/19, the following matter requiring QSEAC level consideration or approval was raised:
- AAC appointments linked to Workforce Sub-Committee

Infection Prevention Sub-Committee
Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to QSEAC:
- Decontamination of a medical device.
- Infection Outbreak escalated to In-Committee QSEAC for discussion

Matters Escalated to QSEAC
During 2018/19, the following matters requiring QSEAC level consideration or approval were raised:
- Funding stream for ICNet
- Faecal Microbiota Transplant

Effective Clinical Practice Sub-Committee
Matters Escalated to Quality, Safety & Experience Assurance Committee
During 2018/19, the following matters requiring QSEAC level consideration or approval were raised:
- Assurance required to ensure adequate mitigation of risk is in place for compliance with mandatory audit
- Assurance required to ensure adequate mitigation of risk is in place for managing ageing stock of medical devices

- Approval for revision of ECPS-C Terms of Reference to accommodate agreed changes for the setup of NICE and National Guidance Review Group and Clinical Audit Group, description of collaboration with UPB, removal of MMG, MDGAG and QIG groups and changes to the Quality & Safety governance structures.
- Concerns were raised regarding the attendance at ECPS-C. Poor attendance was noted and there is often a struggle to reach a quorum. The Sub-Committee has been unable to recruit enough clinical members resulting in a lack of expertise.
- QSEAC, and the Board were informed of a potential system failure in the ECPS-C when the business of the sub-committee and its groups is unable to progress through lack of attendance and expertise. It was agreed that the Chair would write to the Medical Director for advice and discuss ensuring time allocation for attendance at clinical working group meetings in job plan reviews.

Strategic Safeguarding Sub-Committee (SSSC)
The SSSC provides assurance that a focus on safeguarding is integrated into the Health Board functions and influences the direction for service delivery, evidencing themes and changes/improvements to services as a result of analysis of any safeguarding issues. Its purpose is also to oversee and steer the direction of safeguarding in the Health Board, and promote a culture of positive learning.

Key Risks and Issues/Matters of Concern
During 2018/2019, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- Core Safeguarding Training Compliance for level 1, 2 and 3 – this has remained a risk that has been raised to QSEAC. Although there has been an improvement in training compliance, capacity to release staff to attend training remains a risk and this will be continually monitored throughout 2019/20 to ensure the increase in compliance continues.
- Disclosure and Barring Service (DBS) – assurance of DBS compliance remains a risk for the Health Board, both in the context of compliance with 3 yearly checks for those involved in the care of children, and also in identifying those staff who have never had a DBS / CRB (Criminal Records Bureau) check. The Head of Safeguarding is working closely with Workforce and OD and a task and finish group will review the criteria for 3 yearly checks and ensure that the Electronic Service Record (ESR) is subsequently able to report reliably. A scoping exercise with recommendations for those staff who have no evidence of a DBS in ESR will be a priority for 2019/20
- Compliance with the Group 1 VAWDASV National Training Framework – the Health Board failed to achieve 100% compliance by March 2018; while some improvement has been made, continued improvement is required. Services and Directorates are to identify their improvement plans which will continue to be motored through SSSC.

Matters Escalated to QSEAC

- Current dermatology pathway due to a lack of Consultant capacity
- Concerns raised in regard to delayed follow up appointments
- Risks and issues about the sustainability of Sexual Assault Referral Centre (SARC) for paediatrics services in Swansea. Resolved interim pathway in place
- Concerns about patient impact once the refurbishment works on the aseptic units commence.
- Vascular Service Clinical Progress Report and Action - regarding the impact on patient outcomes due to delays in vascular service provision,
- Dementia Care Progress Report – Funding will be required to increase the workforce to improve patient access to Dementia services

Matters Considered at QSEAC Requiring Board Approval

- Approval of the Annual Quality Statement
- Approval of the QSEAC revised Terms of Reference
- Approval for Quality Improvement Strategic Framework

Future Work Plan 2019/20

- Continuous review and evaluation of the QSEAC throughout 2019/20.
- Continues development of assurance processes such as Board to Ward Walkabouts.
- Continue development of quality dashboard with time scales and project plan completed.
- Oversee the progress related to the Quality Improvement Strategic Framework.
- Oversee the evaluation of the OQSEAC ensuring that relevant exceptions are reported through to QSEAC.

Continue to evaluate and gain assurance from Sub–Committees that recommendations from external reports are being embedded into Sub-Committee structures.

Argymhelliad / Recommendation

The Board is asked to endorse the Quality, Safety and Experience Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Operational Quality, Safety and Experience Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Operational Quality, Safety and Experience Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced in the Operational Quality, Safety and Experience Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Operational Quality, Safety and Experience Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Operational Quality, Safety and Experience Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Quality, Safety and Experience Sub-Committee (OQSESC) Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Alison Shakeshaft, Chair, OQSESC, Director of Therapies & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Alison Shakeshaft, Chair ,OQSESC, Director of Therapies & Health Science

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Operational Quality, Safety and Experience Sub-Committee (OQSESC) Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee. The OQSESC Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the OQSESC require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to focus on both acute and 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, freeing up the Quality, Safety and Experience Assurance Committee to be more strategic in its approach and providing onward assurance to the Board.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of quality, safety and experience, and the adequacy of the response, systems and processes in place during 2018/19.

Asesiad / Assessment

The OQSESC has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee most recently at its Board meeting on 29th March 2018.

The OQSESC was established to combine and replace the previous Acute Services and Primary Care & Community Services Quality, Safety and Experience Sub-Committees. The first meeting of the OQSESC was held on 10th July 2018. The terms of reference of the OQSESC

were subsequently approved at its second meeting on 20th September 2018. A revised version was approved at the January 2019 OQSESC, with some slight amendments requested by QSEAC in February 2019 prior to their approval via Chair's Action.

The terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's acute and 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, and providing an upward assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the quality, safety and experience agenda against the following areas of responsibility:

- Resuscitation/RRAILS
- Nutrition and Hydration
- Organ Donation
- Mental Capacity Act and Consent
- Medical Devices

Other areas of focus include:

- Falls
- Pressure Damage
- Dementia
- Frailty
- Clinical pathways such as stroke, diabetes, cardiology, ophthalmology
- Operational risks from the acute, primary and community services, where there is an impact on patient quality, safety or experience.

OQSESC Groups
The Groups reporting to the OQSESC during 2018/19 were as follows:

- **Resuscitation/RRAILS Group** – established to:
  - Provide assurance that robust and reliable mechanisms for the early detection and response to acute illness and management of cardio/respiratory arrest are in place

- **Nutrition and Hydration Group** – established to:
  - Set the strategic direction and provide assurance on all matters relating to nutritional care, including aspects of catering services

- **Organ Donation Group** – established to:
  - Influence policy and practice in order to ensure that organ donation is considered in all appropriate situations and to identify and resolve any barriers to this
  - Ensure that a discussion about organ donation features in all end of life care wherever located and appropriate, recognising and respecting the decisions of individuals and their families
  - Maximise the overall number of organs donated through strong promotion and better support and advice, to potential donors and their families

- **Mental Capacity Act and Consent Group** – established to:
  - Provide clear leadership in the promotion of the application of the Mental Capacity Act in every day clinical practice

- Ensure that there is a framework in place to support staff in relation to the Mental Capacity Act and monitor compliance with this legislation through appropriate assurance mechanisms
- Provide assurance that consent processes are being adhered to across the UHB, and where necessary agree corrective action
- Ensure that the Welsh Government Policy for Consent to Examination and Treatment and the associated consent forms are kept up to date and implemented in all relevant areas of the UHB

- **Medical Devices Group** – established to:
  - Provide assurance around strategic medical devices management and associated risk matters

The OQSESC Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution
From the terms of reference approved in September 2018, the membership of the Sub-Committee was agreed as the following:

- Executive Director of Therapies and Health Science (Chair)
- Assistant Director, Operational Nursing & Quality Acute Services – Vice Chair
- Associate Medical Director, Workforce & Primary Care
- Associate Medical Director, Quality & Safety
- Deputy Director of Operations
- Assistant Director of Nursing Assurance & Safeguarding
- Assistant Director of Therapies and Health Science – Professional Practice, Governance & Safety
- Assistant Director of Workforce & OD
- Assistant Director of Informatics
- County Directors x 3
- Independent Member, HDdUHB
- Head of Medicines Management
- Therapies Lead
- Health Science Lead
- Senior Nurse, Infection Prevention
- Representative from each Triumvirate
- Head of Primary Care

Meetings
Since July 2018, OQSESC meetings have been held on a bi-monthly basis as follows:

- 10 July 2018
- 20 September 2018
- 13 November 2018
- 24 January 2019
- 19 March 2019

As the OQSESC is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the

Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on five occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the OQSESC has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

- Implement and monitor the quality and safety of care delivered to patients through, for example, surveys and patient stories, and escalate issues that cannot be resolved operationally to the Quality, Safety and Experience Assurance Committee
- Monitor service specific action plans arising from internal and external audits, inspections such as HIW reviews, Royal College audits, accreditation issues, CHC reviews, requirements of Welsh Government, etc., and ensure that actions are being delivered in line with agreed timescales, reporting any exceptions to these
- Monitor and ensure compliance with national guidance, including NICE, NSFs, National Confidential Enquiries, outcome reviews and national clinical audits
- Inform and monitor progress against agreed performance targets identified in the Quality & Improvement Dashboard, providing onward assurance to the Quality, Safety & Experience Assurance Committee
- Seek assurance on the management of operational risks that have been aligned to the Sub-Committee, and provide assurance to the Quality, Safety and Experience Assurance Committee that risks are being managed effectively and report any areas of concern, e.g. where risk tolerance is exceeded, lack of timely action
- Receive assurance from those Groups reporting to the Sub Committee, and consider how escalated issues are addressed
- Receive position reports on:
  - Key risks associated with preventing harm to patients:
  - Falls
  - Pressure damage
  - Clinical pathways - ophthalmology
- Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it, and to provide evidence of that assurance to the Clinical Written Control Documentation Policy Review Group when recommending a procedure or guideline for uploading or a policy for final approval by the Written Control Policy Review Group.
- Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Assurance Committee and oversee delivery to improve the quality, safety and effectiveness of care delivered, and enhance the patient experience.
- Inform the work plans for reporting Groups and vice versa.
- Address any other requirements stipulated by the Quality, Safety and Experience Assurance Committee.
- Agree issues to be escalated to the Quality, Safety and Experience Assurance Committee with recommendations for action.

The following areas of responsibility were not specifically considered by OQSESC in 2018/19 and need to be considered in the forward work programme if they are not covered within the remit of any other Sub-Committee:

- Ensure that concerns (incidents, complaints and claims) are being managed in a robust and timely way at service level, agreeing mitigating actions where required
- Monitor action plans following investigations into serious incidents and concerns and learning from events, ensure actions are being delivered in a robust and timely way, and seek assurance that learning is disseminated and embedded across all of the Health Board's activities as appropriate
- Consider the themes arising from triangulated information at service specific level, and agree and monitor any action plans required to deliver improvements

Feedback from Groups
In terms of feedback from Groups:

- **Resuscitation/RRAILS Group** – written update reports from the Resuscitation/RRAILS Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by OQSESC during 2018/19, including the following:

    - Updates from the Hospital-based RRAILS Monitoring Group meetings and the Out of Hospital, Paediatric and Trauma Sub-Group Meetings
    - Assurance that the UHB is represented on national groups in relation to RRAILS
    - Sharing of incidents/learning across the UHB in relation to resuscitation/RRAILS
    - UHB compliance with the sepsis bundle
    - Lack of RRAILS group in Bronglais General Hospital (BGH) – now resolved
    - Peer review of the UHB's embedding of RRAILS agenda (due for completion March 2019)
    - Task and Finish Group established to draft UHB guidance on telemetry and cardiac monitoring standards

    The Resuscitation/RRAILS Group Annual Report 2018/19 is due to be presented to the 14th May 2019 OQSESC meeting.

- **Nutrition and Hydration Group** – written update reports from the Nutrition and Hydration Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by OQSESC during 2018/19, including the following:

    - UHB compliance with Patient Safety Notices and standards e.g. the All Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients and the All Wales Menu Framework
    - Improvement work including: development of guidance on mealtime coordination, pilot of a hydration station, pilot of food service training for hotel services staff, delivery of a NG competency project with nursing, guidance on hydration for staff working in clinical areas
    - Monitoring and reviewing written control documentation in relation to nutritional care and the required implementation and training and scrutiny of compliance through clinical audit (Hand Control MITTS and Nasal Bridles)
    - Work to comply with PSA 008 (NG tube placement and management) and PSN045 (safer modification of food and fluid for patients with dysphagia / IDDSI)
    - The establishment and implementation of a new 4yr +1+1 home enteral feeding contract (with incumbent supplier Nutricia)
    - Consideration of the UHB position regarding the procurement of an All Wales catering information system

- Work to improve the management and reduction of food waste in line with WHC 018-17, across all acute and community hospital sites
- Reviewing and agreeing actions following feedback from patients in relation to catering and nutritional care including routine patient catering surveys, Fundamentals of Care audit, complaints and compliments
- Development and implementation of new patient menus: finger food menus and vegan and review existing texture modified menus
- Challenges in identifying medical support for the group (now resolved)
- Risks 654 and 303 relating to risk of harm to patients in hospital due to malnutrition
- The Regulation 28 Report relating to the nutritional management of an inpatient in Glangwili General Hospital (GGH)

The Nutrition and Hydration Group Annual Report 2018/19 is due to be presented to the 14th May 2019 OQSESC meeting.

- **Organ Donation Group** – written update reports from the Organ Donation Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by OQSESC during 2018/19, including the following:

  - Organ donation activity
  - Recruitment to key posts
  - Scheduling of meetings to better align with OQSESC

  The Organ Donation Group Annual Report 2018/19 is due to be presented to the 14th May 2019 OQSESC meeting.

- **Mental Capacity Act and Consent Group** – written update reports from the Mental Capacity Act and Consent Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by the OQSESC during 2018/19, including the following:

  - Results of the annual audit on consent forms in June 2018, including progress made and areas for improvement
  - Poor attendance at training events – including solutions to correct
  - Progress with updating consent forms across the UHB
  - Adoption of the updated All-Wales Consent to Examination or Treatment Policy
  - Compliance with the new NICE Guideline 108 'Decision Making and Mental Capacity recommendations
  - Revised prioritisation process for triaging Deprivation of Liberty Standards (DoLS) referrals
  - Shortage of DoLS Medical Assessors and actions taken to mitigate associated risks

  The Mental Capacity Act and Consent Group Annual Report 2018/19 is due to be presented to the 14th May 2019 OQSESC meeting.

- **Medical Devices Group** – written update reports from the Medical Devices Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by the OQSESC during 2018/19, including the following:

  - Development of a medical devices database and inspection of all known devices

- Development of a planned preventative maintenance programme for medical devices
- Need to progress a similarly robust process for community equipment
- Work to implement the All Wales Point of Care Testing (PoCT) System
- Work relating to the new Medical Devise Regulations coming into force in 2020
- Reporting of Ultrasound Governance and Radiation Protection through the Medical Devices Group established
- Decontamination audits undertaken across the four acute sites, which have provided a high degree of assurance and have been cited as an exemplar of good practice

The Medical Devices Group Annual Report 2018/19 is due to be presented to the 14th May 2019 OQSESC meeting.

Other Areas of Responsibility
The main focus of the inaugural meeting on 10th July 2019 was to discuss and agree the format, agenda items and reporting mechanisms/sub structures for future OQSESC meetings.

During 2018/19, OQSESC received and considered the following:

- Internal Assurance Report on the Quality, Safety and Effectiveness of the Management of Pressure Damage in HDdUHB
- Internal Assurance Report on the Quality, Safety and Effectiveness of the Management of Falls in HDdUHB
- Internal Assurance Report on the Quality, Safety and Effectiveness of HDdUHB Maternity Services
- Internal Assurance Report and Exception Report on HDdUHB's Health and Care Standards and Scrutiny Matrix
- Internal Assurance Report on the Quality, Safety and Effectiveness of HDdUHB Ophthalmology Services

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- Lack of a RRAILS monitoring group in BGH – now resolved
- Challenges for the OQSESC to adequately monitor the number of operational risks to the level required to provide assurance
- Environmental risks in the North Road facility, Ceredigion
- Lack of medical input to the Nutrition and Hydration Group – now resolved
- Risks 654 and 303 relating to risk of harm to patients in hospital due to malnutrition
- The Regulation 28 Report relating to the nutritional management of an inpatient in GGH
- A list of laboratory equipment for inclusion onto the RAM 5000 system still outstanding
- Risk 684 in relation to the risk of interruption to radiology service provision from a breakdown of ageing imaging equipment

Matters Escalated to Quality, Safety & Experience Assurance Committee
During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- Medical workforce challenges in dermatology, resulting in a paper being received by QSEAC

- Approval of the Operational Quality, Safety and Experience Sub-Committee revised terms of reference

The Sub-Committee is still developing and continues to review its effectiveness on a regular basis. Members continue to discuss and refresh the mechanism for monitoring and providing assurance to QSEAC in relation to operational risks with a potential quality or safety impact on patient care.

OQSESC Developments for 2019/20
The following developments are planned for OQSESC during 2019/20:

- An in-depth consideration of one or two specific operational risks at each meeting
- Review of pressure damage incidents and their management/prevention
- Review of falls incidents and their management/prevention
- Review of clinical pathways, where there is a potential risk to the quality and safety of patient care
- Monitoring of the Regulation 28 Report relating to the nutritional management of an inpatient in GGH
- Any items for consideration/monitoring requested by QSEAC

Argymhelliad / Recommendation

To endorse the Operational Quality, Safety and Experience Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Operational Quality, Safety and Experience Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Operational Quality, Safety and Experience Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Operational Quality, Safety and Experience Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	SBAR template in use for all relevant papers and reports.

Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Operational Quality, Safety and Experience Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Operational Quality, Safety and Experience Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Medicines Management Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr D Ratnasinghe, Consultant Paediatrician (Chair)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jenny Pugh-Jones, Head of Medicines Management

Pwrpas yr Adroddiad **Purpose of the Report**
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Medicines Management Sub-Committee Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee. The Medicines Management Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub- Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Medicines Management Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is:

- to provide assurance to the Quality, Safety & Experience Assurance Committee that robust arrangements are in place for the delivery of safe, effective, evidence-based medicines management across the Health Board and
- to develop the strategy for medicines management focused on improving clinical outcomes, patient experience and reducing unwarranted clinical variation.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of safety and quality, and the adequacy of the scrutiny and assurance in place.

Asesiad / Assessment

The Medicines Management Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the Medicines Management Sub-Committee were subsequently approved at its meeting on 19th September 2018.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's medicines management, ensuring that there is an accurate reflection of the key risks, issues and arrangements to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the medicines management agenda for the Quality, Safety & Experience Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the medicines management agenda against the following areas of responsibility:

- robust arrangements are in place for the delivery of safe, effective, evidence-based medicines management across the Health Board
- develop the strategy for medicines management focused on improving clinical outcomes, patient experience and reducing unwarranted clinical variation.

Medicines Management Sub-Committee Groups

The Groups reporting to the Medicines Management Sub-Committee during 2018/19 were as follows:

- **Medicines Formulary & Guidance Review Group** – established to:
  - provide recommendations to MMSC on the adoption of guidance on all prescribing and medicines management issues, including those relating to National Institute for Health and Care Excellence (NICE) Technology Appraisals and All Wales Medicines Strategy Group (AWMSG) recommendations and on the management of the HDdUHB Formulary and applications for new medicines

- **Patient Group Directions Group** – established to:
  - provide assurance that governance arrangements are operating effectively with regard to the development, approval and audit of Patient Group Directions across the Health Board.

- **Thrombosis Group** – established to:
  - advise on the implementation of best practice in relation to the prevention and treatment of thrombosis as set out in its Terms of Reference
  - provide assurance practice in relation to the prevention and treatment of thrombosis
  - be responsible for the Health Board's Thrombosis Policy and Prescribing Information.

- **Pain Management Group** – established to:
  - advise on the implementation of evidence based practice in relation to Pain Management (mainly acute) as set out in its Terms of Reference
  - provide assurance that pain is managed in accordance with legislation and best-practice guidance.

- **Medicines Event Review Group** – established to:
  - monitor medicines management incidents, identify trends and risk-minimisation strategies
  - communicate to the service both risks and preventative measure as set out in its Terms of Reference
  - provide assurance that a robust risk-minimisation strategy for medication incidents is in place
  - respond to advice from national bodies and other guidance e.g. WG, NICE, MHRA, National Service Frameworks and National Patient Safety Agency (NPSA) that involve medicines.

- **Local Intelligence Network Group** – established to:
  - advise the Health Board and the Accountable Officer on the management, use and monitoring of Controlled Drugs used within the Health Board as set out in its Terms of Reference
  - provide assurance that Controlled Drugs used within the Health Board are used in accordance with legislation and best-practice guidance.

- **Financial Planning and Horizon Scanning Group** – established to:
  - provide information, monitor and provide analysis on medicines expenditure across the Health Board and future medicines under development which will have an impact on the Health Board in the future
  - to review the impact of high cost drugs through horizon planning and in relation to the clinical and financial impact of new medicines on a monthly basis.

The Medicines Management Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution
From the terms of reference approved on 19th September 2018, the membership of the Sub-Committee was agreed as the following:

- Chair - Medical Associate Medical Director – Quality & Safety
- Head of Medicines Management - Vice Chair
- Assistant Director of Nursing
- Assistant Director of Therapies & Health Science
- Acute Services Lead for Pharmacy
- Lead for Pharmacy and Medicines Management - Primary Care
- Head of Financial Planning (Medicines Management)
- Acute Care Medical representative (2)
- Lead Nurse for Planned and Unscheduled Care
- Lead Site Nurse (representation on rotation)
- Senior Nurse Medicines Management
- Primary Care Medical Representative (2)
- Medicines Safety Officer
- Antimicrobial Stewardship Representative
- Clinical Development Pharmacist
- Pharmacy Site Manager (1)
- Independent Member
- Core Group Representatives (Patient Group Directions, Local Intelligence Network, Thrombosis , Medicines Event Review Group and Acute Pain Management)*
  *May also be core member

Meetings
Since April 2018, Medicines Management Sub-Committee meetings have been held on a bi-monthly basis as follows:

25th April 2018	22nd November 2018
11th July 2018	30th January 2019

19th September 2018 27th March 2019

As the Medicines Management Sub-Committee is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on 6 occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Medicines Management Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

- Monitor variation in prescribing practice through national prescribing indicators and similar benchmarking tools, and to develop plans to address any variations identified.

- Oversee actions related to any Patient Safety Alerts/Patient Safety Notices that relate to Medicines Management.

- Provide assurance to QSEAC that the risks related to Medicines Management are being managed effectively by monitoring the risks, considering proposed mitigations and alerting QSEAC when necessary.

- Oversee the development of policies and guidance and to advise on the safe, rational, effective and prudent use of medicines, and to inform and endorse the Health Board's Strategy on Medicines Management.

- Assure itself that written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it, and to provide evidence of that assurance to the Clinical Written Control Documentation Group when recommending a procedure or guideline for uploading or a policy for final approval by the Clinical Written Control Documentation Group.

Feedback from Groups
In terms of feedback from Groups:

- **Medicines Formulary & Guidance Review Group** – written update reports from the Medicines Formulary & Guidance Review Group (MFGG) highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:
  - MFGG was reconvened in June 2018 and 5 meetings have been held.
  - Medical representation has been lacking and the Medical Director will be approached for nominations, whilst nursing representation has been good.
  - MFGG evaluated 36 applications and made recommendations to MMSC.

Approved	21
Not approved	3
Reclassification	7
Deletion	5
Total	**36**

The formulary status of the recommendations were as follows:

Green (1st line including GP)	7
Blue (2nd line including GP)	5
Specialist Recommendation	2
Specialist Initiation	11
Hospital Only	6
Non-Formulary	9
Total	**40**

[This number is higher as other items were deleted when other medicines were accepted**]**

- **Guidance (Policies/Guidelines/Prescribing Information) considered.**
  - Emollient Formulary for primary and secondary care
  - Delirum Pathway and Guideline subject to clarification following NICE removal of olanzapine from their guidance.
  - Primary Care non-acceptance of prescribing Form
  - Adverse Drug Reaction Label
  - Proton Pump Inhibitor Leaflets
  - Decision Support Aid DVT & PE using NOACs
  - Common Drug Interactions with Statins
  - Administration of Magnesium Sulfate 10% in pre-eclampsia
  - Prescribing Decision Support Aid for DVT or PE using NOACs
  - Co-trimoxazole use in pregnancy & breastfeeding Review
  - Enabling Early Medical Abortion in the Home Setting Policy
  - Gentamicin Prescribing Label Neonates
  - Adult Asthma guidelines
  - Just In Case Guideline (to be renamed procedure)
  - Procedure and guidance for the use of clozapine
  - Low Value Medicines SOPs for the Primary Care MM Teams
  - Co-trimoxazole Group Unlicensed Form
  - Rib Fracture Management Guideline
  - Tinzaparin for Medical Prophylaxis (except for maternity)
  - SBAR Dose escalation of Biologic Therapies for Psoriasis
  - Adult IV administration guide for ferric carboxymaltose (Ferinject°□) (Maternity)
  - Variable Rate Insulin Infusion Prescription Label
  - Eye Clinic Eye Drop prescription labels
  - Fentanyl PCA prescription label change

- **Antimicrobial Guidance**
  - Antimicrobial guidelines: Treatment of infective exacerbation of COPD in secondary care

- Antimicrobial guidelines: Antibiotic guidelines for the medical management of miscarriage
- Antimicrobial guidelines: Meropenem Form
- Long term Antibiotic SOP
- Chlamydia (update)
- Antimicrobial guidelines: SBAR Insect stings and bites
- Antimicrobial guidelines: Primary Care Empirical UTI Guidelines
- Paediatric antibiotic guideline
- Antimicrobial Guidelines Lacerations
- Co-trimoxazole Group Unlicensed Form

- **Patient Group Directions Group** – written update reports from the Patient Group Directions Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:

  - Revising and updating existing Patient Group Directions (PGDs) (94 and the Community Pharmacy Common Ailments Scheme PGDs)

  - Rationale for development of PGDs approved:
    - Lidocaine 4% (LMX4) for use as a local anaesthetic cream for use in the paediatric service for cannula siting preoperatively.
    - A rationale was submitted outlining the request to develop a number of eye drop PGD's for use on cataract surgery patients attending the ward on the day for surgery who are already listed for surgery
    - Treatment of urinary tract infections and to administer trimethorpim within the Tenby minor injuries unit (MIU) and walk in centre.
    - Sexual Health: Fluconazole 150mg stat dose for acute vaginal candida instead of Clotrimazole

  - PGD development requests not supported:
    - Treatment of urinary tract infections and to administer nitrofurantoin within the Tenby minor injuries unit (MIU) and walk in centre.
    - Fentanyl, midazalom, xyloclane and Naloxone within the endoscopy services(initially in WGH).

  - An e-learning package related to PGDs is currently being developed by Members of the PGD Group and will shortly be available for staff via ESR.

- **Thrombosis Group** – written update reports from the Thrombosis Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:
  - **Review and updating of the Venous Thromboembolism (VTE) risk assessments forms**.
  - **Omission of doses of thromboprophylaxis**. These have been noted in a review of a Hepatic Artery Thrombosis (HAT). The national redesign of the in-patient administration chart may also be a contributory factor. The reasons for omissions may not be coded accurately on the in-patient administration chart which is audited monthly as part of the Medication Safety Audit (MSA).
  - **Tinzaparin for medical prophylaxis.** The Thrombosis Group has approved the use of tinzaparin instead of enoxaparin with an exception for obstetrics.

- **Use of Octaplex.** Prothrombin Complex Concentrate (PCC) for Warfarin Reversal and in patients on New Oral Anticoagulant Drugs Procedure.
- Emergency management for patients on rivaroxaban, apixaban or edoxaban guideline.
- Terms of Reference, membership and the resources of the Thrombosis Group are being reviewed.

- **Pain Management Group**– written update reports from the Pain Management Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:
  - Rib Fracture Management Guideline.
  - Morphine sulphate 10mg in 5mL Standard Operating Procedure as in MMSC (18).
  - Developing HB guidelines for the treatment of Acute Pain and Chronic Pain.

- **Medicines Event Review Group**– written update reports from the Medicines Management Review Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:
  - Development of the HB Gosport Report Action Plan.
  - Operational Improvement Plans from each site are being be submitted to MERG in detailing actions taken and lessons learnt in response to Datix medication incident reports.
  - Datix reports of insulin being administered using incorrect syringes has been addressed by a bulletin and specialist diabetes nurse training.
  - All Wales medication safety audit report –data submission errors.
  - Concerns expressed regarding the equity of approach between professions in dealing with medication errors.
  - Datix reports of furosemide being administered incorrectly has been addressed by a bulletin.
  - Following audit results reported to MERG, the Medical Director contacted all doctors to remind them that legally all prescriptions have to be signed prior to administration.

- **Local Intelligence Network**– written update reports from the Local Intelligence Network highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:
  - Working with MERG to ensure all Datix incidents involving controlled drugs are investigated whilst avoiding duplication.
  - Contributed to the development of the HB Gosport Report Action Plan.
  - Revised their Terms of Reference and revised Membership.
  - Development of a multi-agency Information Sharing Protocol.
  - Monitoring of the development of a HB process for approving requests for prescribing cannabis-based medicinal products.
  - Endorsed the Welsh Ministry of Defence (MOD) use of Generic Controlled Drugs (CD) Prescriptions.

- **Financial Planning and Horizon Scanning Group**– written update reports from the Financial Planning and Horizon Scanning Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been

regularly received by the Medicines Management Sub-Committee during 2018/19, including the following:

- Development of a more formal process for horizon scanning for medicines.
- Horizon Scanning Report 2019-2020 - with a projected cost pressure from new medicines and indications estimated at £4.6M for 2019-2020 and £1.6M for the full-year effects of medicines already approved under the New Treatment Fund.

Other Areas of Responsibility

During 2018/19, the Medicines Management Sub-Committee also received, and considered the following:

- **Service Development**
  - Gluten-Free Food (GFF) Project Roll Out
  - Lymphoedema Compression Garments-Prescribing/Procurement process Redesign
  - HDdUHB Action Plan for AWMSG: Medicines Identified as Low Priority for Funding in NHS Wales-Paper 2
  - HDdUHB Primary Care Medicines Management Workplan and Standard Operating Procedures (SOPs) 2019-2020
  - Prescribing Management Scheme (PMS) 2018-2019
  - Anti-microbial Quality Dashboard

- **Governance**

  Medicines Policy - full revision and updates:
  - Medicines Policy: Dose ranges for continuous subcutaneous infusions (addition)
  - Medicines Policy: Guidelines for the Self Administration of Inpatients' Own Medicines
  - Medicines Policy: Management of JIC boxes/bags in hospital and Loss of CDs in the Community
  - Medicines Policy: Unidentified suspicious substance Patient Letter and Transfer Form & ITU Storage amendment
  - Controlled Drugs Governance Policy
  - Review of the MMSC Terms of Reference
  - Incorporation of the Vaccination & Immunisation Committee as a sub-group of MMSC
  - Updated Denosumab Shared Care Protocol
  - CDAT Naloxone Procedure
  - Electronic Prescriptions Ophthalmology
  - Rapid Infusion for rituximab (off-label use)
  - Dose-banding and ready-prepared Infliximab for IBD (Adults only)
  - Morriston Renal Unit ESA (erythropoietin) Prescription/Administration Record for Community Use
  - Issue of WP10HPs for Hospital Only medicines Process
  - P&MM Clinical Audit Register
  - Melatonin group unlicensed form
  - Co-trimoxazole group unlicensed form
  - Ozurdex Risk Assessment Form, Patient Information and Consent Form
  - Pharmacists Writing in Clinical Health Records (Medical Notes) Procedure

- **Monitoring:**
  - Closure of WHC (2017) 026 Co-proxamol

- Closure of PSN028 Medicines Reconciliation
- Closure of WAO Medicines Management in Acute Hospitals Report
- Monitoring compliance with CEM CPhA 2018 016c Valproate Pregnancy
- WHC 2018 039 - The Rescheduling of Cannabis
- Letter to GPs, Community Pharmacy & Independent Prescribers & patients. Development of HDUHB Cannabis-based Medicinal Products Access Process

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- PSN 030 Medicines Storage Update
- Medicine Shortages
- New Risk: RR681 Updating infusion pump libraries
- RR553 Falsified Medicines Directive
- RR374:Aseptic Units
- Brexit Risk-Assessment

Matters Escalated to Quality, Safety & Experience Assurance Committee
During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- Ozurdex Risk Assessment Form and Consent
- Gentamicin Prescribing Label Neonates
- 'Off-label' rapid infusion of biosimilar rituximab Group Unlicensed Form
- Melatonin Group Unlicensed Form
- Co-trimoxazole Group Unlicensed Form
- Replacement of Pharmacy Computer System and Introduction of e prescribing system
- Medical Prescribers not signing prescriptions
- Dose Escalation of Biological Therapies for Psoriasis (unlicensed dose)
- Clostridium difficile infection (CDI) Treatment Guideline

Medicines Management Sub-Committee Developments for 2019/20
The following developments are planned for the Medicines Management Sub-Committee during 2019/20:

- Approval of the HDdUHB Pain Guidelines for Chronic, Acute and Palliative Pain Guidelines (including neuropathic pain) and incorporation of existing guidance.
- Approval of the HDdUHB Thrombosis Policy and incorporation of existing guidance as appendices.
- Approval of the HDdUHB Injectable Medicines Policy.
- Completion of first MMSC Committee Effectiveness Review.

Argymhelliad / Recommendation

To endorse the Medicines Management Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Medicines Management Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Medicines Management Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Medicines Management Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Medicines Management Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Medicines Management Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health and Learning Disabilities (MHLD) Services Quality, Safety and Experience Sub-Committee (QSESC) Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape – Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Liz Carroll – Interim Director Mental Health and Learning Disabilities

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the MHLD Quality, Safety & Experience Sub-Committee Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee. The MHLD Quality, Safety & Experience Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the Terms of Reference for the MHLD Quality, Safety & Experience Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to focus on quality and safety governance arrangements at an operational level bringing together accountability and ownership for those quality and safety issues that can only be resolved operationally, freeing up the Quality, Safety and Experience Assurance Committee to be more strategic in its approach.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of quality and safety governance arrangements, and the adequacy of the scrutiny and assurance that is in place.

Asesiad / Assessment

The MHLD Quality, Safety & Experience Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 29th March 2018. The terms of reference of the MHLD Quality, Safety & Experience Sub-Committee were subsequently approved at its meeting on 16th October 2018.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's governance and assurance arrangements, ensuring that there is an accurate reflection of key risks and issues for the service and assurances around actions that are being taken to mitigate those risks from a quality, safety and experience assurance perspective to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the MHLD Directorate's agenda for the Quality, Safety & Experience Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the MHLD agenda against the following areas of responsibility:

Performance

- Monthly Monitoring of Delayed Transfers of Care
- Monthly Monitoring of Mental Health Outpatient Waiting Times
- Monthly Monitoring of Mental Health Therapy Waits over Fourteen Weeks
- Monthly Monitoring of Compliance with the Performance Indicators in relation to the Mental Health (Wales) Measure 2010
- Quarterly Targets for Substance Misuse Services

The above Performance Indicators are submitted to the monthly Directorate Business Planning and Performance Assurance Group (BPPAG) with an overarching report to the MHLD Quality, Safety & Experience Sub-Committee. The focus of the Sub-Committee is in relation to the services ability to deliver against them and what is being done to enhance performance in order to minimise the impact on the quality of service that is being delivered to Health Board residents.

Compliance

- Compliance with relevant HealthCare Standards
- Outcomes of the Fundamentals of Care Reports
- Presentation of the Annual Fundamentals of Care Reports

Action Plan Delivery

- Each Head of Service provides a Service Report covering areas such as, clinical governance /risk management, workforce development and clinical practice/service developments
- Healthcare Inspectorate Wales (HIW) Action Plans
- Delivery Unit (DU) reviews and associated Action Plans
- Action Plans arising from external reviews
- Royal College Reviews
- Welsh Government Requirements

Risk Management

The Directorate has continued to develop and refine the Risk Register for the service. The Directorate BPPAG is where risk register activity is monitored and reviewed and items that are contained within the Risk Register are used to inform the agenda for the monthly BPPAG meetings. The service also carries risk registers and sessions have been provided both within the service and from the Corporate Governance Team throughout the year on risk register development.

Concerns Management

- Complaints
- Ombudsman

- Serious Untoward Incidents (SUIs)
- Datix
- Claims

Considerable work has been undertaken to improve performance in meeting the target requirements for the closure of complaints, Serious Untoward Incidents (SUIs) and Datix during the year with weekly reports being provided in order that increased scrutiny around performance can be undertaken by each service area. The Directorate has also received support from the Assurance Safety and Improvement Team during the year and this has contributed significantly to the work undertaken in this area by the Directorate.

Sub-Committee Groups
The Groups reporting to the MHLD Sub-Committee during 2018/19 were as follows:

- Clinical Incident Review Group
- NICE/Clinical Audit Support Committee
- Directorate Safeguarding Group
- Medication Optimisation Group

Health Board Wide Groups:

- Resuscitation/RRails Group
- Infection, Prevention and Control Group
- Nutrition and Hydration Group
- Mental Capacity Act and Consent Group

In addition to the above meetings the Directorate has a Quality, Assurance and Practice Development Team to strengthen the governance arrangements within the service. The team is working alongside the Heads of Service and has established assurance meetings to ensure that there is cross service learning from incidents and events and robust arrangements for the monitoring of action plans.

The MHLD Quality, Safety & Experience Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution
From the terms of reference approved in November 2018, the membership of the Sub-Committee was agreed as the following:

Head of Nursing, Mental Health & Learning Disabilities (Chair)
Associate Medical Director Mental Health & Learning Disabilities
Director Mental Health & Learning Disabilities
Independent Member
2 X Consultant Psychiatrists
Head of Adult Mental Health Services
Head of Learning Disabilities and Older Adult Mental Health Services
Head of Commissioning
Head of Clinical Innovation and Strategy
Head of Child & Adolescent Mental Health Services and Psychological Services
Senior Nurse, Quality Assurance & Professional Practice
Professional Lead for Psychology and Psychotherapy

Patient Support Services
Ombudsman Liaison
Legal Services Manager
Clinical Effectiveness Coordinator
Clinical Audit Facilitator
Patient Experience Manager
Infection Control
Service Lead Occupational Therapy Mental Health

Meetings
MHLD Quality, Safety & Experience Sub-Committee meetings have been held on a bi-monthly basis as follows:

- 14th May 2018
- 9th July 2018
- 10th September 2018
- 12th November 2018
- 21st January 2019
- 12th March 2019

As the MHLD Quality, Safety & Experience Sub-Committee is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on six occasions and was quorate at all meetings except for July 2018.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the MHLD Quality, Safety & Experience Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

Reports were received from the following Groups:

- Resuscitation/RRAILS Group
- Infection Prevention & Control Group
- Nutrition & Hydration Group
- Mental Capacity Act & Consent Group

and the following Directorate Sub-Groups:

- Clinical Incident Review Group
- NICE/Clinical Audit Group
- Directorate Safeguarding Group
- Medication Optimisation Group

The following issues were brought to the attention of QSEAC and assurance provided that the Sub-Committee was monitoring and taking action to address these:

- Health Care Standards 2018 annual audit in MHLD in patient units.
- Wales Applied Risk Research Network (WARRN) risk assessment training and progress towards sole use of the WARRN Risk Assessment Tool across the Directorate.

- In line with the Mental Health (Wales) Measure 2012 Care and Treatment Planning (CTP) an audit tool has been developed and rolled out to the Directorate in 2018/19.
- Carers' involvement, Investors in Carers Bronze award achievements and service committed to progress towards Silver level.
- Further development of the electronic patient record system (Care Partner) and provision of training and compliance.
- Service provision of clinical supervision of Health Care Support Workers and progress towards developing an inclusive written control document.
- Falls audit and impact on capital funding for improvements.
- Autistic Spectrum Disorder assessments are now included on a database and work is in progress to further integrate services to further the integration across services for an age inclusive service in line with the National work and Integrated Autism Service (IAS) strategy.
- Number of staff trained in Root Cause Analysis investigation where further progress has been made to identify additional Investigators and provision of training to support investigations.
- Waiting times for therapies has been addressed and a structured plan is in place in line with the national performance targets.
- Endorsement of the proposed initiative to improve waiting times for Memory Assessment Services where progress continues.
- HIW Improvement Plans have been updated via Heads of Service alongside the corporate tracker, where compliance with the timescales that have been identified on the Directorate HIW Improvement Plans, with the Sub-Committee continuing to monitor the agreed time scales.
- A work plan has been established to address a number of issues that have arisen through the Restricted Physical Intervention (RPI) reports. This is to include service user feedback post RPI and will be anonymously referenced in future RPI reports. A RPI Task & Finish Group has been established to take forward actions identified under the RPI Improvement Plan.
- Integration of Specialist Mental Health Physiotherapy Services and Community Physiotherapy service in Pembrokeshire.
- The MH&LD Written Control Documentation Group has developed further to progress key written control documents for the directorate.
- The completion of commissioning reviews continues to improve and to date 100% of fully health funded CHC packages and 65% of joint funded have been reviewed in the last 12 months for both MH and LD service users. The NCCU reviews of LD placements has assisted in improving this position and has enabled greater resources to be focused on MH reviews.
- The Neurodevelopment Team have cleared the historic waiting list with all patients now in receipt of an assessment appointment which is in line with the planned trajectory. The service is looking at planning future service delivery and costing various options for achieving compliance with targets going forwards.
- Learning Disabilities Mortality Review (LeDeR) Programme Action Plan: the action plan was accepted by the Board and presented to the Quality, Safety & Experience Assurance Committee (QSEAC).
- Delivery Unit Action Plan: each service area has developed a service specific delivery plan that sits within the service. The assurance also sits with other groups, i.e. Transforming Mental Health and Learning Disabilities Programme Group.
- Bespoke Repatriation Pilot: The Steering Group, workstream leads and contributors have been working to ensure that the project remains on track to deliver identified savings, and that the service users will receive a quality service delivered closer to home.

- Self Assessment of Hywel Dda Older Adult Inpatient Services against the Recommendations of the Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: A Lessons for Learning Report: The report was presented in order to provide an overview of the required actions and recommendations following this report. The Ministerial Trusted to Care (TtC) Spot Checks was carried out in all 3 Older Adult inpatient areas within the Health Board in December 2014. Following these spot-checks action plans were put in place to address the areas for improvement highlighted by the review teams.

Feedback from Groups

In terms of feedback from Groups:

- Resuscitation/RRAILS Group - written update reports from the Resuscitation/RRAILS Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19, including the following:
  - Members were provided with an overview of the training courses that have been offered noting that training has been cancelled due to non-attendance at times, with Carmarthenshire having better attendance, primarily due to location.
  - The Resuscitation Policy has been finalised and taken to the Clinical Written Control Documents group where Members queried the storage of emergency drugs.
  - Regular updates relating to RRAILS to be shared at the MH&LD Ward Manager's Forum with a review after 6 months to consider whether the forum is reflecting an improvement and providing assurance that compliance issues are being addressed.

- Infection Prevention & Control Group - written update reports from the Infection Prevention & Control Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19.

- Nutrition & Hydration Group - written update reports from the Nutrition & Hydration Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19.

- Mental Capacity Act & Consent Group - written update reports from the Mental Capacity Act & Consent Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19, including the following:
  - Highlights include training for staff and the indication by Workforce & OD that there are insufficient resources in the Learning and Development Team to enable Prevention and Management of Violence & Aggression (PAMOVA) training to be made mandatory for staff on general wards. The Consultant Psychiatrist on the Group highlighted the Mental Capacity Act (Amendment) Bill [MCAA] which will replace the Deprivation of Liberty Safeguards (DoLS) with the Liberty Protection Safeguards which is currently going through the House of Lords.
  - the annual board-wide consent audit was undertaken in June 2018 with examples of improvement being found in several areas
  - A comprehensive programme of consent, MCA and DoLS training continues to be provided.

In terms of feedback from the following Directorate Sub-Groups:

- Clinical Incident Review Group - written update reports from the Clinical Incident Review Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19, including the following:
  - It was highlighted that attendance at the CIRG meetings needs to be improved.

- NICE/Clinical Audit Group - written update reports from the NICE/Clinical Audit Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19, including the following:
  - Highlights include a lack of progress with the Group and that the Terms of Reference require reviewing.

- Directorate Safeguarding Group - written update reports from the Directorate Safeguarding Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19, including the following:
  - The Sub-Committee was advised of limited attendance at the Safeguarding Group meeting despite previous requests for improved attendance having been made. Members were reassured that safeguarding concerns are discussed directly with Heads of Services and that there is a strong working relationship with the Health Board's Safeguarding team. A commitment was made by the members to ensure that representation is prioritised at Group meetings in future.

- Medication Optimisation Group – No written update reports from the Medication Optimisation Group were received by the MHLD Quality, Safety & Experience Sub-Committee during 2018/19. This has been largely due to service pressures for pharmacy. It is anticipated that the additional posts that the Directorate have created through Transformation and Innovation funds will assist in resolving this.

Key Risks and Issues/Matters of Concern

During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- During 2018/19, inpatient capacity and high levels of bed occupancy in adult mental health services continue to be robustly scrutinised to monitor demand across our service areas. The Sub-Committee continues to report to the QSEAC and escalate as required.
- Recruitment challenges across the Directorate in a number of key areas such as medical and nursing remains a concern and is closely monitored, although assurances have been received due to a number of positive recruitment campaigns. However, medical recruitment remains an area of significant challenge.
- Learning Disabilities registered nurses are also an area of potential recruitment challenges due to the high numbers of staff who are nearing or at the eligible age of retirement. The Directorate has a number of plans in place to mitigate the impact of this.
- A report on the Fragility of Mental Health services updated QSEAC on the current risks the Directorate encounters in order to provide assurance that escalation processes are in place to manage those risks.
- Vagal Nerve Stimulation (VNS) Device Monitoring: The Sub-Committee received the VNS device monitoring report, noting that VNS monitoring had previously been

undertaken within Hywel Dda UHB by an Epilepsy Clinical Nurse Specialist, however since their departure in 2017, there has been a gap in service provision pending recruitment into the post. This has resulted in a lack of monitoring for some clients. An agreement has been received from Abertawe Bro Morgannwg University Health Board (ABMUHB) regarding the establishment of a Service Level Agreement to deliver VNS follow-ups for individuals.

- The service is facing some key IT Infrastructure issues**.** It was noted that the poor and ageing IT infrastructure is identified within the Risk Register. However, it also needs to include reference to the risk with having a number of different systems in operation.. A comprehensive reporting-system is required from Care Partner rather than an information-storing system. This is being progressed through the informatics group.
- Positive Behaviour Management (PBM). Members received a report on Positive Behaviour Management and were reminded that due to the PBM trainer shortly retiring from the Health Board, there is a concern that this will cause a gap in training. Members noted that a national working group is currently developing a new training programme which will be align with relevant NICE guidance, with updates of the all Wales passport training modules to follow. The Positive Behaviour Management Policy requires updating and the RPI Task & Finish Group is working with the Clinical Practice Development Nurse/Lead PBM Trainer to progress this.
- Review of Directorate Clozaril Monitoring: Members noted that investment is required into the pharmacy workforce and there needs to be uniformity for the provision of clozaril monitoring for the service. Members were advised that bids have been submitted for transformation and innovation funds in addition to requests to Welsh Government for non-medical prescribers. This would allow locality based pharmacists to be present within the HB.
- Bespoke Repatriation Project: A risk has been identified to the project success in relation to the approval of the purchase of an updated version of STORM. The latest version of STORM is required for staff to deliver the training to teams. This will provide staff with the appropriate skills to manage the highly complex individuals being repatriated. There has been a delay with purchasing STORM with a resolution being explored via the Business, Planning, Performance and Assurance Group (BP&PAG) structure.
- Waiting Times Initiative for ASD: The ASD recovery plan is on track to deliver on the historic waits in line with the planned trajectory however, whilst this is being addressed, there is an increasing demand for new referrals and the current Integrated Service will not be able to meet demand within current allocated resources. This is an issue which needs to be escalated for senior management and the Health Board to consider and plan future service delivery.

Matters Escalated to Quality, Safety & Experience Assurance Committee

During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- Sustained pressures within adult mental health inpatient services.
- Recognition and endorsement of the MHLD Written Control Documentation Group (WCDG).

MHLD Sub-Committee Developments for 2019/20

The following developments are planned for the MHLD Quality, Safety & Experience Sub-Committee during 2019/20:

- A review of all Mental Health placements is due next year; meetings between the Commissioning team and Adult Mental Health (MH) colleagues are ongoing to strengthen processes in regard to individual patient commissioning for secure services.

This includes the development of a pathway for secure services, clarity on care co-ordination, 'move on' plans and engagement in Care and Treatment Plan reviews.
- Informatics work plan to continue to be progressed.
- Continuation of Care and Treatment Plan (CTP) audit and training cycle.
- Compliance with mandatory training will continue to be monitored and reported through the integrated dashboard.

Argymhelliad / Recommendation

To endorse the Mental Health and Learning Disabilities (MHLD) Quality, Safety & Experience Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.2 Provide assurance to the Board that risks relating to quality, safety, statutory duty/inspection (and workforce/OD/staffing/competence and safeguarding via Sub Committees) are being effectively managed across the whole of the University Health Board's activities, including for hosted services, and through partnerships and Joint Committees. 10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Risk Register Reference:	Contained within the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	7. To improve the mental health and wellbeing of our local population through improved promotion, prevention and timely access to appropriate interventions.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of MHLD Quality, Safety & Experience Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety & Experience Assurance Committee:	MHLD Quality, Safety & Experience Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are financial impacts associated with the current risks, mainly in relation to variable pay – medical and nursing as well as an over-stretched commissioning budget. A sound system of internal control, as evidenced in the MHLD Quality, Safety & Experience Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from the report however impacts of each risk are outlined in the risk description.
Gweithlu: Workforce:	There is an impact for the work force as many of the risks are associated with recruitment challenges. The workforce will need to be redesigned on the basis of safe and sustainable staffing.
Risg: Risk:	The Directorate works continually to mitigate risks as the service needs evolve.

Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact. A sound system of internal control, as evidenced in the MHLD Quality, Safety & Experience Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the MHLD Quality, Safety & Experience Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No A full EqIA was undertaken on the Transforming Mental Health Programme of work

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Workforce and OD Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lisa Gostling, Director of Workforce & OD
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lisa Gostling, Director of Workforce & OD

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Workforce and Organisational Development Sub-Committee (WODSC) Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee (QSEAC). The WODSC Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the WODSC require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance to QSEAC on compliance with legislation, guidance and best practice around the WODSC agenda.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of Workforce and OD, and the adequacy of the scrutiny and assurance in place.

Asesiad / Assessment

The WODSC has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 29th March 2018. The terms of reference of the WODSC received their annual review at its meeting on 19th March 2019.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's workforce, ensuring that there is an accurate reflection of key risks, issues and arrangements to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the WODSC agenda for the Quality, Safety & Experience Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the Sub-Committee's agenda against the following areas of responsibility:

- Monitor and oversee the development of the values and vision of the Health Board.
- Oversee the development and deliver of an implementation plan for the workforce and OD strategy
- Monitor operational performance to ensure the sustainability of current and future workforce models.
- Monitor key workforce savings targets and productivity measures
- Monitor employee relations activity across the organisation to identify trends and agree relevant strategy for issues identified
- To ensure robust mechanisms are in place to deliver effective staff engagement and an organisational culture of effective leadership, innovation and continuous improvement.
- Oversee the management of performance issues for all clinical staff, including primary care
- Provide assurance to the Board that risks relating to workforce, OD, staffing, competence, etc are being effectively managed across the whole of the Health Board's activities (including in primary care, for hosted services and through partnerships and Joint Committees)
- Proactively address the educational needs of the current future workforce
- Assure the quality, accuracy and integrity of workforce planning and redesign processes (including medical workforce planning)
- To monitor, review and implement Welsh Government and external Workforce & OD initiatives.
- To consider internal and external workforce reports, audits and reviews and monitor the delivery of subsequent action plans.
- Provide assurance of workforce data quality.
- Develop OD and HR strategies to support redesign. To support the University Partnership Board Committee agenda by ensuring workforce development occurs in line with work programme.
- Consider and approve Workforce Policies.

Workforce & Organisational Sub-Committee Groups

The Groups reporting to the WODSC during 2018/19 were as follows:

- **Strategic Workforce Development Group** – established to: provide a forum which is tasked with reviewing all aspects of workforce development, encompassing:
  - Workforce Planning
  - Education and Training
  - Service development / change
  - Modernisation and practice including new role development
  - Specific professional standards and practice and
  - Productivity, efficiency and sustainability

  Identifying where there are opportunities to refine current workforce models, systems and processes, to deliver the most sustainable high quality service for our healthcare community through a robust University Health Board (UHB) workforce plan.

- **Volunteering for Health Governance Group** – established to: provide strategic direction for Volunteering for Health and develop and monitor governance arrangements, comprising:
  - Overseeing the development of both the long term vision and the annual work programme for the service which aims to ensure the widest possible benefits across the whole of the UHB.
  - Providing guidance and input into the services and planning systems to ensure that volunteering opportunities are considered at all times.
  - Proactively encouraging the effective engagement of all UHB services with volunteering.
  - Providing assurance to the UHB relating to the added value of the service – both quantitative and qualitative.
  - Recognising opportunities for new funding steams to support the service workplan and the UHB.

- **Colleague Experience Group** – established to: provide leadership and support to the UHB in facilitating the health and well-being of staff as an integral part of its corporate objectives. It carries this out by:
  - Supporting the implementation of any location actions arising for the Welsh Government's Health Working Wales Programme.
  - Continuing to maintain evidence to ensure re-validation of the Corporate Health Standard gold and platinum awards for future re-validations.
  - Supporting the implementation of any actions arising from the UHB's Integrated Medium Term Plan (IMTP).
  - Managing the implementation of the agreed action plan to support delivery.
  - Demonstrate a commitment to UHB Values and Behaviour Framework to support the health and well-being of staff.

- **Workforce Information Systems Programme Group** – established to: agree the strategy for workforce information management systems within the UHB by:
  - Providing vision, strategic direction, guidance and support in maximising the benefits of Employee Self Service on the Electronic Staff Record (ESR)and related workforce systems within the UHB.
  - Promoting the significance and benefits of workforce information systems at all levels.
  - Driving the Workforce Information Systems (WfIS) programme forward, and in particular the Hire to Retire workstream, to ensure delivery of outcomes and benefits:-
    - Producing high quality workforce information
    - Reducing transactional costs
    - Establishing interfaces between ESR and other electronic workforce systems
    - Increasing productivity through process redesign
  - Reviewing resource for any workforce systems implications of projects and agreeing the most appropriate forum for debate.

- **Medical Education Group** – established to: provide assurance to the WODSC on compliance with the Service Level Agreements with the Deanery for Postgraduate Medical Education, and with the Welsh Government for the placement of Medical students from both Cardiff and Swansea Medical Schools; by:
  - Producing, implementing and monitoring an educational governance strategy for the provision of medical and dental education and training.

- Creating a unified and co-ordinated approach to medical and dental postgraduate/undergraduate education to ensure the process of programme delivery and quality control of training are standardised and reporting in a similar way enabling cross referencing between sites.
- Aligning medical training and education with the service objectives as defined by the Health Board.
- Monitoring financial performance against Deanery and SIFT budgets.
- Monitoring the Deanery Risk Register and ensuring implementation of appropriate management actions.
- Discussing new developments in Medical Education, reviewing progress against medical education projects and implementation programmes.
- Sharing good practice and solving common issues around the Quality agenda.
- Reviewing Deanery and Medical School initiatives and policies to ensure Health Board compliance.
- Considering relevant internal and external reports, audits and reviews and monitor the subsequent action plans.

- **Mandatory Training Steering Group** – established to: provide the mechanism for the identification of mandatory training requirements to enable the UHB to prioritise the delivery of statutory, mandatory and patient safety training activity, ensuring that resources are targeted effectively and allowing the organisation to meet its legal and clinical governance responsibilities; by:
  - Establishing the required systems and processes to support identification, development, monitoring and evaluation of statutory, mandatory and patient safety training initiative;
  - Agreeing the appropriate delivery mechanisms by which these programmes can be made available.

The WODSC Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution
From the terms of reference approved in March 2019, the membership of the Sub-Committee was agreed as the following:

Title
Director of Workforce & OD (Chair)
Assistant Director of Workforce (Vice-Chair)
Independent Member (Trade Union)
Director of Mental Health & Learning Disabilities
County Director & Commissioner x 1
Health Board wide General Manager x 1
Unscheduled Care General Manager x 1
Trade Union Chair, Ceredigion Partnership Forum
Trade Union Chair, Carmarthenshire Partnership Forum
Trade Union Chair, Pembrokeshire Partnership Forum
Director of Estates
Assistant Director of Finance (Sustainability)
Assistant Director of Informatics

Assistant Director of Nursing (Practice)
Assistant Director of Primary Care
Assistant Director of Therapies & Health Science
Associate Medical Director (Workforce)
Head of Medicines Management
Consultant in Public Health

Meetings
Since April 2018, WODSC meetings have been held on a bi-monthly basis; unfortunately one meeting in November 2018 had to be cancelled due to non-quoracy. The meetings which were held were as follows:

- 17th May 2018
- 5th July 2018
- 14th September 2018
- 17th January 2019
- 19th March 2019

As the WODSC is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on five occasions and was quorate at all five meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the WODSC has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

Monitor and oversee the development of the values and vision of the Health Board

- The Sub-Committee received an update on the implementation of the Health Board's Values and Behavioural Framework two years following implementation to monitor progress and actions. Linked to this, the staff survey results were also discussed by the Sub-Committee.

Oversee the development and delivery of an implementation plan for the Workforce and OD Strategy

- Each quarter the Annual Plan's implementation plan is received and reviewed by the Sub-Committee. Progress is noted and discussion held where the position has deteriorated.

Monitor operational performance to ensure the sustainability of current and future workforce models.

- Areas regarding workforce sustainability link to papers which were received from Mental Health and LD services regarding Workforce, Primary Care and Medicines Management workforce sustainability.

Monitor key workforce savings targets and productivity measures

- At each meeting, a bank and agency report is produced which highlights actions being taken at a corporate level to drive variable pay reduction.

Monitor employee relations activity across the organisation to identify trends and agree relevant strategy for issues identified

- Bi-annually, an Employee Relations report is produced for scrutiny. These reports analyse volume of cases, outcomes, and consistency across services and trends.

To ensure robust mechanisms are in place to deliver effective staff engagement and an organisational culture of effective leadership, innovation and continuous improvement.

- The OD team produced regular reports to highlight activity across the Health Board, including an update on the launch of Hywl Innovate Hub.

Oversee the management of performance issues for all clinical staff, including primary care

- At each meeting a Workforce Information report was presented which monitored progress against a number of measures, including personal appraisal and development reviews (PADR), mandatory training and sickness absence. It has been pleasing to note the following improvements:-
    - PADR 75% February 2019 compared to 64% in January 2018 (Wales 69%)
    - Mandatory Training 78.6% February 2019 compared to 64% January 2018 (Wales 77%)
    - Sickness Absence Actual in month 4.88% compared to 4.97%; Rolling average 5.2% January 2019 compared to 6.31% January 2018 (Wales 5.31% Actual)

Provide assurance to the Board that risks relating to workforce, OD, staffing, competence, etc are being effectively managed across the whole of the Health Board's activities (including in primary care, for hosted services and through partnerships and Joint Committees)

- Each Sub-Committee meeting received the revised Workforce and OD Risk Register. This has been challenging however a clear view is now held on workforce risks and how these will be managed and scrutinised moving forward.

Proactively address the educational needs of the current future workforce

- Progress relating to this area of responsibility has not been as required. Updates are received from Sub Committees and via the workforce section of the Annual Plan. A Higher Awards report was discussed in September 2019. This will feature more regularly in 2019/20.

Assure the quality, accuracy and integrity of workforce planning and redesign processes (including medical workforce planning)

- The Annual Plan was presented in draft form and approved for comment together with quarterly progress reports. In addition, the Sub-Committee received updates on schemes to develop our workforce.

To monitor, review and implement Welsh Government and external Workforce & OD initiatives.

- The Sub-Committee, via the Wfis Group, has overseen the successful implementation of the paperless payslips programme.
  The Sub-Committee has also overseen the implementation of the Auto Allocation programme for student nurses.
  The Sub-Committee has also received regular updates regarding the 2018/19 pay deal including how pay progression would occur in 2019/20.

To consider internal and external workforce reports, audits and reviews and monitor the delivery of subsequent action plans.

- Throughout the year the Committee has considered the following reports:
    - Implications of the Nurse Staffing (Wales) Act
    - WAO Report relating to Temporary Staffing
    - HCPC Professional Registration
    - Internal Audit Report on Workforce Planning
    - Internal Audit Report Primary Care Workforce Plan

Provide assurance of workforce data quality

- The Sub-Committee received reports from the Workforce Information Systems Group which reviews data quality as part of their agenda. This group also led the implementation of paperless payslips.

Develop OD and HR strategies to support redesign. To support the University Partnership Board Committee agenda by ensuring workforce development occurs in line with work programme.

- The Sub-Committee received a Draft Retention & Attraction Strategy to support workforce design linked to the Health & Care Strategy.
  The Sub-Committee also receives reports at each meeting regarding Partnership Forum activities.

Consider and approve Workforce Policies.

The following workforce policies have been approved during 2018/19:

- Ordinary Parental Leave Policy
- Shared Parental Leave Policy
- Industrial Injury Claim Procedure
- Volunteer Policy
- General Data Protection Policy
- Maternity, Adoption and Paternity Leave Policy
- Psychological Wellbeing Policy
- Workforce Annual Equality Report
- All Wales Capability Policy and Procedure
- Study Leave documentation
- Employee References
- Time off for Medical & Dental Appointments
- NHS Wales Menopause Policy
- Alcohol, Drugs, Substance Mis-Use Policy

At the 19th March 2019 meeting, the Sub-Committee was asked for six month extensions to review dates on the following documents, pending receipt and review of updated All Wales Guidance documentation:

- 443 All Wales Pay Progression Policy
- 130 All Wales Dignity at Work policy
- 202 All Wales Dress Code
- 465 All Wales Social Media Policy
- 348 All Wales Reserves Forces Training and Mobilisation Policy
- 142 All Wales Grievance Policy
- 204 All Wales Secondment Policy

And six month extensions pending completion of a full review:

- Rostering Policy
- Guidance on Referral of Employees to the Occupational Health Service
- Preceptorship Foundation Policy for Newly Qualified Nurses

A policy relating to Personal Employee Records Management was received however not approved as it was believed more actions required progressing prior to implementation.

Feedback from Groups

In terms of feedback from Groups:

- **Strategic Workforce Development Group** – written update reports highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the WODSC during 2018/19, including the following:
  - Continual improvement in PADR and mandatory training performance was highlighted.
  - Sickness absence showed a decrease between June and July 2018 with performance noted as stable. In January 2019, long term sickness since November 2018 reduced to 3.13%, the lowest rate reported in the 12 month period.

The Group has not yet produced an annual report.

- **Mandatory Training Group** – written update reports highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the WODSC during 2018/19, including the following:
  - Continued compliance improvement was noted although further progress is required.
  - Display Screen Equipment safety training was included on the mandatory training register.
  - A report focused on a pilot programme to deliver work-based moving and handling training which showed improvements in compliance by 40%, completion of patient handling documentation, financial savings and patient and staff experience.
  - Aseptic Non Touch Technique (ANNTT) was supported for identified staff.

The Group has not yet produced an annual report.

- **Colleague Experience Group (amalgamation of the Health and Wellbeing Group and Anti Bullying Group)**– written update reports highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been received by the WODSC during 2018/19, and included the following:
  - Group membership was reviewed and the Health & Wellbeing and the Anti Bullying Groups merged to become the Colleague Experience Group which will meet bi-monthly from January 2019
  - Work on maintenance of staff hydration levels
  - 2018 NHS Wales Staff Survey
  - New NHS Wales products and toolkits
  - Psychological wellbeing activity reports and policy
  - Corporate Health Standard

The Group has not yet produced an annual report.

- **Medical Education Group** – written update reports highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the WODSC during 2018/19, including the following:
    - Health Education and Improvement Wales (HEIW) risk report showed 2 risks relation to Anaesthetics and General Surgery Foundation had been removed; a programme of work continues to improve this.
    - Concerns were raised about the availability of WiFi connection in hospital accommodation areas giving a negative effect on the ability to study and also to carry out general everyday activities including banking and social media. It was agreed that this could affect the Health Board's recruitment and retention of medical staff and students.
    - 2018 GMC National Trainee and Trainer Survey.
    - Physician Associates students.

The Group has not yet produced an annual report.

- **Volunteering for Health Group** – written update reports from the Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, were received by the WODSC during 2018/19, including the following:
    - Concerns raised around the Volunteering for Health Group's members attendance.
    - High prices on the Shop Trolley service made staff and volunteers feel awkward when patients struggled to find money to pay. The senior OD manager and the Volunteer manager took this forward and have since learned that the company will bring in a range of more affordable items.
    - The Volunteer Policy was reviewed, updated and approved by the Policy Review Group; the policy now includes a governance framework for external organisation involving volunteers in UHB services.
    - Volunteer attendance on wards has been difficult to capture due to some failing to sign in and out; mechanisms to monitor this are being explored.
    - Volunteer Forums were established in Pembrokeshire and Carmarthenshire; Chairs from each had members reporting to the Group.
    - The UHB achieved the National Investing in Volunteers National Standard in 2018.

- **WfIS Group** – written update reports highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the WODSC during 2018/19, including the following:
    - Paperless Payslips
    - ESR Structure update which included an HCPC cleanse of registration numbers. ESR Hub went live in July 2018, phase 1 ESR Self Service access, password queries to include 'live chat'. The self service portal has been further enhanced, usage has increased due to e-payslips.
    - Deanery interface: intrepid numbers were reviewed.
    - Medical & Dental supervisor hierarchy was agreed and entered.
    - Stage 1 of E-job planning was implemented on 1st September 2018.
    - Hywel Dda Digital Workforce Vision: ESR usernames and passwords are issued at PEC to allow e-learning to be completed prior to start date.
    - Flu reporting allowed Occupational Health to target areas with a low take up of the vaccine.

- A GDPR overview was given to the group by the Head of Information Governance.
- CAJE contract is due to expire, NWSSP are working with suppliers to extend.
- All paper expenses were removed, all expenses, including those for medical staff are coming through e-Expenses.

Other Areas of Responsibility
During 2018/19, the WODSC also received, and considered the following:

- Regular recruitment reports
- Moving and Handling Project
- Honorary Contracts Procedure
- Registration lapses

Key Risks and Issues/Matters of Concern
During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- Surgery at F2 level was escalated to Targeted visit; it is also anticipated that Obstetrics and Gynaecology will escalate to Targeted visit.

Matters Escalated to Quality, Safety & Experience Assurance Committee
During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- AAC appointments linked to Workforce & OD Sub-Committee

Workforce & OD Sub-Committee Developments for 2019/20
The following developments are planned for the WODSC during 2019/20:

- Workforce Development programmes linked to Education Strategy
- Robust management

Argymhelliad / Recommendation

To endorse the Workforce and Organisational Development Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	Focus on What Matters to Patients, Service Users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Workforce & Organisational Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Workforce and Organisational Development Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Workforce and Organisational Development Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.

Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Workforce and Organisational Development Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Workforce and Organisational Development Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 April 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Effective Clinical Practice Sub-Committee Annual Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Phil Kloer, Medical Director & Director of Clinical Strategy
SWYDDOG ADRODD: REPORTING OFFICER:	Ingaret Eden, Clinical Effectiveness Coordinator Alison Armitage-Hicks, NICE Support Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Effective Clinical Practice Sub-Committee (ECPS-C) Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee.

The Effective Clinical Practice Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub- Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Effective Clinical Practice Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance to QSEAC that robust arrangements are in place for the delivery of safe, effective, evidence based clinical practice across all UHB activities as part of core business, focused on improving clinical outcomes and the patient experience and reducing unwarranted clinical variation.

The ECPS-C is process focused, and gives assurance on safe, effective, evidence-based clinical practice. Ineffective practice is not monitored by the Sub-Committee: this is a function of the operational quality, safety and experience sub-committees' risk management. However, reviews of practice in operational departments are undertaken by the ECPS-C, and may uncover issues that need support or input from the ECPS-C, such as the commissioning and review of local written control documents, a recommendation for auditing, or an application for use of a procedure.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of the adequacy of the key controls, assurances, and action plans in place.

Asesiad / Assessment

The Effective Clinical Practice Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the ECPS-C were initially approved at its meeting on 19th April 2016. They were then updated to incorporate the Blood Transfusion Group as a contributory group to the ECPS-C in May 2017. In November 2018 the terms of reference were further amended to take into account the establishment of a new -group framework and reporting structure, incorporating the NICE & National Guidelines Review Group (NNGRG) and the Clinical Audit Group (CAG), and removing the Medicines Management Group, the Medical Devices Governance and Assurance Group (MDGAG) and the Quality Indicators Group (QIG). There were also changes to the Quality & Safety governance structures, and the inclusion of links with the University Partnership Board.

The terms of reference of the Effective Clinical Practice Sub-Committee have recently been reviewed under their annual review, and to incorporate the formation of the Mortality Quality & Scrutiny Group and reporting structure, and ratification of the new group framework, and are submitted with this report to QSEAC for approval of the new -group and reporting framework for the Sub-Committee.

The Terms of Reference clearly detail the Sub-Committee's purpose to provide assurance to QSEAC around the organisation's effective clinical practice, ensuring that there is an accurate reflection of key controls, assurances, and action plans to deliver against gaps in assurance.

In discharging this role during 2018 - 2019, the Sub-Committee was required to oversee and monitor the Effective Clinical Practice agenda for QSEAC in respect of its provision of advice to the Board, and ensure the implementation of the Effective Clinical Practice agenda against the following areas of responsibility:

- Effective Clinical Practice Programme
- Clinical Policies
- Medical Devices
- Medicines Management
- Quality Indicators
- Clinical Audit
- National Guidance
- Blood Transfusion

Effective Clinical Practice Sub-Committee Groups

The Groups reporting to the ECPS-C during 2017/18 were as follows:

Clinical Written Control Document Review Group (formerly the Clinical Policy Review Group) – established to:

- Approve clinical written control documents (policies, procedures and guidelines) on behalf of the Board in line with the HDUHB 190 Written Control Documentation Policy.
- Provide assurance to the Board that the governance arrangements are working effectively and therefore that the clinical written control documents comply with legislation, meet mandatory requirements and support the delivery of healthcare that is evidence-based, safe and sustainable.
- Commission on behalf of the Board clinical written control documents in order to minimise risk to patients, employees and the organisation.

(Reporting to ECPS-C from April 2018 to March 2019)

Medicines Management Group – established to:

- Provide assurance to the Effective Clinical Practice Sub-Committee on all prescribing issues and develop guidance/policy for the safe, evidence-based, cost-effective use of medicines, including those relating to National Institute for Health and Care Excellence (NICE) Technology Appraisals and All Wales Medicines Strategy Group (AWMSG) drug recommendations.

(Reporting to ECPS-C from April 2018 to September 2018)

Medical Devices Governance and Assurance Group – established to:

- Provide assurance to the Effective Clinical Practice Sub-Committee that governance arrangements are operating effectively with regard to the acquisition, use, maintenance and repair of medical devices and equipment across the Health Board.

(Reporting to ECPS-C from April 2018 to September 2018)

Quality Indicators Group – established to:

- Support the implementation of the recommendations from the Palmer Review* in particular to ensure that the Health Board is developing and learning from case note reviews, accurate coding, condition specific mortality data and consistent contribution to and learning from national clinical audits. **Review of Risk Adjusted Mortality Data in Welsh Hospitals. Report. Professor Stephen Palmer, July 2014*

(Reporting to ECPS-C from April 2018 to September 2018)

Blood Transfusion Group – established to:

- To promote safe and appropriate blood transfusion practice across the Health Board; and to provide assurance to the Effective Clinical Practice Sub-Committee that governance procedures around transfusion practice within the Health Board are robust, safe and follow local and national guidelines, and comply with legislation.

(Reporting to ECPS-C from April 2018 to March 2019)

Clinical Audit Group - established to:

- The Group is to provide assurance that a robust clinical audit function is in place, supporting the organisation's strategic direction, priorities and identified risks as well as national priorities, with strong links to the quality, safety and experience sub-committees who will provide assurance with regard to the dissemination and implementation of actions arising from clinical audits and service evaluations.

(Reporting to ECPS-C from March 2019)

NICE and National Guidance Review Group – established to:

- The Group is to provide a forum to oversee the consideration and implementation of National Institute for Health and Care Excellence (NICE) guidelines and quality standards and interventional procedures guidance, guidance on interventions not normally undertaken, and other relevant evidence based guidelines and standards, providing the Sub-Committee with assurance of implementation and ensuring where necessary that action plans are in place and being monitored to ensure compliance.
- Guidance sources usually within the remit of the Group:
  NICE (with the exception of Technology Appraisals Guidance)
  Public Health Wales (PHW): INNU

Royal colleges, UK & European professional bodies, World Health Organisation
Scottish Intercollegiate Guidelines Network (SIGN)
UK Government where relevant.

- Guidance sources usually outside the remit of the Group:
  Welsh Government
  All Wales guideline development groups
  Public Health Wales (except for INNU, above)
  NPSA/Welsh PSA
  NICE Technology Appraisals Guidance (these are the responsibility of the Medicines Management Group)
  AWMSG drugs recommendations (these are the responsibility of the Medicines Management Group)

(Reporting to ECPS-C from March 2019)

The ECPS-C Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution

From the terms of reference approved in March 2018, the membership of the Sub-Committee was agreed as the following:

Core Members

- Associate Medical Director for Clinical Effectiveness (Chair)
- Vice Chair [clinician]
- Independent Member
- Associate Medical Director for Quality & Safety
- Assistant Director of Therapies and Health Science
- Assistant Director of Nursing
- Assistant Director, Quality Improvement
- Assistant Director, Medical Directorate
- Chair of Quality, Safety & Experience Sub-Committee: Acute Services
- Chair of Quality, Safety & Experience Sub-Committee: Primary Care and Community
- Chair of Quality, Safety & Experience Sub-Committee: Mental Health & Learning Disabilities
- Head of Medicines Management [to represent Medicines Management and the Medicines Management Group]
- Chair of Medical Devices Governance and Assurance Group
- Chair of Clinical Written Control Documentation Review Group
- Chair of Blood Transfusion Group
- Chair of Quality Indicators Group
- Clinical Effectiveness Co-ordinator
- Clinical Audit Manager

Non-Core Members

- Medical Director and Director of Clinical Strategy
- Assistant Director of Workforce & OD
- Representative from Public Health

Meetings

Since March 2018, ECPS-C meetings have been held on a bi-monthly basis as follows:

- 23rd March 2018
- 11th May 2018
- 14th September 2018 (Workshop)
- 16th November 2018

As the ECPS-C is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on four occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties

In addition to work by its constituent contributing groups and other areas of responsibility, the ECPS-C has additional responsibilities relating to the areas listed below. No issues in these areas were brought to the Sub-Committee's attention, nor escalated to other Committees during 2018/19.

Internal Audit

- The Sub-Committee has a responsibility to recommend to the Audit and Risk Assurance Committee areas of activity for review by internal audit. No recommendations were made during the year 2018/19.

Service Delivery

- The Sub-Committee has a responsibility to review the evidence to support strategic shifts in service delivery, service developments etc, as mandated by the Business Planning and Performance Assurance Committee and/or the Quality, Safety and Experience Assurance Committee.
- A mandate for the ECPS-C to formulate two new -groups for NICE Guidance and Clinical Audit was received from QSEAC.
- The Medical Devices Governance and Assurance Group was moved to report to the Operational Quality, Safety and Experience Sub-Committee.

Feedback from Groups

In terms of feedback from Groups:

- **Clinical Written Control Document Review Group (CWCDRG) (formerly the Clinical Policy Review Group)** – written update reports from the Clinical Written Control Document Review Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Effective Clinical Practice Sub-Committee during 2018/19, including the following:
  - Lists of approved documents; documents under review or development; removal of redundant documents from the Intranet; queries from staff
  - Approval of the Group's Terms of Reference
  - Management of the significant number of clinical written control documents uploaded directly onto the Intranet without recourse to CWCDRG.
  - Review of Clinical Written Control Documentation exceeding 24 months
  - Recognition of the need for continued monitoring for local service leads to take ownership of and responsibility for local guidelines

Key risks and issues and matters of concern

- Risks of departmental uploading of documentation to intranet without recourse to the CWCDG governance process continued to be monitored
- Replacement of the intranet system with old content being removed poses a risk to the organisation which requires careful management

- **Medicines Management Group (MMG)** *(Reporting to ECPS-C from April 2018 to September 2018)* – written update reports from the Medicines Management Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the ECPS-C during 2018/19, including the following:
    - Routine reports: additions to the formulary; approved policies, guidelines and prescribing information.

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- **Medical Devices Governance and Assurance Group (MDGAG)** – written update reports from the Medical Devices Governance and Assurance Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Effective Clinical Practice Sub-Committee during 2018/19, including the following:
    - Progress on the standing work programme
    - Development of a suite of procedures around medical devices
    - Provide assurance to ECPS-C on the key risks for the Group
    - Escalate matters of concern to ECPS-C and continue to monitor these.
    - The Medical Devices Governance and Assurance Group was moved to report to the Operational Quality, Safety and Experience Sub-Committee from September 2018.

Key areas of work scrutinised

- Removal of Infusions Group from the ECPS-C reporting structure
- Progress on the Medical Devices Action Plan, Safety Alert Tracking System and Medical Devices Training sub-group.
- Ongoing assurance and scrutiny relating to the Control Group work
- Urgent review of options for community CPAP/BiPAP
- WHC 027-34 '*Policy on the Management of Point of Care Testing (POCT). What, When and How?'* concerning quality and safety for POCT formally handed over to MDGAG for future reporting to Operational Quality, Safety and Experience Sub-Committee.

Key matters of concern, actioned by the Group and monitored by the Sub-Committee:

- Risk of ageing medical devices still in use in the Health Board reported March 2017, continued to be monitored throughout the year and the risk remained high. The three main mitigations for this were staff education, visual inspection and Clinical Engineering maintenance. Clinical Engineering (C Eng) maintenance was cited within the risk as a main control. Concerns related to C Eng performance reduced confidence in this control/mitigation and the risk score was raised from 10 to 15. (Risk register: Estates/Operations, EBME/CE, score 15).
- Issue of anaesthetic and intensive care leadership and concerns this was limiting medical device issues from these areas being escalated

- **Quality Indicators Group** – written update reports from the Quality Indicators Group were not received as the group did not meet during the year.

- **Blood Transfusion Group (BTG)** - Written update reports from the BTG highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern have been regularly received by the ECPS-C during 2018/19, including the following:

  Key areas of work scrutinised
  - A mock MHRA inspection to ensure readiness for inspection was undertaken
  - Welsh Health Circulars (WHC): WHC 028-17, NHS Wales Blood Health Plan was received. A number of groups nationally coordinated the work to implement the recommendations. The BTG reported routinely on progress made.

  Key risks and issues and matters of concern
  - Whilst the Blood Transfusion service was preparing for inspection it was noted that it was not actually inspection-ready, although assurance was given that the risks were adequately managed and effective controls were in place.
  - The mock inspection report showed critical failures on all 4 hospital sites, including ongoing competency assessments, validation of equipment and transport boxes. The transfusion laboratory managers have drawn up an action plan to address these issues, and update reports will be submitted to ECPS-C.

- **Clinical Audit Group** – Establishment of a Clinical Audit Group has commenced. Draft terms of reference for the Clinical Audit Group were submitted to the ECPS-C and approved, subject to minor amendments, in particular in relation to membership. The purpose of the group will be to 'provide a mechanism by which operational leads are able to provide assurance that robust arrangements are in place for the delivery of an effective clinical audit programme that supports the key priorities and strategic direction of the Health Board, appropriately addressing identified risks as well as incorporating national priorities'. In addition to providing reports to the ECPS-C, the group will report to the Audit and Risk Assurance Committee (ARAC). The Clinical Audit Programme for the Health Board has been transcribed. The group membership will be invited and meetings will commence in 2019/20.

  Key risks and issues and matters of concern
  - There is a concern regarding maintaining attendance of clinical expertise in the group meetings. Measures will be taken to raise this concern with the Medical Director along with concerns regarding attendance at clinical working group meetings.

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- **NICE and National Guidance Group** – Draft terms of reference for the NICE and National Guidance group were submitted to the ECPS-C and approved, subject to minor amendments, in particular in relation to membership. University Partners have agreed to provide advice on evidence base, for example in review of applications to introduce new procedures. The purpose of the group will be to provide a forum to oversee formal adoption and implementation of nationally recognised guidelines and standards, including National Institute for Health and Care Excellence (NICE) guidelines, quality standards and interventional procedures guidance, and guidance listed under the Health Board INNU procedure. This will provide assurance to the Board of implementation and ensure where necessary that action plans are in place and being monitored, by the relevant

services, to ensure compliance. The Group will advise ECPS-C when the organisation is unable to implement NICE guidance or other national guidance deemed appropriate for adoption. The group membership will be invited and meetings will commence in 2019/20.

Key risks and issues and matters of concern

- There is a concern regarding maintaining attendance of clinical expertise in the group meetings. Measures will be taken to raise this concern with the Medical Director along with concerns regarding attendance at clinical working group meetings.

- **Mortality Review Group** – An existing Mortality Review Group has been meeting informally to discuss the All Wales Mortality Reviews in the Health Board. The Medical Examiners Steering Group recommended that this group be formalised, reporting to ECPS-C. Process flowcharts were presented, and draft terms of reference have been approved by ECPS-C, subject to minor amendments. The purpose of the group is given as: "To provide strategic direction, guidance and oversight for the collection, interpretation and dissemination of mortality related information within the Health Board". It was recognised that there may be changes to the framework when the Medical Examiner process is in place.

Other Areas of Responsibility

During 2018/19, the ECPS-C also received, and considered the following:

- **Clinical Effectiveness Programme**

  This was not progressed as a standalone project, as it is considered to be an integral part of ECPS-C work.

  Consideration of a new strategy approach of collaboration with UPB members in the evidence review process and the setup of two new contributory groups in support of a more robust approach to management of national guidelines and clinical audit.

  - **Issues relating to NICE and other national guidance**
  - The Sub-Committee is responsible for the oversight of consideration and implementation of NICE guidelines, quality standards and interventional procedures guidance, guidance on interventions not normally undertaken, and other relevant evidence based guidelines and standards, providing assurance of implementation and ensuring where necessary that action plans are in place and being monitored to ensure compliance.

- **Clinical Audit**

  The Clinical Audit Manager provided written reports to the Sub-Committee identifying key issues, risks and areas of improvement. A number of items have been brought to the Sub-Committee's attention including the following:

  - Plans for the creation of a Clinical Audit Group
  - Concerns around UHB participation with national mandatory audit projects, and the lack of resource for compliance.
  - The forward Clinical Audit Programme and Internal Audit requirements

Key Risks and Issues/Matters of Concern

During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

Clinical Effectiveness Programme

- Consideration of a new strategy approach of collaboration with UPB members in the evidence review process
- The setup of two new contributory groups in support of a more robust approach to management of national guidelines and clinical audit.
- Concern was noted regarding attendance at meetings and the lack of clinical expertise in attendees to progress the sub-committee's business effectively.
- The Chair will write to the Medical Director for advice and to discuss ensuring time allocation for attendance at clinical working group meetings in job plan reviews.

NICE and other national guidance

- Concern at the large number of non-responders to requests for implementation information on NICE guidance was recorded. The Chair wrote to clinical leads for an explanation and action.
- Concern that the processes for dissemination of NICE guidance to Primary Care is weak and a review to be undertaken in alignment with the new quality and safety governance structure.
- A process for forward planning for NICE proposed to be included in the terms of reference of the new NICE and National Guidance Review Group.
- Concern that NICE should be explicitly embedded in the IMTP planning process prior to publication.
- Updates to the NICE policy regarding variation where other national guidance is followed were presented but not approved by ECPS-C as the Sub-Committee considered that other members were required in order to approve the new form for seeking adoption of guidelines other than NICE. The Sub-Committee is aware that there are medico-legal implications in this.

Clinical Audit:

- Concerns regarding compliance with key mandatory audits and the risk that non-participation poses for the UHB.
- A Clinical Audit report submitted to ARAC had not been approved.
- ARAC requested assurance on compliance in undertaking national mandatory audits and on other audit outcomes, and implementation of recommendations.
- A recommendation was made for clear monitoring of outcome measures to be recorded within the actions associated with the clinical audit forward plan.
- Compliance with national mandatory audit requirements and recommendations were made a clear priority for the Clinical Audit Group.
- Clarity is needed regarding the reporting function of Clinical Audit as it reports both to ARAC and to QSEAC. This will be addressed in the 2019/20 ECPS-C workplan.
- WHC 028/18 '*NHS Wales National Clinical Audit and Outcome Review Plan 2018/19'* received. Barriers to full participation in mandatory national clinical audits remain. ECPS-C is monitoring this risk (Risk Register ECPS-C/275, score 15). An update report received in March 2019 highlighted the following progress:
  - **IBD Registry:** Welsh Government has now classified this audit as non-mandatory for Health Boards. Withybush General Hospital (WGH) will continue to contribute however no other site will be expected to.
  - **National Ophthalmology Audit:** the Health Board is not currently participating in this audit as the software required for data

submission is not yet in place

- • **Myocardial Ischaemia National Audit Project (MINAP):** Concerns remain over data collection across all sites. The last Cardiology report indicated excellent improvements in case ascertainment.
- • **Trauma Audit and Research Network (TARN):** Improvements have been made at WGH but Glangwili General Hospital (GGH) remains a concern. Work is being progressed and there is additional nursing support for the project, with further support planned. Compliance with the TARN audit is also now part of the standards for the Wales Trauma Network and with the establishment of a Trauma Unit in the Health Board, work is also progressing on providing a dedicated TARN Coordinator role through the Trauma Unit Task & Finish Group to meet national standards for a Trauma Unit.
- **Fracture Liaison Service:** We are not currently participating in this audit. The only applicable site is Bronglais General Hospital (BGH). Work is ongoing to create a Fracture Liaison Service at other sites. Should this progress we would expect to see future sign up to this audit at those sites.

Heart Failure: Participation with this audit has been raised as a concern at GGH. Corrective action has already been taken for 2018-19 with data collection being monitored and on target. Concerns around future data collection at BGH have been raised and the new SDM is in the process of completing a risk assessment and providing the committee with mitigating actions.

Matters Escalated to Quality, Safety & Experience Assurance Committee

During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- Assurance required to ensure adequate mitigation of risk is in place for compliance with mandatory audit
- Assurance required to ensure adequate mitigation of risk is in place for managing ageing stock of medical devices
- Approval for revision of ECPS-C Terms of Reference to accommodate agreed changes for the setup of NICE and National Guidance Review Group and Clinical Audit Group, description of collaboration with UPB, removal of MMG, MDGAG and QIG groups and changes to the Quality & Safety governance structures.
- Concerns were raised regarding the attendance at ECPS-C. Poor attendance was noted and there is often a struggle to reach a quorum. The Sub-Committee has been unable to recruit enough clinical members resulting in a lack of expertise.
- QSEAC, and the Board were informed of a potential system failure in the ECPS-C when the business of the Sub-Committee and its groups is unable to progress through lack of attendance and expertise. The Chair will write to the Medical Director for advice and to discuss ensuring time allocation for attendance at clinical working group meetings in job plan reviews.

ECPS-C Sub-Committee Developments for 2019/20

The following developments are planned for the Effective Clinical Practice Sub-Committee during 2019/20:

- The existing Mortality Review group will come under the ECPS-C and report to QSEAC through the ECPS-C reporting framework for 2019/20.

- The three new groups, Clinical Audit Sub-Group, NICE and National Guidelines Review Group and the Mortality Review Group will be established for 2019/20 and will hopefully enable a broadening of management of responsibilities and expertise in their respective areas.
- A workplan for ECPS-C will be developed, in coordination with the functions of the groups and will be discussed with other Sub-Committees to ensure there is no duplication.

Argymhelliad / Recommendation

To endorse the Effective Clinical Practice Sub-Committee (ECPS-C) e Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Effective Clinical Practice Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Effective Clinical Practice Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Effective Clinical Practice Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	SBAR template in use for all relevant papers and reports.
Cyfreithiol: Legal:	A sound system of internal control, as evidenced in the Effective Clinical Practice Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Effective Clinical Practice Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.

Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Improving Experience Sub-Committee (IESC) Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Louise O'Connor, Assistant Director Patient Experience and IESC Chair

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Improving Experience Sub-Committee Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee. The Improving Experience Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub- Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Improving Experience Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance that a focus on improving patient experience is integrated into Health Board functions and influences the direction for service delivery, evidencing changes/improvements to services as a result of patient feedback. It is also to oversee and steer the direction of patient experience and public engagement in the Health Board, and promote a culture of positive patient experience, together with the development and delivery of the Board's Strategy/ies for reactively gathering patient experience. The Sub-Committee is also required to provide assurance on all matters relating to Concerns (Claims, Incidents and Complaints) across the Hywel Dda community and provide assurance that the arrangements are consistent with the Putting Things Right Regulations and associated Guidance.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of experiences of care and concerns management, and the adequacy of the systems and arrangements in place for implementation of the NHS (Concerns, Complaints and Redress) Arrangements (Wales) Regulations 2011.

Asesiad / Assessment

The Improving Experience Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the Sub-Committee were subsequently approved at its meeting in May 2017.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee in discharging its function to oversee and monitor the wider patient and staff experience agenda for the Quality, Safety & Experience Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the agenda against the following areas of responsibility:

- Triangulation of patient and staff experience data (including from complaints, compliments, claims, patient and staff surveys, Continuing Health Care (CHC) Hospital Patient Environment Audits**,** engagement events, media coverage, MP correspondence and other relevant sources) for approval by the Quality, Safety and Experience Assurance Committee.
- Identify themes/gaps, risks and training needs based on the information analysed from all aspects of patient and staff experience.
- Developing a culture of engaging patients and the wider public in its work.
- Receive assurance from the Quality, Safety and Experience Sub-Committees that concerns are being managed in a timely way, actions arising from concerns are being monitored for delivery and lessons learnt are being identified, with plans in place for dissemination of learning.
- Provide assurance that the Health Board's legal responsibilities for Equality, Diversity Human Rights, and Welsh Language are being met and embedded across the Health Board and in partnership arrangements.
- Monitor compliance with Welsh Governments (WG's) Serious Incident Reporting.

Improving Experience Sub-Committee Groups
The Groups reporting to the Sub-Committee during 2018/19 were as follows:

- **Concerns Scrutiny Group**

A Scrutiny Panel was established by the Sub-Committee in May 2017. The panel is chaired by the Board's Independent Member with responsibility for Putting Things Right. Its primary purpose is to provide assurance to the Improving Experience Sub-Committee that the organisation is properly implementing the NHS (Concerns, Complaints and Redress) Regulations 2011, and that the delivery of the process is consistent with the principles of the Review of Concerns Handling in Wales in 2014 – 'Using the Gift of Complaints'.

The overall aim of the panel is to drive quality and improvement in the management of concerns by ensuring the patient is at the heart of the process and that the Health Board is learning effectively from patients' experiences. In facilitating organisational learning, the panel will ensure that outcomes from lessons learned are being implemented in practice.

The panel reviews the quality of responses to concerns and reviews the outcomes and satisfaction with the concerns handling process. This approach will provide the Concerns Team and the services investigating concerns with appropriate support and scrutiny to continuously improve the handling of concerns, learning and outcomes.

Constitution

From the terms of reference approved in May 2017, the membership of the Sub-Committee was agreed as the following:

Assistant Director (Patient Experience (Chair)
Assistant Director, Assurance, Quality & Governance (Vice Chair)
Independent Member (Putting Things Right Lead)
Director of Nursing, Quality and Patient Experience (Executive Lead)
Medical Director (or Deputy Medical Director)
Director of Governance, Communications and Engagement
Chief Operating Officer/Deputy Chief Executive (depending on agenda items)
Senior Representative from each Directorate
Assistant Director of Nursing (Practice)
Assistant Director of Therapies (professional practice, quality and safety)
Associate Medical Director / Quality and Assurance Manager Primary Care
Assistant Director, Quality Improvement
Assistant Director, Workforce and Development
In Attendance: Assistant Investigation Manager, Public Services Ombudsman for Wales
Head of Legal Services
Putting Things Right/Ombudsman Facilitator
Community Health Council Representation
Concerns Manager
Patient Experience Manager
Head of Public & Patient Engagement
Senior Equality & Diversity Adviser
Legal Representation as required
Representatives from partner organisations to be invited according to agenda items

Meetings

Since 1st April 2018, Sub-Committee the following meetings have been held:

- 29th May 2018
- 19th November 2018

Although a Sub-Committee meeting had been scheduled for 19th September 2018 with the agenda and papers issued, it had to be stood down on the morning of the meeting due to the number of non-attendees and late apologies received.

As the Improving Experience Sub-Committee is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on two occasions as it was not quorate on 19th September 2018. Due to the large number of late apologies received (including from those presenting papers) the agenda items could not be progressed and a decision was taken to stand down the meeting. Subsequently, a decision has been taken to review the terms of reference and membership of the Sub-Committee and establish a Listening and Learning From Events Group, which will strengthen the governance arrangements of the lessons learnt process. The revised terms of reference will be discussed at the next meeting of the IESC in April 2019.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Improving Experience Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

IMPROVING EXPERIENCE

Implementing the Framework for Assuring Service User Experience
The framework sets out three domains for what makes a positive experience and requires Health Boards and Trusts to collect experience using a number of methods to gain a picture of what it feels like to receive care within a service provided by the organisation. Feedback from the WG for 2017-18 has been positive, and there is evidence that the Board is using a variety of methods to gather feedback, with particular mention given to the feedback methods in use within primary care and the work being undertaken by women and children's services to improve the patient experience. A focus for the Sub-Committee moving forward will be to further enhance the work in relation to community care and patient transport and to ensure that feedback from wider consultations and from Siarad Iechyd/Talking Health is incorporated and service improvements made as a result.

- **Assuring a Positive Patient Experience Strategy**
  A review of the extant strategy was undertaken, and a draft revised version discussed and consulted upon and subject to wider consultation. This discussion has since evolved and a Patient Experience Charter is in the process of being developed with an associated delivery plan and toolkit for staff members.
- **Patient Stories**
  The main themes emerging from receiving patient stories during the year:
  i) Maintaining dignity/improving communication/HDU Environment
  Assurance of the actions undertaken in response to the feedback was received by the Sub-Committee. The importance of strengthening the local resolution process by arranging meetings at the earliest opportunity and ensuring support is offered to families following the death of a family member was emphasised.
  ii) Equality and Diversity / Dignity in A&E
  The Sub-Committee listened to feedback from a patient story in response to an emerging theme about the sharing of personal information within the A&E environment which may often be overheard by other patients. The Professional Nurse Forum will discuss ways that this might be improved. Training has also been provided to the governance/lessons learnt groups in each directorate regarding the equality / consent issues which also featured in the patient story.

- **Encouraging and Receiving Feedback**
  The Sub-Committee received significant assurance from Members throughout the year on the work being undertaken to encourage and receive feedback, which included:

- Establishment of a patient support group in critical care;
- Feedback mechanisms in pre assessment clinics;
- Audits/Surveys in a range of services including Endoscopy; Ophthalmology; Upper GI; Audiology; SCBU, Maternity; Paediatrics;
- Establishment of Carers Experience Group within Mental Health/Learning Disabilities;
- Patient story videos being undertaken relating to colorectal service feedback;
- Introduction of reminiscence interactive therapy activities for older patients at Prince Philip Hospital (PPH) to improve patient experience through activity – this scheme was a finalist at the 2018 Patient Experience Network Awards;
- Introduction of a revised process in Withybush General Hospital (WGH) for patients who are admitted onto hospital wards with a learning disability. The process is designed to

improve communication and enhance the patient experience. This was also successful in becoming a finalist at the 2018 Patient Experience Network Awards.

- **Listening and Learning from Feedback**
  The Sub-Committee received reports from directorates in relation to the patient experience feedback collated and actions taken in response. The overriding concern and root cause of much of the negative feedback received related to the area of communication. This matter was escalated to the Quality, Safety and Experience Assurance Committee. To ensure improvement in this area, communication will form one of the quality improvement work streams as part of the Health Board's new Quality Improvement Strategy implementation.

  Other themes from concerns related to: recognition of the ill and deteriorating patient; waiting times and access; record keeping; information and consent; inpatient falls; family experience following a death of a relative in hospital; pressure damage; nutrition/ hydration; and delayed or missed diagnosis.

  - Nutrition/Hydration – in response to the Wales Audit Office Report on patient catering, a presentation was received on the significant amount of work undertaken on working with patients and staff to improve patient experience of food and beverages. A wide range of approaches had been utilised, such as meal time observations, patient stories and real time feedback. Further feedback will be requested in terms of outcomes from the implementation of the action plan.
  - NG Tube Education – a presentation from the Lead Clinical Nurse Specialist was received on the positive work undertaken on 'at the bedside nasogastric tube insertion competency'. This training has resulted in significant improvements for patient experience and outcomes.
  - Communicating effectively in language of choice – the Wales Audit Office Report – Speak my language report - was received. The Sub-Committee reviewed the self-assessment and following discussion on the recommendations, it was suggested that the self-assessment be extended out to operational teams and submitted for further consideration at a future meeting.

EQUALITY AND DIVERSITY

The Strategic Equality Plan Annual Report and Workforce Equality Annual Report were both discussed and commended to the Business Planning and Assurance Committee for approval.

POLICIES AND PROCEDURES

The following policies and procedures were approved by the Sub-Committee and commended to the Quality, Safety and Experience Assurance Committee for approval:

- Claims Policy

PUTTING THINGS RIGHT PROCESS

- **Concerns (incidents/claims/complaints)**

The performance of concerns management has been addressed through the revised performance management arrangements, in particular the Executive Performance Review Process. Assurance reports to Sub-Committee provide a focus on improving experience/outcomes arising from the concerns process and patient experience feedback. Oversight of the process in relation to referrals to the Ombudsman and compliance with the Welsh Government targets for responding to complaints has also been a priority for the Sub-Committee and Members welcomed an improving trajectory for both positions. The increasing volume of cases being managed by the Patient Advice and Liaison Service team

and the patient support hub is also having a positive impact; however significant capacity issues within this service is inhibiting the development and impact on patient experience.

- **Public Services Ombudsman for Wales (PSOW)**

Throughout the year, the Sub-Committee has received a detailed report at each meeting on the cases submitted to the PSOW and reviewed any areas of exception where agreed actions had not been completed within the required timescale. Two cases were upheld as a Section 16 (public interest) report.

The Sub-Committee has also benefitted from the attendance of the PSOW, Assistant Investigation Manager, who has addressed Members on the themes/issues across Wales relating to Ombudsman investigations and any specific areas of concern relating to Hywel Dda.

Key Risks and Issues/Matters of Concern

During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- Attitude/communication/assault – highlighted as a new emerging theme impacting on both staff and patient experience and it was proposed that a detailed analysis would be presented for review at the next Sub-Committee meeting.
- Communication and information – between teams and professionals highlighted as the most significant area for improvement following a review of feedback. This will form part of a new quality improvement collaborative programme.

Improving Experience Sub-Committee Developments for 2019/20

The following developments are planned for the Improving Experience Sub-Committee during 2019/20:

- Review of terms of reference and membership
- Development and implementation of a Patient Experience Charter & Delivery Plan
- Expansion of Friends and Family Test
- Implementation and monitoring of compliance with new Welsh Language Standards
- Further improvement of Patient Experience Feedback Systems
- Development of Complex Patient Panel Arrangements
- Improvement of Lessons Learnt Processes – establishment of Listening and Learning from Events Working Group

Feedback from Scrutiny Panel

- Outcomes of the review of the randomly selected cases were presented to the Sub-Committee. Evidence of actions taken to address concerns were demonstrated on each case and the monitoring / audit arrangements confirmed. Key themes from case handling related to the need to improve communication and timeliness of investigations.
- In light of the new peer review assurance process for the Putting Things Right arrangements in Wales, together with the strengthened scrutiny and assurance process within the Welsh Risk Pool, the local scrutiny panel arrangements will be stood down and replaced by the Listening and Learning From Events Group which will take on a wider function of escalating themes/trends within the governance structures following triangulation.

Argymhelliad / Recommendation To endorse the Improving Experience Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	Focus On What Matters To Patients, Service users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Improving Experience Sub-Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Improving Experience Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	A sound system of internal control, as evidenced in the Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Improving Experience Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Improving Experience Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Infection Prevention Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sharon Daniel, Assistant Director of Nursing, Professional Standards and Workforce Meleri Jenkins, Senior Nurse, Infection Prevention

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Infection Prevention Sub-Committee Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee. The Infection Prevention Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2018/19, and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the Infection Prevention Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide assurance to the Quality, Safety & Experience Assurance Committee around all matters relating to the prevention of infection.

The Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of Healthcare Associated Infections and infection prevention measures to protect patients, staff and the wider public and the adequacy of the controls and measures in place.

Asesiad / Assessment

The Infection Prevention Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the Infection Prevention Sub-Committee were approved at its meeting on 5th October 2018 and subsequently approved by QSEAC on 16th October 2018.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around all matters relating to the prevention of infection, ensuring that there is an accurate reflection of performance against Delivery Unit infection reduction targets and identified risks to deliver against gaps in assurance.

In discharging this role, the Sub-Committee is required to oversee and monitor the infection prevention agenda for the Quality, Safety & Experience Assurance Committee in respect of its provision of advice to the Board, and ensure the implementation of the infection prevention agenda against the following areas of responsibility:

Performance

- Delivery Framework Targets
- Hand Hygiene compliance rates
- Surgical Site Infection rates

Leadership

- Policy - review, development and implementation
- Work plan – monitor delivery
- Monitor hospital performance, identifying and rectifying irregularities
- Environment & Cleanliness – receiving and monitoring reports
- Monitor hospital and community outbreaks
- Monitor Quality Improvement work
- Monitor and report on staff infection prevention issues

Risk

- Monitor Risk Register and Issue Log
- Review the analysis and learning from adverse events
- Monitor implementation of recommendations from national organisations such as Health Inspectorate Wales, Shared Services and Welsh Health Circulars.

Infection Prevention Sub-Committee Groups

The Groups reporting to the Infection Prevention Sub-Committee during 2018/19 were as follows:

- **Decontamination Group** – established to:
  - Monitor compliance with and oversee the Health Board's decontamination arrangements regarding practice, regulation, standards and guidance.
  - Make recommendations on all matters concerned with decontamination of medical devices and other equipment requiring decontamination or sterilisation.

- **Antimicrobial Stewardship Group** – established to:
  - Implement and deliver the Health Board's Antimicrobial Resistance Plan
  - Review Health Board antibiotic guidelines

- **Water Safety Group** – established to:
  - Provide assurance that there is an appropriate system for the delivery of water services focusing on the delivery of water to point of use for all the Health Board premises.
  - Monitor Water Safety/Quality and ensure compliance with HTM 04-01 and Approved Code of Practice – L8, thereby positively contributing to the health and wellbeing of patients/visitors and staff in all health related premises.

- **Locality Infection Prevention Groups x 4 –** established to:
  - Monitor operational delivery of the infection prevention agenda
  - Deliver National surveillance schemes
  - Implement the infection prevention work plan
  - Support Clinical Teams in scrutiny of health care associated infections

The Infection Prevention Sub-Committee Annual Report 2018/19 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution

From the terms of reference approved at IPSC on 5th October 2018, the membership of the Sub-Committee was agreed as the following:

- Assistant Director of Nursing, Professional Standards and Workforce (Chair)
- Senior Nurse Infection Prevention (Vice-Chair)
- Director of Nursing, Quality & Patient Experience
- Director of Public Health
- Consultant Microbiologists
- Associate Medical Director
- Independent Member responsible for cleanliness and infection control
- County Director Community Services (or representative)
- Assistant Director, Mental Health & Learning Disabilities (or representative)
- Assistant Director, Family & Child Health (or representative)
- Head of Nursing Acute Services
- Head of Facilities
- Decontamination Lead
- Health & Safety Officer (or representative)
- Consultant in Communicable Disease Control
- Public Health Nurse
- Lead for Occupational Health
- Head of Medicines Management (or representative)

Meetings

Since 20th July 2018, Infection Prevention Sub-Committee meetings have been held on a bi-monthly basis as follows:

- 20th July 2018;
- 5th October 2018;
- 14th November 2018;
- 18th January 2019;
- 5th March 2019.

As the Infection Prevention Sub-Committee is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on 5 occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, the Infection Prevention Sub-Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its terms of reference:

Performance
Performance is reviewed against the Delivery Framework Targets as set out in the document WHC 2018 (020) 'AMR Improvement Goals & HCAI reduction expectation by March 2019: Primary & Secondary care antimicrobial prescribing goals: *C. difficile, S. aureus* bacteraemias and gram negative bacteraemias'.

- The Health Board will not achieve any of the infection reduction targets set by the Delivery Framework
- The Health Board has achieved a reduction in *Clostridium difficile* infection (CDI) rates over the financial year and did not sustain the high levels of infection seen in April and May 2018 as a result of the high incidence of influenza at the beginning of 2018. Despite some improvement, Hywel Dda remains 6th out of 6 across the Welsh Health Boards
- The Health Board has achieved a reduction in *E. coli* Blood Stream Infections over the financial year of 23%, however this does not meet the Delivery Framework 30% reduction target. The reduction has been seen as a result of work around Urinary Management Training delivered across the Health Board, especially in the community and primary care, working collaboratively with the Medicines Management Team and Primary Care Antibiotic Pharmacist.
- The Health Board data for *Staph. aureus* Blood Stream Infections shows Hywel Dda had one more infection than during the previous year representing a slight upwards trend which is reflected across Wales. Work has been completed in hospitals to reduce peripheral venous cannula infections and contamination of blood cultures. Work is ongoing in the community on the importance of oral care in reducing *Staph. aureus* related aspiration pneumonia.
- Two new targets were added this year relating to gram negative blood stream infections; these are *Klebsiella* sp. and *Pseudomonas aeruginosa* from April 2018. The Health Board did not receive laboratory data on these targets until August 2018, therefore this year a basic number surveillance has been completed and crude data is available to review and action.
- ICNet has linked to the Health Board's (HB's) Patient Alert System (PAS) system and provides a higher quality information for the Infection Prevention Team to work with. Support was requested during the year for the funding requirement that was needed from April 2019 going forward.

- Review compliance with Hand Hygiene
  - Hand Hygiene compliance against the World Health Organisation '5 Moments' has been below the recommended 95%, with the Health Board reporting 87% to 91% compliance. This has been highlighted in reports by Healthcare Inspectorate Wales (HIW) and the Community Health Council. The Infection Prevention Team has developed an action plan going forward for 2019/20.
  - The requirement to be 'Bare Below the Elbow' was reinforced by the CMO/CNO letter received in January 2019 and circulated by the CEO to all staff groups. This has also been incorporated in to the Infection Prevention Team Hand Hygiene audit tool.
- Surgical Site Infection (SSI) Surveillance
  - Caesarian Section SSI retrospectively reported a rise in infections in Quarter 4 of 2017/18 these were reviewed by the service with no single identifying issue however it was recognised that the service should work with Obstetricians to look at the higher than average C-section rate in the HB.

- Orthopaedic SSI retrospectively reported in October 2018 an increase in SSI in Bronglais General Hospital (BGH). This was reviewed by the service and the Infection Prevention Team and it was established that the reporting process was not robust with mis-reporting of SSI's. The situation has been resolved with the reporter now having contacts with the Infection Prevention Team and Orthopaedic Consultants, with the data submitted corrected.

Environment

- Credits for Cleaning (C4C) Reports - these have been received throughout the year. Audits are being undertaken with improvement in involving department leads in these audits. Recent reports were rated amber and green with the exclusion of Estates scores. Assurance was sought that these should be monitored and scrutinised through the Locality Infection Prevention meetings. Ensuring that a senior member of the nursing team should be engaged on these audits still needs to be addressed in some areas.
- Community C4C reports were disappointing; action plans are therefore to be developed and reviewed through Locality meetings.
- WHC (2018) 033 Airborne Isolation Room Requirements was published in July 2018 and Health Board facilities were reviewed against the new guidance. It was noted that further work on isolation facilities was required and a Task and Finish Group has been set up to review the guidance.
- The Major Infrastructure/Ward Refurbishment Programme Business Case was briefly discussed. It was noted that this is being monitored via the Capital, Estates, and Information Management & Technology Sub Committee. IPSC members requested assurance, given the potentially long timescales associated with the Health Board's Clinical Strategy that areas will continue to be prioritised and standards maintained whilst the approval and planning processes are in progress.

Quality Improvement

- Development of a Faecal Microbiota Transplant (FMT) service through clinician engagement, product procurement, development of protocols and patient information. There is supporting evidence that this procedure is an effective treatment for patients with relapsing CDI which accounted for 25% of cases in 2017/18.
- Aseptic Non Touch Technique (ANTT) data on e-learning and completion of competency assessment were reported during the year with the aim of achieving 40% compliance by the end of year. The IPT have trained over 140 assessors although currently only 25% of these are actively assessing staff.
- The Health Board agreed to fund Rapid Respiratory testing in Bronglais and Glangwili Microbiology Laboratories. The cost implication of this was noted and the laboratories are working to strict criteria on its usage. The testing has a fast turnaround which will have a positive impact on patient flow and treatment.
- Minimum Standards have been developed for Community Leg Ulcer Clinics and the clinics are currently being audited against these. The clinics support continuity for patients and are associated with improved rates of healing.
- Support for hydration work across the HB and development of staff guidance.

Risk

- The risk register has been reviewed with two of the three risks owned by the Sub-Committee removed and placed on to an issues log; this will be monitored in future Sub-Committee meetings.
- Concerns were raised around capacity by Health and Safety Officers to deliver facial mask fit-testing. It was agreed that a trainer the trainer education delivery was appropriate and high risk areas were asked to identify trainers. This process is now in place with testers trained throughout the HB.

Policy

- Extensions were granted for policies to aid review and updating by the Infection Prevention Team
- Two national policies have been written on Aseptic Non Touch Technique and Multi Drug Resistant Organisms; these are in the process of being adopted by the HB.

Feedback from Groups

In terms of feedback from Groups:

- **Decontamination Group** – written update reports from the Decontamination Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Infection Prevention Sub-Committee during 2018/19, including the following:
    - A 10 year plan has been developed to look at the equipment replacement needs of the Hospital Sterilizing and Decontamination Units (HSDU's) across the HB.
    - Glangwili General Hospital (GGH) and Prince Philip Hospital (PPH) HSDU have been successful in achieving accreditation for ISO 13485:2016
    - Decontamination from HB dental practices has been centralised during the course of the year and all areas will have changed over by April 2019. This provides greater assurance of processes for the HB going forward.
    - All Wales Endoscopy Audit has been completed, with an action plan developed, where actions are being progressed. . High risk issues identified were the Endoscopy Decontamination process in Withybush General Hospital which has been resolved and the decontamination of Nasendoscopes on Merlin Ward in GGH. The service is looking to resolve this issue with the purchase of further scopes to enable them to be decontaminated in the HSDU.

- **Antimicrobial Stewardship Group** – written update reports from the Antimicrobial Stewardship Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Infection Prevention Sub-Committee during 2018/19, including the following:
    - The Group now has a requirement to report against Delivery Framework antibiotic reduction targets. Reporting is undertaken retrospectively for Primary and Secondary Care areas. The data supplied showed that Primary Care is achieving a 3.6% reduction in usage with a target of 5% and Secondary Care has not been achieving its target, however GGH came close to doing so; this was believed to be partly related to the use of the All Wales Antimicrobial Medication Chart.
    - Review of Antibiotic Guidelines within Secondary Care, with removal of co-amoxiclav has been completed and consulted upon, with the intention of publishing in March 2019. Concerns have been raised regarding the need for increased phlebotomy due to the recommendations for Gentamycin use.
    - Start Smart then Focus antibiotic audit tool, will be launched nationally in the spring of 2019. Clarity is required on the mandatory status of this audit and clinician involvement. The HB will be undertaking a small pilot ahead of the national launch.
    - The All Wales Antimicrobial Medication Chart which has been trialled in GGH for the previous18 months is to be rolled out nationally in the spring of 2019.
    - Two new Antibiotic Pharmacists have been appointed in GGH and BGH
    - CDI training for ward based Pharmacists rolled out across the HB.

- An audit of GP practices with high usage of co-amoxiclav, cephalosporin and quinolones has been completed by the Community Antibiotic Pharmacist with feedback sessions delivered with the support of a Consultant Microbiologist. This has led to an improvement in prescribing practice.

- **Water Safety Group (WSG)** – written update reports from the Water Safety Group highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Infection Prevention Sub-Committee during 2018/19, including the following:
  - Water Safety Policy reviewed and agreed
  - Pre-planned testing for Pseudomonas from Clinical Hand Wash Basins in Augmented Care areas has been carried out with positive results being acted upon.
  - Legionella Risk Assessment was completed by the WSG with guidance for when testing should be completed.
  - Legionella risk in WGH highlighted during refurbishment work (included on the Estates Risk Register). Budget secured for schematic drawings of the area and work is in progress to remove redundant pipework.
  - Maintenance, testing and removal of ice machines continues due to the risk of infection. This work now needs to be taken forward with water coolers.
  - The Water Safety Group report was discussed and the request for approval for 'Aquafund' to review the HB's water safety management was agreed. There is no upfront cost to the Health Board, Aquafund will recoup money from savings made. From the experience of other HB's there will be an estimated cost saving of 10-30% with Hywel Dda receiving 50% of this for the first five years and 100% thereafter.

    Aquafund will :-
    - Validate and verify all water bills;
    - Survey all sites and provide data on water usage;
    - Install and maintain water efficiency technologies;
    - Optimize water tariffs;
    - Provide visibility on water consumption through a portal;

- **Locality Infection Prevention Groups x4** – written update reports from the four Locality Infection Prevention Groups highlighting the key areas of work scrutinised and identifying key risks and issues and matters of concern, have been regularly received by the Infection Prevention Sub-Committee during 2018/19, including the following:
  - Healthcare Inspectorate Wales audited three wards in WGH; a draft report has been received and an action plan developed for improvement. Work is required from the Infection Prevention Team on mandatory education and hand hygiene compliance.
  - A trial of ultra-violet light disinfection for the environment was completed in WGH; this trial is currently being evaluated.
  - 'Who needs Gloves?' pilot to promote the appropriate use of non-sterile gloves is to be completed on one ward in GGH and PPH in the spring of 2019. This pilot aims to improve compliance with Hand Hygiene, reduce hospital acquired infections and have a positive effect on the environment.
  - Decant wards have become available in WGH and GGH; this is a positive development for Estates in the cleaning and refurbishment of wards.
  - Outbreaks monitored throughout the year with recommendations fed back to services.

- The issue of contaminated equipment being returned to equipment libraries and Clinical Engineering has been resolved with the introduction of decontamination labels.
- Terms of reference for the Groups were reviewed to ensure engagement from Community, Mental Health & Learning Disabilities.
- The intravenous lines infection action plan developed in WGH as a response to cannula related blood stream infections resulted in the purchase of Venous Access Trolleys and a reduction in declared infections. This good practice is being rolled out across the other acute sites.
- Increased wound infections on a surgical ward in GGH are being reviewed and actions taken to improve practice focusing on Hand Hygiene, ANTT and equipment cleaning.
- Work has been completed to improve Meticillin Resistant *Staph. aureus* screening in orthopaedic patients in GGH.
- Jabs to Tabs training, looking at the review of intravenous antibiotics and the change to oral antibiotics has been delivered across all the acute sites.

Other Areas of Responsibility

During 2018/19, the Infection Prevention Sub-Committee also received, and considered the following:

- Phlebotomy Service use of reusable tourniquets was reviewed and highlighted poor decontamination practices; work is on-going to draft a decontamination procedure.
- Portable Fans - following an Estates and Facilities Alert regarding the use of portable fans in clinical areas national guidance and risk assessment has been developed.
- Sharps/Needlestick Injuries – Occupational Health raised a concern regarding an increase in sharps injuries, however on review of the basic data this was not found to be the case but it was requested that these be monitored through the Health & Safety and Emergency Planning Sub-Committee. A report was submitted by Occupational Health in March 2019 highlighting 70 needlestick injuries in a 6 month period; this is concerning considering the Sharp Safety initiatives. It was also noted that there was a discrepancy in reported figures between Occupational Health and DATIX.

Key Risks and Issues/Matters of Concern

During 2018/19, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- Legionella Risk in WGH due to water system changes that were not mapped; work is being undertaken to resolve the issue and mitigation processes are in place.
- Decontamination of endoscopes in WGH, decontamination of Nasendoscopes on Merlin Ward in GGH. WGH have now centralised the service of decontamination to the HSDU. The Ear, Nose & Throat service is looking to purchase additional Nasendoscopes to allow for central decontamination.

Matters Escalated to Quality, Safety & Experience Assurance Committee

During 2018/19, the following matters requiring Quality, Safety & Experience Assurance Committee level consideration or approval were raised:

- Funding stream for ICNet
- Faecal Microbiota Transplant

Infection Prevention Sub-Committee Developments for 2019/20

The following developments are planned for the Infection Prevention Sub-Committee during 2019/20:

- The Sub-Committee has agreed SMART targets for the Delivery Framework infection reduction organisms for 2019/20, these will be monitored through the Sub-Committee.
- Hand Hygiene Improvement Plan - agreed as a work plan to improve compliance for the year ahead. Noted that leadership is essential in driving the work around 'Bare Below the Elbow' 'Who Needs Gloves?' with work to be fed back.
- Task and Finish Group to look at Isolation Facilities to provide recommendations to the IPSC.
- Portable Fans - work with Procurement and Estates to action the UK national alert.
- Sharp Safety – Health and Safety, Occupational Health and Infection Prevention to develop recommendations and action plan to be monitored through IPSC.
- Policies - to ensure that all policies are up to date
- Engagement with Estates and Hotel Services on Hospital walkabouts to review the environment.

Argymhelliad / Recommendation

To endorse the Infection Prevention Sub-Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	Protect Patients From Avoidable Harm From care Focus On What Matters To Patients, Service Users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Living and working well. 3. Growing older well.

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Support people to live active, happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agenda, papers and minutes of the Infection Prevention Sub-Committee. Antimicrobial Delivery Plan "Together for Health, Tackling Antimicrobial Resistance and Improving Antimicrobial Prescribing" http://www.wales.nhs.uk/sitesplus/documents/888/Antimicrobial%20Resistance%20Delivery%20Plan.pdf HDUB Infection Prevention Improvement Plan 2018/19 Att 3 Improvement Plan 2018 Update Jan 2019.pdf WHC 2018 020: https://gov.wales/docs/dhss/publications/whc2018-020en.pdf Hand Hygiene Improvement Plan \\Client\I$\Hywel Dda\Infection Control\Reports\2019\QSEAC\Attachement 6 Hand Hygiene Action Plan 2019 v2.pdf CMO/CNO Letter re bare Below the Elbow Att 7 CMO CNO letter - Bare Below the Elbow (BBE) (003).pdf
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Infection Prevention Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Infection Prevention Sub-Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	SBAR template in use for all relevant papers and reports.
Gweithlu: **Workforce:**	SBAR template in use for all relevant papers and reports.
Risg: **Risk:**	SBAR template in use for all relevant papers and reports.
Cyfreithiol: **Legal:**	A sound system of internal control, as evidenced in the Infection Prevention Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Infection Prevention Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 April 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Safeguarding Sub-Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Passey Assistant Director of Nursing Quality, Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Strategic Safeguarding Sub-Committee Annual Report 2018/19 to the Quality, Safety & Experience Assurance Committee.

The Strategic Safeguarding Sub-Committee Annual Report provides an overview in respect of the work that has been undertaken by the Sub- Committee during 2018/19, and outlines the main achievements, which have contributed to robust integrated governance across the University Health Board (UHB).

Assurance regarding the functions of the Strategic Safeguarding Sub Committee is detailed within this SBAR; in addition, this is supplemented by an annual report (Annex 1) which has been produced for 2018/19 to support a more visual and reader friendly document. This report summarises the work of the Strategic Safeguarding Sub Committee.

Cefndir / Background

The Health Board's Standing Orders and the terms of reference for the Strategic Safeguarding Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The Strategic Safeguarding Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Assurance Committee at its Board meeting on 26th January 2017. The terms of reference of the Strategic Safeguarding Sub-Committee were subsequently approved at its meeting on 22nd March 2018.

The fundamental purpose of the Strategic Safeguarding Sub-Committee is to assist the Health Board and Quality, Safety & Experience Assurance Committee to deliver its statutory and mandatory responsibilities in relation to the safeguarding duty.

The Annual Report specifically comments on the key functions that are considered by the Sub-Committee, these include:

- The assurances that are in place to safeguard children, young people and adults who access the services within Hywel Dda University Health Board.
- The Health Board's progress against implementation of Welsh Government legislation and policies.

The SSSC provides assurance that a focus on safeguarding is integrated into the Health Board functions and influences the direction for service delivery, evidencing themes and changes/improvements to services as a result of analysis of any safeguarding issues. Its purpose is also to oversee and steer the direction of safeguarding in the Health Board, and promote a culture of positive learning.

The SSSC will facilitate the University Health Board compliance with external standards, good practice guidance and any other relevant legislation.

This SBAR and the supplementary report specifically comments on the key areas considered by the Sub-Committee in terms of safeguarding and the adequacy of the arrangements in place to meet the legislative changes in relation to safeguarding at national and local levels.

Asesiad / Assessment

The SSSC Annual Report 2018/19 is intended to outline in a reader friendly format how the Sub-Committee and its Groups have complied with the duties delegated by the QSEAC through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

It must be noted that the report remains in draft pending completion of quarter 4 reporting. Any key areas of risk and governance relating to the detail of the Terms of Reference are noted in the Annual Safeguarding Report 2018/19.

The terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's ability to deliver its statutory and mandatory responsibilities in relation to the safeguarding duty.

The Sub-Committee will seek to provide assurance, via the QSEAC, that an appropriate system for safeguarding of children and adults accessing health care or health care premises is in place across the organisation and that the relevant guidance and standards are being achieved or progressed in order to reduce risk and ensure the safety and delivery of high standards.

Members of the SSSC need to reflect multi professional working with safeguarding expertise. This is achieved by close working relationships with the Local Authority County Safeguarding leads across the region.

In discharging this role, the Sub-Committee is required to oversee and monitor the safeguarding agenda for QSEAC in respect of its provision of advice to the Board, and ensure the implementation of the safeguarding agenda is clear and meets the legislative requirements in relation to:

- Social Services & Well-being (Wales) Act (2014),
- Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Modern Slavery Act (2015)
- Wales Interim Policy and Procedures for the Protection of Vulnerable Adults 2013
- Safeguarding Children Working Together under the Children Act 2004 (2006)

- All Wales Child Protection Procedures (2008)
- Female Genital Mutilation Act (2003)
- Mandatory Reporting of Female Genital Mutilation- procedural information, Home Office, 2015
- NHS Wales Child Sexual Exploitation Prevention Strategy (2016-2019)
- Progress on partnership working with other agencies to improve the safeguarding of adults and children in line with legislation

Meetings

The Strategic Safeguarding Sub-Committee meetings have been held on a quarterly basis throughout 2018/19. As the SSSC is directly accountable to the QSEAC for its performance, following each meeting it provides an assurance to the Committee through a formal written update report which is received at the subsequent Committee meeting.

During 2018/19, the Sub-Committee met on four occasions and was quorate at all meetings

Governance, Leadership and Accountability,

The Strategic Safeguarding Sub Committee reviewed its work plan in 2017 to support delivery of safeguarding agenda; the work plan provided a clear vision and strategic direction for the committee during the year. All objectives within the work plan have been reviewed and where there is an exception in achievement, the rationale reported to SSSC.

The Director of Nursing for Patient Experience and Quality has the Executive lead for Safeguarding; delegated responsibility is to the Assistant Director of Nursing for Quality, Assurance, Safeguarding and Professional Standards. For further support leadership and accountability at a corporate level, the Head of safeguarding has accountability for both safeguarding adult and children responsibilities. This position supports alignment of both adult and children safeguarding procedures as set out in the Social Services and Well-being Act (Wales) 2015. This integrated approach continues to be built upon.

In 2018, the Named Doctor for Safeguarding Children retired. This post has been backfilled on an interim basis to ensure continuity of medical governance and leadership with a job share arrangement pending approval of the substantive job description by the Royal College.

Assurance Reports received by Strategic Safeguarding Sub-Committee

Safeguarding exception reports are received from each of the nominated accountable service level leads, across acute, community, mental health and learning disability and long-term care areas. Each lead will report on the safeguarding referrals, their outcomes and any external reviews This allows the committee to discuss the referrals and support assurance that the referrals are being managed in line with the Health Board Policies and Procedures.

The Lead Doctor for Children and the Associate Medical Director responsible for Safeguarding also attend the SSSC meeting.

Strategic Safeguarding Committee relationship with County and Regional Safeguarding Boards and the NHS Wales Safeguarding Network

The Assistant Director of Nursing for Assurance, Quality, and Safeguarding and the Head of Safeguarding has strong working relationships with partner agencies including local authority Heads of Safeguarding. These working relationships have supported excellent progress since the implementation of Part 7 of the Social Services and Well-being (Wales), Act 2014 and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 on a Regional basis.

The Assistant Director of Nursing for Assurance and Safeguarding is the vice chair of the Regional Children Safeguarding Board (CYSUR), which was established in June 2014 and the Mid and West Wales Adult Protection Board (CWMPAS) was established in April 2016. Both have strong governance arrangements underpinning their work.

Both the Assistant Director of Nursing and the Head of Safeguarding are active members of these committees.

Hywel Dda University Health Board plays its full role in each of the Local Authority County Local Operational Groups for safeguarding adults and children.

The Lead for Adult Safeguarding within Hywel Dda University has worked collaboratively with the regional County Leads for Adult Safeguarding, Dyfed Powys Police and the Welsh Ambulance Service to develop a Regional Adult Safeguarding Threshold Guidance Document which was implemented across the region in 2018.

Update against relevant Acts reported to the Strategic Safeguarding Sub-Committee during 2017/18

Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (VAWDASV) 2015

A Mid and West Wales VAWDASV Strategic Group is well established chaired by the Head of Mental Health and Learning Disabilities, Carmarthenshire Local Authority. The direction of the group is guided by a Strategic Delivery Plan.

The VAWDASV Regional Strategy was launched during National Safeguarding Week in November 2018. There are six regional priorities agreed as follows.

- Improve public knowledge and awareness and challenge attitudes towards equality and domestic abuse among citizens
- Increase the awareness of children and young people of the important of safe and healthy relationships and abuse is always wrong
- Increase the focus on holding perpetrators to account and providing them with opportunities to understand their behaviour and its consequences.
- Make early intervention and prevention an integrated priority
- Ensure professionals are trained to provide timely and effective responses to victims and survivors
- Provide victims with equal access to appropriately resourced services.

We will work jointly with our partners to deliver on these priorities and continue to report progress through Strategic safeguarding Sub Committee.

The National Training Framework is statutory guidance issued under Section 15 of the Act. The Health Board were to have achieved 100% compliance with Group 1 training (via e learning) by March 2018, we are currently reporting 72% compliance. This is identified as a risk on the safeguarding risk register and services are to identify plans to achieve full compliance across all areas.

We are now complaint with Group 6 training which is for public sector leaders. The Head of Safeguarding delivered a presentation to Board on 28th February 2019

The roll out of Ask and Act training has been delayed due to delays in the national training programme; however, since receipt of the NHS Ask and Act training package, we are planning roll out during 2019/20.

Serious Crime Act 2015.

Female Genital Mutilation (FGM) as detailed within the new provisions in the Serious Crime Act 2015. Following implementation of the Act, there is a legal requirement for all HB's to report the number of FGM cases. In 2017, a FGM Flow Chart was developed for Health Board staff and the All Wales FGM Pathway was disseminated and made available on the Health Board safeguarding intranet site. This provides support to staff to facilitate recognition and enable them follow the guidance set out in the Act.

During 2018/19 there were four reported FGM cases in the Hywel Dda Health Board area all were managed in accordance with the guidance.

The Named Safeguarding Midwife is the identified lead for FGM within the HB.

Social Services and Well-being Act (Wales) (SSWBA) 2014

The Health Board is able to provide assurance of compliance with the Act and associated statutory guidance through the assurance and exception report to SSSC during 2018/19. We continue to have a Safeguarding Adults at Risk Interim Policy; which remains under constant review awaiting the development of the All Wales Procedures for Safeguarding Children and Adults which are expected later in 2019.

Learning from Reviews

The Health Board has a statutory duty to co-operate with and engage in child and adult practice reviews under the Social Services and Wellbeing (Wales) Act 2014. Such reviews take place where a child or adult involved in a significant incident where abuse or neglect of a child is known or suspected.

Under statutory guidance of the Domestic Violence, Crime and Victims Act 2004, the Health Board also has a duty to participate in Domestic Homicide Reviews. Domestic Homicide Reviews are held with a view to identifying the lessons to be learnt from the death of those age 16 yrs or over, which appears to have resulted from violence, abuse or neglect by a person to whom he was related, or with whom he was or had been in an intimate personal relationship, or a member of the same household as himself.

The Health Board engagement in multi-agency reviews in 2018/19 has included activity with the following.

Adult Practice Reviews	Child Practice Reviews	Domestic Homicide Reviews
1	4	

Learning from reviews for health care professional includes record keeping. However, good practice has been identified with the Sharing Information Pathways for Midwifery.

In addition to the above reviews, our staff have participated in 7 Multi-agency Practitioner Forums (MAPFs) for children and 1 for adults. A MAPF is a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep people safe.

Learning from reviews is included in safeguarding training which demonstrates our commitment to ensuring the safety and wellbeing of children and adults.

Sexual Assault Referral Centres (SARC)

Over the past four years, the NHS Wales Collaborative has been undertaking a review of SARC Services across South West Wales. A proposed model has been identified for implementation. In the meantime, an interim solution to support services for the local population of Hywel Dda has bene agreed and continues to be monitored.

Safeguarding Training Compliance

Safeguarding training is integral to ensuring our staff have the competence to recognise abuse and neglect involving children and adults. As a Health Board, we comply with the Safeguarding children and young people: roles and competences for health care staff intercollegiate document (March 2014). Until August 2018, there was no intercollegiate document for adult safeguarding. Level 1 and 2 training was generally agreed across the region with multi-agency colleagues prior to the establishment of the regional board and also agreed across NHS Wales.

All face to face training includes lessons learned from safeguarding referrals and reviews. Training compliance is monitored by Strategic Safeguarding Sub Committee. All Directorate / services are to identify improvement plans to improve compliance with training; further to this, safeguarding training compliance is also monitored through Executive Team Performance Reviews.

	Level 1	Level 2	Level 3
Safeguarding Children	78.91%	73.36%	42.45%
Safeguarding Adults	77.24%	64.40%	

Other training delivered by the corporate safeguarding team includes FGM, CSE and Modern Slavery.

Summary of Achievements in 2018/19

- Completed a training needs analysis for VAWDASV.
- Completed the UHB action plan to support the NHS Wales Child Sexual Exploitation Strategy and have made NETSAFE available on our intranet
- Contributed to the development of a Regional Adult Safeguarding Threshold Document
- Participated in the consultation of the All Wales Procedures drafted to date.
- Continued to provide safeguarding training at all levels.
- Completed a presented a thematic review of learning from APRs, CPRs and DHRs.
- Met our statutory requirements in meeting the health needs of Looked After Children (LAC).
- Participated in the development of the Regional VAWDASV Strategy.

Key Risks and Issues/Matters of Concern

During 2018/2019, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

Core Safeguarding Training Compliance for level 1, 2 and 3 – this has remained a risk that has been raised to the Quality, Safety & Experience Assurance Committee. Although there has been an improvement in training compliance, capacity to release staff to attend training

remains a risk and this will be continually monitored throughout 2019/20 to ensure the increase in compliance continues.

Disclosure and Barring Service (DBS)– assurance of DBS compliance remains a risk for the Health Board, both in the context of compliance with 3 yearly checks for those involved in the care of children, and also in identifying those staff who have never had a DBS / CRB (Criminal Records Bureau) check. The Head of Safeguarding is working closely with Workforce and OD and a task and finish group will review the criteria for 3 yearly checks and ensure that the Electronic Service Record (ESR) is subsequently able to report reliably. A scoping exercise with recommendations for those staff who have no evidence of a DBS in ESR will be a priority for 2019/20

Compliance with the Group 1 VAWDASV National Training Framework – the Health Board failed to achieve 100% compliance by March 2018; while some improvement has been made, continued improvement is required. Services and Directorates are to identify their improvement plans which will continue to be motored through SSSC.

Future Work Plan 2019/20

- Continue good working relationships with Local Authority and other partner agencies
- Continues review of annual work plan
- Concentrated effort to support wider learning from Safeguarding reviews, consideration to be given to processes to facilitate this.
- Concentrate on analysis of data to support outcome focused reports over the year.

Argymhelliad / Recommendation

To endorse the Strategic Safeguarding Sub Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Risk Register Reference:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working:	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term - the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs
	Prevention – the importance of preventing problems occurring or getting worse
	Integration - the need to identify how the Health Board's well-being objectives may impact upon each of the well-being goals, on its other objectives, or on the objectives of other public bodies
	Collaboration – acting in collaboration with anyone else (or different parts of the organisation itself) which could help the Health Board to meet its well-being objectives
	Involvement - the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the Health Board serves

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Strategic Safeguarding Sub Committee meetings 2018/19

Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety & Experience Assurance Committee:	Strategic Safeguarding Sub-Committee Chair and Lead Director

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	SBAR template in use for all relevant papers and reports.
Cyfreithiol: Legal:	A sound system of internal control, as evidenced in the Strategic Safeguarding Sub-Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and the Strategic Safeguarding Sub-Committee's Terms of Reference, requires the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee.
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	SBAR template in use for all relevant papers and reports

Hywel Dda University Health Board
Safeguarding

Annual Report 2018-2019

Foreword

I am pleased to present the 2018/19 safeguarding annual report. The report outlines the progress Hywel Dda University Health Board has made with safeguarding children and adults both internally and with our partners through CYSUR and CWMPAS and our contribution to a once for Wales approach in the NHS through the NHS Wales Network.

This report is based on the progress of the Health Board and the Strategic Safeguarding Sub Committee. It is important to recognise in the Health Board that while we have a corporate safeguarding team, the delivery of safe and effective services is the responsibility of all professional groups in operational teams in acute, community, primary care and mental health and learning disabilities.

2018/19 has seen us make progress against our strategic safeguarding work plan; we have participated in a self-assessment against the NHS Wales Safeguarding Maturity Matrix and their families and we contributed to the development of the CWMPAS Adult Safeguarding Threshold Guidance regionally.

I am delighted that our Lead Nurse for Looked After Children was a runner up in the safeguarding category of the RCN Wales Nurse of the Year awards.

As a Health Board our commitment to safeguarding people is integral to our core business. We will continue to ensure our staff are aware of their responsibilities and we will continue to work with our partners across all agencies to promote and maintain the safety and wellbeing of people of all ages.

Mandy Rayani

Director of Nursing, Quality and Patient Experience

CONTENTS

Introduction

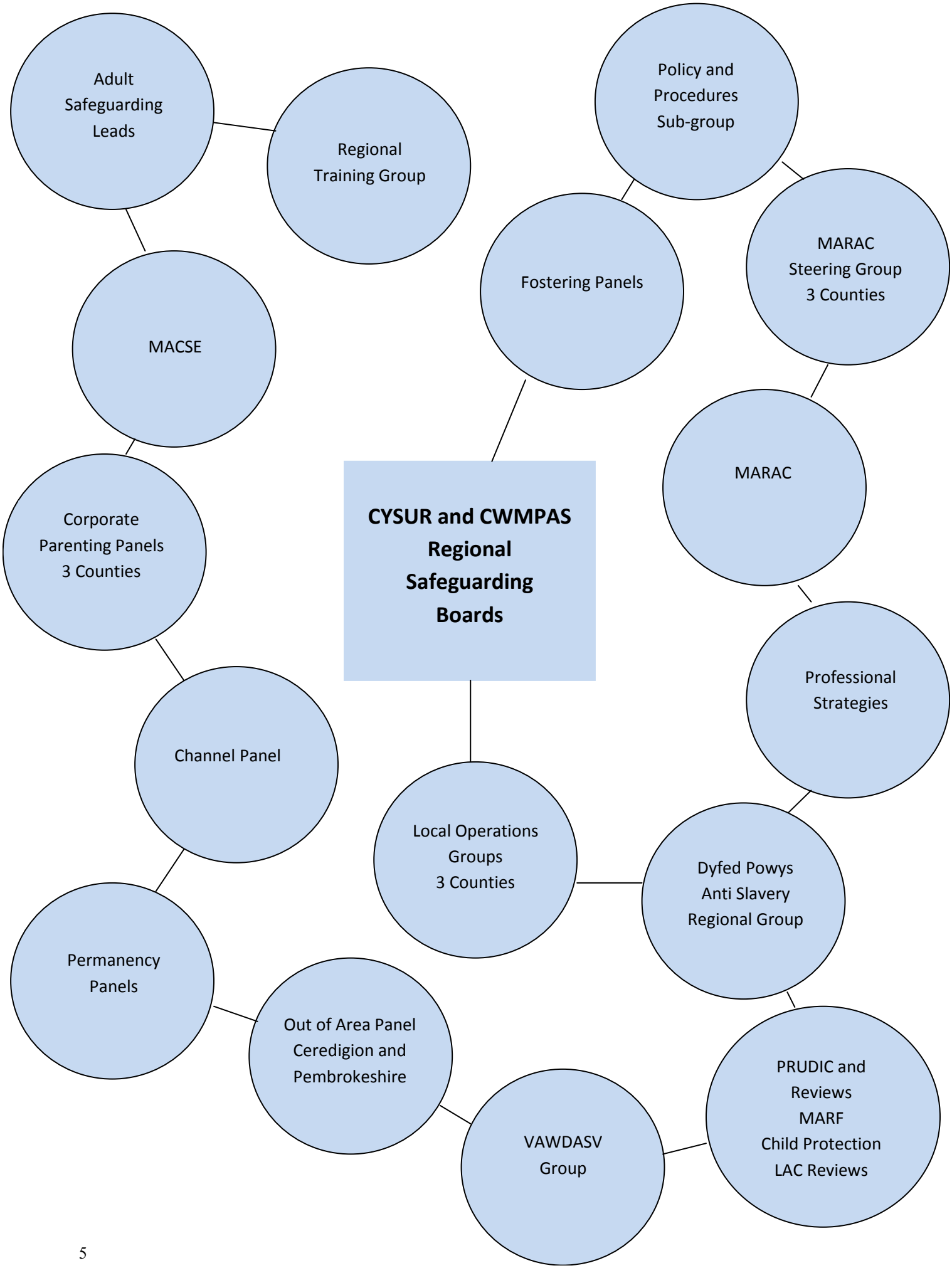
The Social Services and Wellbeing (Wales) Act 2014, places a statutory duty on the University Health Board to safeguard children and adults who may have needs for care and support. Furthermore the keeping children and adults who may have needs for care and support safe is everyone's responsibility. This means feeling and being safe with those, with whom they live, care and support them, as well as being safe in environments outside the home.
The Strategic Safeguarding Sub-Committee was established as a Sub-Committee of the Quality, Safety & Experience Assurance Committee and constituted from 1st June 2015. The primary purpose of a Sub Committee is to assist the University Health Board and Quality, Safety & Experience Assurance Committee to deliver its statutory and mandatory responsibilities in relation to the safeguarding duty. In particular, the Sub-Committee seeks to provide assurance to the Board that an appropriate system for safeguarding of children and adults accessing health care or health care premises is in place across the University Health Board and the relevant guidance and standards are being achieved or worked towards in order to reduce risk and ensure the safety and delivery of high standards.

The Strategic Safeguarding Sub Committee met four times during 2018/19 and was quorate at each meeting. Exception and assurance reports to the Quality, Safety, Assurance and Experience Committee were provided following each meeting.

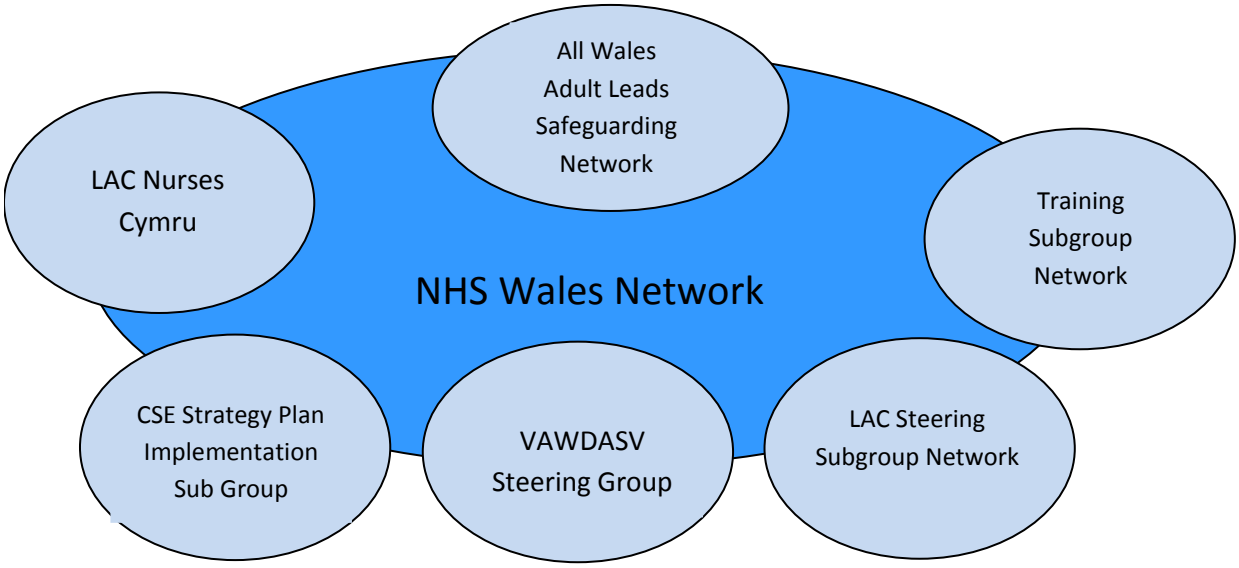
The operational delivery of safeguarding is supported by the University Health Board's Corporate Safeguarding Team through the provision of training, safeguarding supervision, specialist safeguarding children, adult and Looked after Children support and advice and policy development.

The Director of Nursing, Quality and Patient Experience is the executive director with responsibility for safeguarding.

As a statutory partner, the University Health Board works in partnership with the 3 Local Authorities and Dyfed Powys Police. We collaborate and provide leadership across the region through our engagement at the Regional Executive Boards, CYSUR and CWMPAS; Community Safety Partnerships, Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Regional Group and other groups as shown below.


Adult Safeguarding Leads
Regional Training Group
Policy and Procedures Sub-group
Fostering Panels
MARAC Steering Group 3 Counties
MACSE
MARAC
Corporate Parenting Panels 3 Counties
CYSUR and CWMPAS Regional Safeguarding Boards
Professional Strategies
Channel Panel
Local Operations Groups 3 Counties
Dyfed Powys Anti Slavery Regional Group
Permanency Panels
Out of Area Panel Ceredigion and Pembrokeshire
PRUDIC and Reviews MARF Child Protection LAC Reviews
VAWDASV Group

The University Health Board are committed to ensuring a 'once for Wales' approach to safeguarding systems and processes in NHS Wales, as such, we participate in the work of the NHS Wales Safeguarding Network.



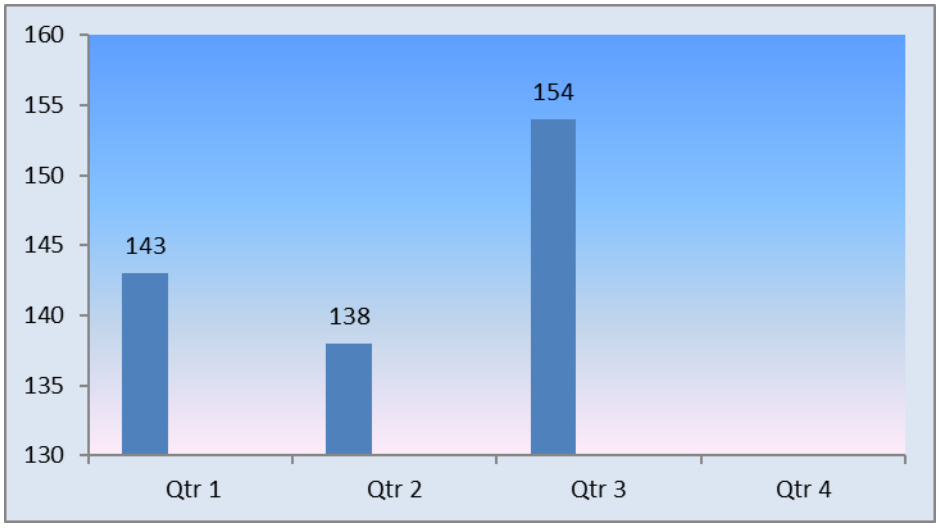
Our Achievements in 2018/19

Each year, the University Health Board has a safeguarding strategic work plan. Below is a summary of our key achievements.

- Completed a training needs anaylsis for VAWDASV
- Completed the UHB action plan to support the NHS Wales CSE Strategy and have made NETSAFE available on our intranet
- Contributed to the development of a Regional Adult Safeguarding Threshold Document
- Participated in the consultation of the All Wales Procedures to drafted to date
- Continued to provide safeguarding training for all levels
- Completed and presented a thematic review of learning from APRs, CPRs and DHRs in Wales
- Met our statutory requirements in meeting the health needs of Looked After Children (LAC)
- Participated in the Regional VAWDASV Strategy

Safeguarding Children

Safeguarding Children Referrals
The Health Board is complies with the requirements of the Children Act 2004, Social Services and Well-being (Wales) Act (SSWBWA) 2014, Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV), as well as the Health and Care Standard 2.7 safeguarding referrals are made by practitioners within the Health Board to Local Authorities Children Services in accordance with the Regional Safeguarding Board (CYSUR) Regional Threshold and Eligibility for Support Document, 'The Right help at the Right Time' (2017). Copies of Multi Agency Referrals (MARF's), made to any local authority in respect of safeguarding concerns are received by the Health Board safeguarding team which enables scrutiny and audit of the quality of such referrals.



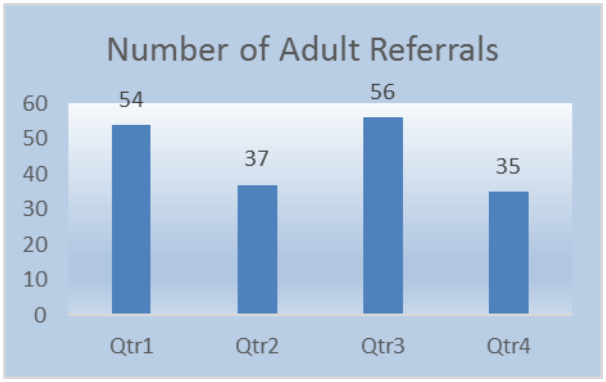
Future development of an electronic record and data collection system in line with the safeguarding adult model, will enable the commencement of a MARF audit. This will commence in April 2019 and will review all MARF's to identify the links to Adverse Childhood Experiences (ACE'S) and outcomes for children and young people.

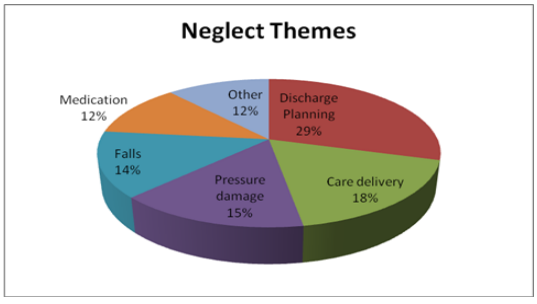
Female Genital Mutilation (FGM).
As FGM is a form of child abuse, professionals have a statutory obligation to protect girls and women at risk of FGM. Since October 2015 registered professionals in health, social care and teaching have a mandatory duty to report case of FGM to the police where a girl under the age of 18 years either discloses that she had has had FGM or the professional observes physical signs of FGM, under the Serious Crime Act, 2015. Within the Health Board we have made appropriate referrals under the All Wales Clinical Pathway - Female Genital Mutilation (FGM).

Safeguarding Adults

The adult safeguarding referral numbers represent all referrals related to adults who experience alleged abuse or neglect whilst under the care of the Health Board, either in the community or acute settings. The data is further broken down into categories, with Neglect being the most prominent category. Physical abuse is the next most prominent occurrence, the majority of which is as a consequence of patient to patient incidents, this theme is reflected in the sexual abuse category. Financial abuse, although less in number as a minimum reflect poor handling of patient funds and at worst direct theft from patients.

All incidents and allegations are scrutinised to determine if appropriate care and support plans were in place and any immediate risks addressed. Further to this, generally, a formal investigation will be take place and subsequent action taken and learning identified.





Examples of improvements from the learning from adult safeguarding referrals involving Health Board services includes work to improve communication between agencies on discharge from hospital; risk assessment of ligature points; scrutiny of pressure damage incidents and implementation of a pressure damage passport for all discharges and inter ward transfers; a training programme for pressure damage prevention; scrutiny of falls and medication error incidents and sharing of learning.

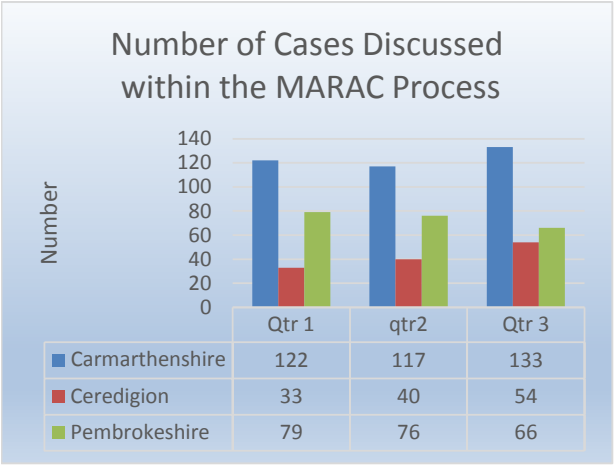
Domestic Violence

MARAC (Multi-agency Risk Assessment Conference

A multi-agency risk assessment conference(MARAC), is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health including mental health services, local authorities, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim and any children or unborn babies at risk.

The Health Board safeguarding team is a key member of the five MARAC's that occur monthly across the Health Board area.



	Qtr 1	qtr2	Qtr 3
Carmarthenshire	122	117	133
Ceredigion	33	40	54
Pembrokeshire	79	76	66

VAWDASV (Violence Against Women, Domestic Violence and Sexual Violence)

In 2015, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act (VAWDASV) became a landmark piece of legislation to address domestic abuse and sexual violence in Wales. The Act aims to ensure that there is a consistent approach to tackling all forms of domestic abuse and violence, and requires all public sector organisations to provide their employees with statutory training to improve awareness and response to VAWDASV through the National Training Framework.

A training needs analysis has been undertaken to identify the number of staff requiring training within the priority groups.

The Health Board has been instrumental in the development of the Regional Strategy to implement the key identified priorities.

Safeguarding Training

Safeguarding training is integral to ensuring our staff have the competence to recognise abuse and neglect involving children and adults. As a Health Board, we comply with the Safeguarding children and young people: roles and competences for health care staff intercollegiate document (March 2014). Until August 2018, there was no intercollegiate document for adult safeguarding. Level 1 and 2 training was generally agreed across the region with multi-agency colleagues prior to the establishment of the regional board and also agreed across NHS Wales.

All face to face training includes lessons learned from safeguarding referrals and reviews.

Training compliance is monitored by Strategic Safeguarding Sub Committee and improvement plans sought from operational service leads. An improvement plan to increase compliance with Level 3 child safeguarding training and Level 2 adult safeguarding training is a priority for 2019.

Safeguarding Training

	Level 1	**Level 2**	**Level 3**
Safeguarding Children	78.91%	73.36%	42.45%
Safeguarding Adults	77.24%	64.40%	

The VAWDASV National Training Framework was launched in March 2016.

VAWDASV Group 1	69.32%

An improvement plan to achieve 100% compliance with Group 1 has been identified as a priority for 2019/20 in addition to rolling out Ask and Act training for priority groups.

Other training delivered by the corporate safeguarding team includes FGM, CSE and Modern Slavery.

Supporting Staff

Safeguarding Children Supervision

Safeguarding is emotive and can be complex in its nature. With safeguarding being everybody's business safeguarding children supervision is available to all Health Board staff as required. Additionally specific staff groups that are case holders working with children and their families have formal supervision on a six monthly basis. The staff groups accessing safeguarding children supervision on a six monthly basis are Health Visitors, School Nurses and Midwives.

Safeguarding children supervision develops practitioner knowledge and skills in relation to safeguarding, aids reflection and provides support, provides a mechanism audit and governance and is a building block to ensuring best practice and ensures that staff are confident and competent practitioners who are able to make sound professional judgements to safeguard.

Safeguarding Adult Supervision

Safeguarding supervision is in the process of being piloted in South Pembs Hospital and has been positively received by the staff who participated. The safeguarding team also aim to offer short term supervision when requested in response to specific concerns, in addition to bespoke training.

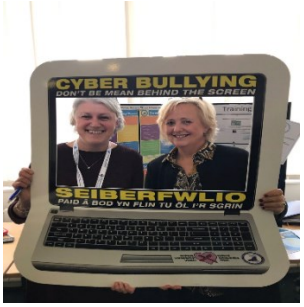
Safeguarding Newsletter

The Health Board produces a quarterly electronic safeguarding newsletter, to enable staff to be updated on the latest safeguarding legislation, policies, procedures, training and safeguarding events.

National Safeguarding Week

Wythnos Genedlaethol Diogelu
National Safeguarding Week

During November 2018, the corporate safeguarding team held a number of successful events to promote awareness of safeguarding issues and the role of the safeguarding team. The team worked collaboratively with Dyfed Powys Police, Hafan Cymru and Local Authorities to offer advice and support to staff on a number of safeguarding topics.

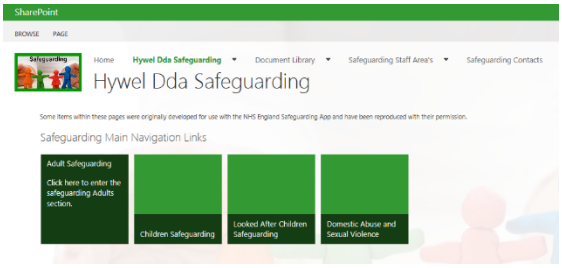


Additionally the Health Board teamed up with The Lucy Faithfull Foundation, to raise awareness regarding Child Sexual Abuse and Exploitation and what we all need to know about this difficult and emotive subject. Information and resources were sent via global emails to all General Practitioner practices. Further information regarding this is available via the Stop it Now! Get Help website- www.get-help.stopitnow.org.uk

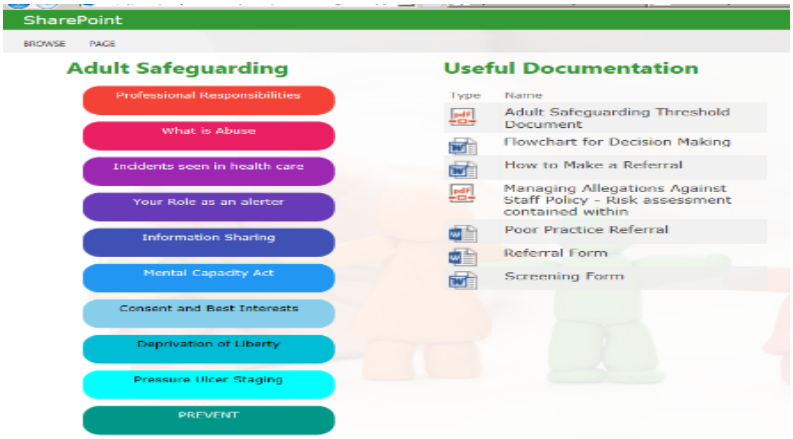
Single Point of Contact

Both the adult and children safeguarding teams offer a single point of contact to Health Board staff and our Statutory Partners. This ensures that all referrals are appropriately scrutinized by the Health Board safeguarding team and actioned appropriately. The action triggered dependents on the type of referral, but would usually involve signposting to the appropriate practitioner and ensuring where needed, that a suitable action plan is in place to safeguard the individual. The Health Board team also support the collection and sharing of information to further inform the enquiry process or investigation.

Safeguarding Intranet Site



The safeguarding team have achieved the first part of the roll out of a new safeguarding interactive intranet site. The adult safeguarding section has been completed with children safeguarding, Looked After Children and Domestic Abuse and Sexual Violence sections to follow. The site aims to provide a host of resources to support staff in everyday practice as well as helping them identify what abuse and neglect may look like in different setting.



Learning from Reviews

The Health Board has a statutory duty to co-operate with and engage in child and adult practice reviews under the Social Services and Wellbeing (Wales) Act 2014.

Under statutory guidance of the Domestic Violence, Crime and Victims Act 2004, the Health Board has a duty to participate in Domestic Homicide Reviews.

HDUHB engagement in multi-agency reviews in 2018/19 has included activity with the following.

Adult Practice Reviews	Child Practice Reviews	Domestic Homicide Reviews
1	4	3

Learning from reviews for health care professional includes record keeping. However, good practice has been identified with the Sharing Information Protocols for Midwifery.

In addition to the above reviews, our staff have participated in 7 Multi-agency Practitioner Forums (MAPFs) for children and 1 for adults. A MAPF is a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep people safe.

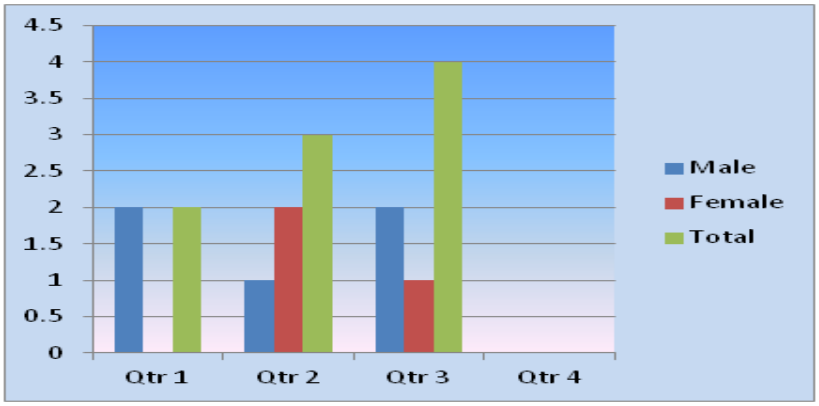
Learning from reviews is included in safeguarding training which demonstrates our commitment to ensuring the safety and wellbeing of children and adults.

Procedural Response Unexpected Death in Childhood

The Health Board complies with the Public Health Wales Procedural Response for the Unexpected Deaths in Childhood (PRUDiC) (2018). PRUDiC sets the minimum standard for a consistent and sensitive and safe response across Wales, to unexpected deaths in infancy and childhood through a process of communication, collaborative action and information sharing.
Each case follows the PRUDiC process in relation to information sharing meeting, review meeting and final closure meeting. The process is completed in a 12 month time frame.

The corporate safeguarding team take lead responsibility within the Health Board for ensuring appropriate reporting, representation, collation of information from primary and secondary care and support for staff members involved in the case.
The financial year 2018-2019 saw the PRUDiC process instigated 9 times within the Health Board region.

Quarterly PRUDiC's within the Health Board region 2018 -2019.



There is no learning identified for the Health Board to date through the reported PRUDiCs in 2018/19.

Looked After Children

Hywel Dda University Health Board has statutory responsibilities in relation to the planning, commissioning and delivery of services in order to address the health needs of Looked After Children which are residing in the Hywel Dda UHB area and Hywel Dda UHB children placed in other Health Board areas.

681
Total number of LAC

278
Number of LAC from Out of Area

557
Completed Health Assessments

19
Number of Children's Homes in Hywel Dda

53
Looked After Children in Children's Homes

113
Notifications received from Out of Area

376
Total Referrals from HA

76
Dental examinations

Foster Care Training

Very interesting, learnt a lot. Just what training I needed to help with parent and baby placements.

77
LAC Supervision

Sally Holland
@childcommwales

Very good to meet up with looked after children nurses from all over Wales today. Very interesting discussion based on your knowledge & experience. Diolch bawb am y gwaith cymhwys.

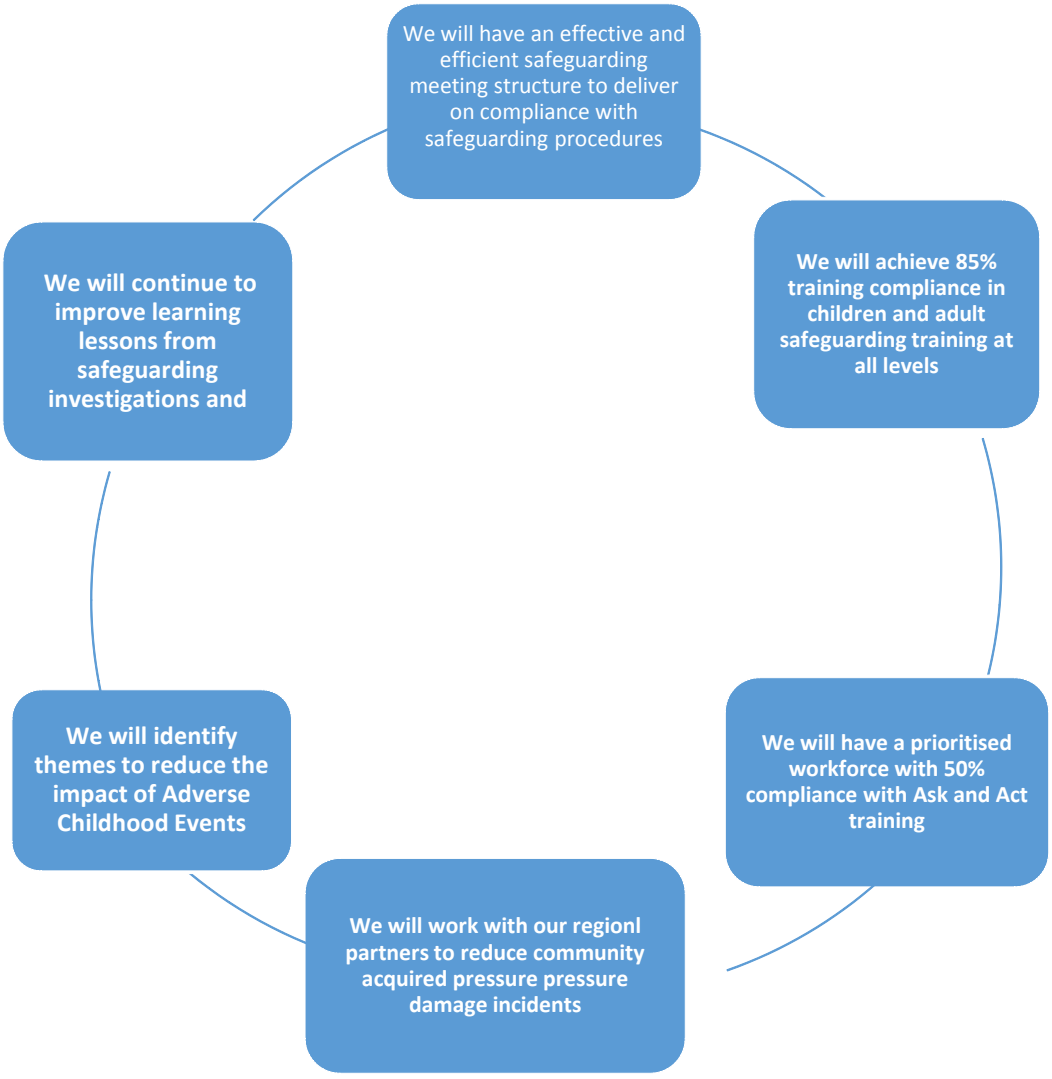
104 referrals to CAMHS

9 receiving support

23 other services

Our priorities for 2019/20

We will build on our achievements to date and will continue to work with our Regional Executive Boards CUSUR and CWMPAS to align our strategic priorities. However, for Hywel Dda University Health Board our priorities for the coming year are:



Conclusion

Hywel Dda University Health Board will remain committed to safeguarding the health and wellbeing of children and adults. We will continue to work with our multi-agency partners to focus on prevention and will prioritise ensuring our staff understand their responsibilities through awareness, training, sharing lessons and supervision. We acknowledge we have opportunities for improvement and look forward to the challenges and opportunities the forthcoming year will bring.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Charitable Funds Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Simon Hancock, Charitable Funds Committee Chair
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Jennings, Director of Partnerships & Corporate Services

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Charitable Funds Committee's Annual Report for 2018/19 to the Board.

The Annual Report outlines how the Charitable Funds Committee has complied with the key responsibilities set through its terms of reference and also identifies key areas of work intended to provide further assurance that the Committee's terms of reference are being adequately discharged.

Cefndir / Background

The Hywel Dda University Local Health Board was appointed corporate trustee of the charitable funds by virtue of Statutory Instrument 2009 No. 778 (W.66) and that its Board serves as its agent in the administration of the charitable funds held by Hywel Dda University Health Board (HDdUHB).

In accordance with Hywel Dda University Local Health Board's standing orders and scheme of delegation, the Board has nominated a committee to be known as the Charitable Funds Committee, established as a Committee of Hywel Dda University Local Health Board, and constituted from 22nd July 2010.

HDdUHB holds charitable funds as sole corporate trustee and board members, whilst not 'trustees' in their own right, are jointly responsible for the management of those charitable funds.

The charitable funds linked to HDdUHB are independent of the 'exchequer' funds of HDdUHB and must be managed separately. The Charity Commission has regulatory responsibility for ensuring the proper management of these funds.

The purpose of the Charitable Funds Committee is to 'make and monitor arrangements for the control and management of the University Health Board's charitable funds, within the budget, priorities and spending criteria determined by the Board and consistent with legislative framework'.

This paper outlines the governance arrangements in place to ensure that the Committee's terms of reference are adequately discharged and that our registered charity, Hywel Dda Health Charities, operates to a high standard with limited exposure to any kind of risk, both financial and non-financial.

Asesiad / Assessment

The Charitable Funds Committee (CFC) Annual Report 2018/19 is intended to outline how the Committee and its Sub-Committee has complied with the duties delegated by the Board through the terms of reference set, and also to identify key actions that have been taken to address issues within the Committee's remit.

The CFC has been established under Board delegation with the CFC reviewing its current terms of reference at its meeting on 14th March 2019.

These terms of reference clearly detail the Committee's purpose to provide assurance to the Board in its role as corporate trustee of the charitable funds held and administered by the Health Board. The Committee is required to make and monitor arrangements for the control of the Board's charitable funds, within the budget, priorities and spending criteria determined by the Board and consistent with legislative framework.

1. Key responsibilities

In discharging this role, the Committee is required to oversee and monitor implementation against the following areas of responsibility:

- Within the budget, priorities and spending criteria determined by the UHB as trustee and consistent with the requirements of the Charities Act 2011 (or any modification of these acts) to apply the charitable funds in accordance with its respective governing documents.
- Devise, implement and approve appropriate procedures and policies to ensure that fundraising and accounting systems are robust, donations are received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.
- Ensure that the UHB policies and procedures for charitable funds investments are followed.
- In addition, make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:
  - Trustee Act 2000
  - The Charities Act 2011
  - Terms of the fund's governing documents
- Receive at least twice a year reports for ratification from the Director of Finance and investment decisions and action taken through delegated powers upon the advice of the UHB's investment adviser.
- Oversee and monitor the functions performed by the Director of Finance as defined in the UHB's Standing Financial Instructions.
- Monitor the progress of Charitable Appeal Funds where these are in place and considered to be material.
- Monitor and review the UHB's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

2. Charitable Funds Operations Sub-Committee

There is currently one Sub-Committee reporting to the CFC; the Charitable Funds Operations

Sub-Committee which was constituted from 1st April 2017.

The Sub-Committee was established following a review of charitable funds governance arrangements at a local level to provide assurance to the CFC that the University Health Board's policies and procedures are followed in relation to the control and management of our named charitable funds. The Sub-Committee was established alongside the establishment of a central business function within the operations directorate with the intention of also providing administration support to the Sub-Committee function.

During 2018/19, the Sub-Committee met on eight occasions and was quorate at seven of the meetings.

The operational responsibilities of the Sub-Committee are to:

- Consider and approve all requests for expenditure over £5,000 and under £25,000 against named charitable funds, within the scheme of delegation for authorisation of charitable funds expenditure.
- Consider and recommend for approval all requests for expenditure over £25,000 against named charitable funds, within the scheme of delegation for authorisation of charitable funds expenditure.
- Provide scrutiny and onward assurance to the CFC on charitable income and expenditure.
- Receive assurance from fund managers on activity relating to their designated charitable funds.
- Provide scrutiny to all unusual or novel expenditure requests of any value, and expenditure requests resulting in ongoing charitable funds commitment, prior to CFC consideration.
- Develop and oversee the implementation of annual expenditure plans for the use of the named charitable funds.
- Consider and approve all requests for the establishment of new charitable funds.

The Sub-Committee's Annual Report for 2018/19, submitted to the March 2019 meeting of the Charitable Funds Committee, outlines how the Sub-Committee has complied with the key responsibilities set through its terms of reference to provide assurance that its terms of reference are being adequately discharged.

2.1 Sub-Committee Feedback

The Sub-Committee is required to report to the CFC on a quarterly basis to provide assurance that it is exercising its duties in line with its terms of reference. During 2018/19, the CFC received quarterly written reports from the Sub-Committee highlighting the key areas of work scrutinised, key risks and issues and matters of concern.

This included:

<u>Sub-Committee update to June 2018 CFC meeting</u>

- The Sub-Committee updated the Charitable Funds Committee on the charity's education & training eligibility criteria to charitable expenditure. The update was subsequently approved by the Committee during the meeting.

<u>Sub-Committee update to October 2018 CFC meeting</u>

- The Sub-Committee had been asked to consider charitable funds support for the development of Prince Philip Hospital choir. It was noted that before approval was given a report should be submitted to the Charitable Funds Committee for consideration

however the request was subsequently withdrawn.

- During a discussion on the process of purchasing items of equipment or refurbishment schemes, the Sub-Committee agreed to set up a Task & Finish Group to review the current documentation for these types of applications.
- A lessons learnt paper in respect of the importance of following correct processes and giving a realistic figure of costs for all expenditure requests was submitted for review at the Sub-Committee's meeting held on 9th July 2018.
- The Sub-Committee noted a request to increase Tŷ Bryngwyn's equipping budget by £88.746 in order to support an enhanced refurbishment. This extra funding would come from a legacy donation received in July 2018. The Charitable Funds Committee was asked to approve this request via Chair's Action.

Sub-Committee update to December 2018 CFC meeting

- The Sub-Committee approved a request at its 4th October 2018 meeting to set up a new charitable fund for the Carmarthenshire Colorectal Service. This request had been further revised to incorporate the whole geographical area of the Health Board and would be formally approved at a future Sub-Committee meeting. The Sub-Committee also approved a request to set up a new Carmarthenshire Liver Fund.

Sub-Committee update to March 2019 CFC meeting

- It was noted that two Sub-Committee meetings had been stood down therefore a higher level of items had been approved through Chair's Action.
- An application was made to set up a new charitable fund; Health Board Wide Colorectal Fund.
- A written update to be provided to the Sub-Committee on the utilisation of IT devices to support patient centred care and service improvement, with an impact report to be provided 6 months from implementation and purchase date.

3. Membership

From the terms of reference approved in March 2019, the membership of the Committee was agreed as the following:

- Independent Member (Chair)
- Independent Member (Vice-Chair)
- 4 x Independent Members
- Chief Executive
- Director of Finance
- Director of Partnerships & Corporate Services (Executive Lead) for Hywel Dda Health Charities

In attendance:

- Assistant Director of Finance (Finance Systems and Statutory Reporting)
- Senior Finance Business Partner (Accounting & Statutory and Reporting)
- Deputy Director of Operations
- Head of Hywel Dda Health Charities
- Staff Side Representative

The Committee's membership ensures that HDdUHB's charitable funds are managed by a clearly identifiable body of people (as the corporate trustee) who take responsibility for management and control of the funds.

Since March 2015, a standing invitation has been extended to the Hywel Dda Community

Health Council to attend Committee meetings in an observer capacity. A standing invitation for a staff side representative has also been extended although no nominations have been received for this position during 2018/19.

4. Meetings

Since March 2018, CFC meetings have been held on four occasions and were quorate at each:

- 21st June 2018
- 3rd October 2018
- 20th December 2018
- 14th March 2019

5. Reporting to the Board

As the CFC is directly accountable to the Board for its performance, following each meeting it provides an assurance to the Board through a formal written update report which is received at the subsequent Committee meeting. These reports highlight any significant matters which require the Board's attention and are also used to request Board ratification of any relevant decisions made by the Committee. The Committee provided four update reports to the Board during 2018/19:

- 31st May 2018
- 26th July 2018
- 29th November 2018
- 31st January 2019

6. Matters escalated to Board

During 2018/19, no key risks and issues/matters of concern were escalated to the Board for consideration, other than for the following:

- In July 2018, the Committee advised the Board that whilst concerns were raised that donations to Just Giving and My Donate had decreased by 57%, the rationale for this may be negative publicity towards the fees charged by some online giving platforms.

During 2018/19 there were no matters requiring Board level consideration or approval.

7. Committee Terms of Reference and principal duties

In discharging its duties, the CFC has undertaken work during 2018/19 against the following areas of responsibility:

7.1 Financial control

A financial procedure which includes expenditure guidelines is in place to ensure that there are sufficient management controls to provide assurance that:

- Spending is in accordance with objects and priorities agreed by the CFC.
- Criteria for spending charitable monies are fully met.
- Accounting records are maintained.
- Devolved decision making is within specified parameters.

HDdUHB's Standing Financial Instructions cover the charity in so far as it is possible. Where it is not possible to follow the Standing Financial Instructions then prior authority needs to be sought through the Committee.

Charitable Funds are managed through HDdUHB's Oracle finance system in line with the Health Board's financial procedures. Internal Audit and Wales Audit Office conduct annual audits of the financial procedures in place.

Internal staff expertise ensures that all Charity Commission requirements and changes are

adhered to and also reported to the CFC as they occur.

7.2 Agreed spending objectives and charitable expenditure
Charity law recognises 'the relief of those who are ill including the support of those who care for the sick' as a charitable purpose. Our charitable funds must therefore only be utilised to support activity over and above our NHS responsibilities by providing additional benefits to frontline healthcare.

Our internal policies, procedures and systems relating to charitable funds expenditure have been subject to recent refinement. Our comprehensive 'User Guide' for staff provides clear guidelines on our charitable aims, eligible and ineligible items of expenditure and how to use the funds of the charity in a responsible and appropriate manner.

Every request for charitable expenditure must be approved by staff with the necessary authorised limits before being passed on to the Finance team for assessment and final authorisation.

Expenditure over £50,000 and expenditure under £50,000 which is unusual or contentious is presented to the CFC as it arises, and is discussed and agreed before being committed.

7.3 Resources to maintain management and control of charitable funds
Staff are employed by the UHB to ensure the effective management and operations of our charitable funds. Salary costs are reclaimed from the charity's resources to support the following duties:

- Maintenance of accounting systems
- Production of annual accounts
- Compilation of management information
- Scrutiny of expenditure proposals to ensure propriety
- Preparation of committee papers
- Fundraising and support to internal and external stakeholders

The Committee considers these costs on an annual basis when a paper is submitted at the final meeting of each financial year to seek approval to cover both pay and non-pay costs associated with the running of the charity.

On 14th March 2019, the Committee considered and approved the annual governance and support charge of £305,160.00 for the 2019/20 financial year. The Committee also considered and approved the 2019/20 support costs for Tŷ Bryngwyn Hospice of £52,848.00.

7.4 Risk management
The Chief Executive of the UHB, together with the other Directors, is responsible for ensuring that an effective system of financial control is maintained. The Chief Executive and other Directors are also responsible for reviewing the effectiveness of this system and have confirmed that the minimum control standards laid down by the Welsh Government have been in existence throughout the financial year. The minimum control standards apply equally to the management of the charity by officers of the University Health Board as to the exchequer funds of the University Local Health Board. In this way the major risks to which the charity is exposed have been reviewed and systems have been established to mitigate those risks.

Historically the Committee's risk register has had high risk scores around a number of risks relating to public confidence and reputational damage. However recent efforts to rebuild trust and confidence have significantly helped to reduce the risks to the charity as mitigating actions

have had a great impact.

At the CFC meeting on 14th March 2019 an update was given on the risk of a decrease in charitable giving to Hywel Dda Health Charities due to a potential lack of trust by the public and media interest. This could bring a risk to the Health Board's reputation through association by default. It was added that it is of importance that donors are made clear about where their donations go and how they will be used. A proposed Risk Action Plan was discussed and approved.

Committee members agreed with the risk scoring in the report and an update on the risk register and score was provided at the March 2019 meeting.

7.5 Investments and performance
The charity retains the services of investment advisors to manage its investment portfolios. Policy is set by the charity trustee in its instruction to their advisors. The advisors are instructed to manage the portfolios to produce both income and capital returns, and manage those funds within the value they retain on the accounts. The charity also holds funds in short term investments that are not managed by the investment advisor. The CFC monitors the performance of the Investment Advisor (Sarasin & Partners LLP) through the quarterly Integrated Performance Report.

7.6 Reserves
The charity has a reserves policy and has defined reserves to be the element of funds that are unrestricted and uncommitted. The charity shall hold reserves of 10% of the value of its fixed asset investments and £500,000, and shall only fall below to cover losses in value of those investments. In order to maintain the reserves as low as possible, it is important that expenditure plans are developed for all funds. Reserves are needed where there may be insufficient balances in individual restricted and designated funds to meet the objectives of those funds. There is also a need for reserves where there may be a requirement to incur expenditure which is exclusively charitable, and cannot be funded from revenue, for which there is not a relevant fund.

The reserves held by the charity as at 31st March 2018 is made up as follows:

- £3,655,695 Charity unrestricted funds
- £2,588,460 Charity restricted funds
- £2,012,951 Endowment funds
- **£8,257,106 Charity reserves held as at 31st March 2018**.

The charity's reserves are in excess of the minimum detailed in the reserves policy.

7.7 Internal audit
Internal audit undertake annual reviews to evaluate the adequacy of procedures and controls, to ensure compliance, and to provide reasonable assurance over:

- Achievement of management objectives for the systems
- Use of resources in accordance with donors requirements
- Compliance with policies and procedures
- Safeguarding assets

The internal audit reports are presented to both the CFC as well as the Audit and Risk Assurance Committee.

The most recent Internal Audit Report on charitable funds (HDUHB1819-17) was presented to the Committee on 14th March 2019. 'Substantial assurance' was given to the

effectiveness of the systems of internal control in place for the administration of charitable funds.

Two medium priority and one low priority issues were highlighted that are classified as weaknesses in the operation of the designated system/control of the charitable funds process (operation of system/controls), which have been accepted by management, to be addressed as per the report's management action plan.

7.8 Compilation of annual report and accounts
As part of its delegated role, the CFC reviews, approves and adopts the charity's annual report and accounts on an annual basis. Wales Audit Office (WAO) conducts an annual audit of the charity's annual reports and accounts with the outcome reported to the Committee as well as the Audit and Risk Assurance Committee. The annual audit provides assurance that all financial procedures are being adhered to. The 2017/18 annual report and accounts were approved by the CFC in December 2018 following their audit by WAO who issued an unqualified audit report.

7.9 Professional development
The Board, as corporate trustee, has a sound knowledge of the purpose of the charity and the procedures that govern its operations to fulfil its duties.

All Board Members (Executive Directors and IMs) are aware of their statutory duties and responsibilities to the charity and have unrestricted access to officers of the charity to enquire about its activities.

The Committee receives regular updates on relevant changes to charity law and any other areas of interest from verbal updates from staff or papers from the Charity Commission or from the national Healthcare Financial Management Association (Charitable Funds Special Interest Group).

An overview of the charity and roles and responsibilities of the corporate trustee is to be developed as part of the formal induction arrangements for new Board members, led by the Corporate Governance team, with a more informal induction undertaken by the Head of Hywel Dda Health Charities for new Committee members when required.

An annual self-assessment of effectiveness was completed by Committee Members and those in attendance with the outcome reported to the CFC in March 2019.

8. Chair's actions
Outside of Committee meetings, the Chair has delegated authority to act on behalf of the Committee. Chair's Actions typically focus on the approval of items of expenditure over £50,000, as required by the charitable funds approval thresholds. Requests for 'Chair's actions' are infrequent but are always accompanied by detailed papers for audit and reporting purposes, with any activity reported back to the next meeting for ratification.

During 2018/19, the following items were considered under 'Chair's Action':

- A request was made to the Committee for an additional charitable funds contribution of £88,746.41 to the Tŷ Bryngwyn Palliative Care Services refurbishment project budget, from a significant legacy donation that had been received in July 2018, which had been expedited through Chair's Action due to its urgent nature. The proposal was supported at the Operations Charitable Funds Sub-Committee meeting in August 2018 and was referred to the Charitable Funds Committee due to the additional request exceeding Sub-Committee and Executive Director limits. The Committee ratified the Chair's Action

to approve this request.

9. Other areas of responsibility

During 2018/19, the CFC also received and considered the following:

- Members of the Committee were given a presentation on the charity's investments by Mr Alexander True, Sarasin Investments. It was noted during this session that the Committee should have a 6-12 month expenditure plan to allow the Investment Advisor to realise the best profits from the fund.
- A report was provided to the Committee in respect of the JC Williams Fund which seeks to provide additional health facilities for the Llanelli population. It is proposed that the capital costs for the Hydrotherapy Pool would be funded from this fund, and there is now a realistic opportunity to include the pool within the planned leisure centre at the Wellness Village. The Committee supported the recommendation to proceed with the development and approve the transfer of funds.
- The Charitable Funds Sub-Committee Terms of Reference were approved in the Charitable Funds Committee meeting held on 15th March 2018.
- Funding for a pilot on the provision of psychological support to people affected by cancer and the cancer workforce was approved by the Committee in the Charitable Funds Committee meeting held on 15th March 2018.
- Approval of managing Post Graduate Charitable Funds through revenue funds and a staggered approach adopted when transferring the balances held in charitable funds to revenue was approved by the Committee at its meeting held on 15th March 2018.
- A central fund for unrestricted income to be set up and a minimum retained surplus figure agreed was approved by the Committee at its meeting held on 15th March 2018.
- Updates on the current position of the ward 10 development at Withybush General Hospital were received throughout the year.
- Mr Bernie & Mrs Trish George were presented with British Empire Medals for services to Withybush Hospital's Chemotherapy Day Unit, with a letter of gratitude sent from the Committee.
- The Utilisation of IT Devices to Support Patient Centred Care and Service Improvement was approved by the Committee at its meeting held on 20th December 2018.
- Following Charitable Funds Committee approval in December 2017 for the release of legacy funds totalling £470,531.00 to support the development of the proposed new Integrated Care Centre in Aberaeron, further updates have been provided to the Committee. An update report was presented to the Charitable Funds Committee meeting in December 2018, confirming that the project was proceeding to plan and was on budget. The build would be complete by July 2019 for people to move in to the building in August 2019.
- Following the formation of a Cardiology Equipment Stakeholder Group in April 2018 to review the requirements of cardiology services in Withybush General Hospital, funding of £161,351.16 from the Pembrokeshire Cardiology Equipment Income Fund was approved by the Charitable Funds Committee meeting in December 2018. The funding was for the purchase of two new ultrasound machines for Cardiology Services at Withybush Hospital.
- Following its opening in February 2017, an evaluation was undertaken on the Pembrokeshire Haematology and Oncology Day Unit at Withybush Hospital that had been part-funded by charitable fund donations. The evaluation focused on assessing the original estates and service objectives identified by the then CDU and Ward 10 Project Group in their Project Initiation Document (PID). The evaluation also explored the effectiveness of processes including planning, stakeholder engagement, implementation and project governance via a questionnaire sent to all members. As an outcome, a design checklist was prepared and an overview of responses on this new

facility cross matched against PID objectives. The report was presented to the Charitable Funds Committee at its meeting in December 2018.

- Closing report – 6 bedded escalation area at Bronglais General Hospital.Due to a request for an unforeseen cost escalation of £42,000 being declined for charitable funds support, this was subsequently referred to Discretionary Capital for approval. A report was submitted to the Operations Business Team and a further closing report submitted to the October 2018 Committee meeting. Within the report, improved patient experience was noted and thanks were conveyed to the Triumvirate Team at Bronglais General Hospital for enabling the unit to be commissioned.
- A verbal update was provided on the Cardiology Hypertrophic Cardiomyopathy (HCM) Project advising that progress had been slower than expected and that there had been no charitable funds expenditure to date.
- A paper was presented to the December 2018 meeting to note changes to the Finance support and to approve changes in the Bank Mandate section and receive assurance that the level of support will help drive the Charitable Funds future agenda and direction.

Argymhelliad / Recommendation

The Board is asked to endorse the Charitable Funds Committee Annual Report for 2018/19.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Standing Orders Standing Financial Instructions Charity legislation and guidance Minutes of CFC & Sub-Committee meetings and CFC update reports to Board
Rhestr Termau: Glossary of Terms:	HDdUHB – Hywel Dda University Health Board CFC – Charitable Funds Committee
Partïon / Pwyllgorau â ymgynhorwyd	Director of Partnerships & Corporate Services

ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Chair of Charitable Funds Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	No direct impacts
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	No direct impacts
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	No direct impacts

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Committee Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Michael Hearty, Chair, Finance Committee
SWYDDOG ADRODD: **REPORTING OFFICER:**	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Finance Committee Annual Report 2018/19 to the Board.

The Finance Committee Annual Report provides assurance, in respect of the work that has been undertaken by the Committee during 2018/19, and that the Terms of Reference, as set by the Board, are being appropriately discharged.

Cefndir / Background

Hywel Dda University Health Board's Standing Orders, and the Terms of Reference for the Finance Committee, require the submission of an Annual Report to the Board to summarise the work of the Committee and to identify how it has fulfilled the duties required of it.

The purpose of the Finance Committee, as expressed in its Terms of Reference, is to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, to provide early warning on potential performance issues and make recommendations for action to continuously improve the financial position of the organisation.

This includes:

- Scrutiny and provision of oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability).
- Review of financial performance, review of any areas of financial concern, and reporting to the Board.
- Conducting 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.
- Regular review of contracts with key delivery partners.

Asesiad / Assessment

The Finance Committee has been established under Board delegation with the Terms of Reference approved by the Board at its meeting on 27th September 2018.

This Annual Report outlines how the Finance Committee has complied with the duties set through its Terms of Reference and identifies key actions to address developments.

Constitution
There is a core membership of the Committee which is comprised of:

- Associate Member of the Board (Chairman)
- Independent Member (Vice Chairman)
- Health Board Vice-Chair
- Independent Member
- *Invitation extended to the Chair of ARAC to attend (not counted for quoracy purposes)

The following In Attendance Members have also been identified to serve on the Committee:

- Chief Executive
- Deputy Chief Executive/Director of Operations
- Director of Finance
- Turnaround Director
- Other key Executive Directors/Directors to attend as and when the Committee request their attendance

Meetings
During 2018/19, Finance Committee meetings were held on a monthly basis.

The Finance Committee is directly accountable to the Board for its performance, and it provides assurance to the Board, through either a formal written update report or a verbal update, which is received at each subsequent Board meeting. A full set of papers for each Committee meeting is routinely made available on-line from the Health Board's website.

During 2018/19, the Committee met on the following occasions and was quorate at each:

- 28th September 2018
- 25th October 2018
- 22nd November 2018
- 20th December 2018
- 24th January 2019
- 25th February 2019
- 25th March 2019

Areas of Responsibility
In discharging its duties, the Finance Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its Terms of Reference:

- **Discussion Items**
  At each meeting the Committee is presented with the following papers to scrutinise with regard to the in-year financial position:
    - Finance Update
    - Turnaround Update
    - Financial Projections Assurance
    - Referral to Treatment Financial Plan and Trajectory 2018/19

- Capital Financial Management

A report has also been presented to each Committee meeting regarding an on-going project being undertaken jointly by Finance and Workforce, to align the establishment in ESR and Oracle. The report set out the scope of the project, the project plan, and progress.

In September 2018, the Financial Strategy Assurance report was presented to the Committee, which outlined the key budget setting principles to be adopted for the 2019/20 Financial Plan, project plan, and deliverables. Updates were presented in subsequent meetings covering progress, forecast savings requirements and opportunities, Welsh Government and Finance Delivery Unit comments.

The Corporate Financial Risk report was presented to the Committee for scrutiny in September 2018, October 2018, November 2018, and December 2018. The Operational Financial Risks were presented to the Committee in October 2018.

The Committee was also presented with updates during the year with regards to the Financial Improvement Plan for the Finance Department. The Strategy for the Finance Department was presented to the Committee in February 2019.

The Committee was presented with the Health Board's Healthcare Contract Management Approach in November 2018. This outlined the creation of a Central Contracting Team which would:

- scope and identify the extent of the issue
- develop, implement, and maintain a standard Hywel Dda healthcare contract for all externally contracted healthcare
- maintain a central database of all healthcare contracts
- perform 'due diligence' checks on providers prior to allowing them to treat patients or have information shared with them.

During the year presentations were made by the Directorates to the Committee on the following areas:

- Primary Care Risks
- Focus on Mental Health and Learning Disabilities
- Pembrokeshire County/Withybush General Hospital
- Carmarthenshire County/West Wales General Hospital

- **Information Items**
  In November 2018, the Committee was informed of the deterioration in the credit rating of Interserve Plc who is the appointed supply chain partner for the Cardigan Integrated Care Project and the Women & Children's Phase 2 Project at Glangwili General Hospital. The Committee was assured that this is being kept under review by Shared Services.

  In January 2019, the Committee was presented with a briefing prepared by the Welsh NHS Confederation. The briefing provided an overview of the Welsh NHS funding system, the challenges it faces, and examples of what is being done within Local Health Boards and NHS Trusts to address them.

- **Approval Items**
  In September 2018, the Committee were asked to approve the Scheme of Financial Delegation.

In November 2018, the Committee approved the following Financial Procedures:

- Overseas Visitors
- Purchasing Cards

In December 2018, the Committee was requested to scrutinise and approve the contract briefing paper for the replacement Orthodontics contract for the Health Board. The contract is worth up to £11m over a maximum 7 year period.

In January 2019, the Committee received a briefing paper prepared by NHS Wales Shared Services on their review of laundry services within the Health Board.

In January 2019, the Draft Financial Plan was presented to the Committee for scrutiny and approval. This was further updated and re-presented to the Committee in March 2019 for scrutiny and approval. The Committee discussed and noted the Draft Financial Plan with further discussions to be held in April's Committee meeting.

- **Key Risks and Issues/Matters of Concern raised by the Committee to the Board during 2018/19 included:**

  During 2018/19 the Committee raised concerns regarding the ability of the Health Board to deliver the forecast deficit of £35.5m.

Argymhelliad / Recommendation

The Board is asked to endorse the Finance Committee Annual Report for 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Committee meetings 2018/19

Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control, as evidenced in the Committee's Annual Report, will assist with ensuring financial control, and the safeguard of public funds.
Ansawdd / Gofal Claf: Quality / Patient Care:	SBAR template in use for all relevant papers and reports.
Gweithlu: Workforce:	SBAR template in use for all relevant papers and reports.
Risg: Risk:	SBAR template in use for all relevant papers and reports.
Cyfreithiol: Legal:	A sound system of internal control, as evidenced in the Committee's Annual Report, ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. Compliance with the Health Board's Standing Orders, and Committee's Terms of Reference, requires the submission of an Annual Report to the Finance Committee.
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	SBAR template in use for all relevant papers and reports

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Primary Care Applications Committee Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Judith Hardisty, Chair, Primary Care Applications Committee
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jill Paterson, Director of Primary Care, Community & Long Term Care Rhian Bond, Assistant Director of Primary Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Primary Care Applications Committee (PCAC) Annual Report 2018/19 to the Board.

The PCAC Annual Report provides assurance in respect of the work that has been undertaken by the Committee during 2018/19, and that the terms of reference as set by the Board are being appropriately discharged.

Cefndir / Background

Hywel Dda University Health Board's Standing Orders and the Terms of Reference for the Primary Care Applications Committee require the submission of an Annual Report to the Board to summarise the work of the Committee and to identify how it has fulfilled the duties required of it.

The purpose of the Primary Care Applications Committee as expressed in its Terms of Reference is to determine Primary Care contractual matters on behalf of the Health Board, and in accordance with the appropriate NHS regulations.

The contractual matters to be determined by the Primary Care Applications Committee include:

- General Medical Services Vacant Practices in accordance with Welsh Health Circular (WHC) (2006) 063.
- General Medical Services Sustainability Applications made in accordance with the local sustainability assessment process.
- General Medical Services contractual changes in accordance with the NHS (General Medical Services Contracts) (Wales) Regulations 2004.
- Community Pharmacy contractual changes in accordance with NHS (Pharmaceutical Services) (Wales) Regulations 2013.
- General Dental Services contractual changes in accordance with the National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006 and the National Health Service (General Dental Services Agreements) (Wales) Regulations 2006.

Asesiad / Assessment

The Primary Care Applications Committee has been established under Board delegation with the Health Board initially approving Terms of Reference for the Committee at its Board meeting on 30th July 2015. These were subsequently revised and approved by the Board as part of its annual cycle of review of Committees Terms of Reference at its meetings on 26th November 2015, 26th January 2017 and 31st May 2018.

This Annual Report outlines how the Primary Care Applications Committee has complied with the duties set through its Terms of Reference, and also identifies key actions to address developments.

Constitution

There is a core membership of the Committee which is comprised of:

- University Health Board Vice Chair (Chair)
- Independent Member (Vice-Chair)
- Two Independent Members
- Director of Primary Care, Community & Long Term Care (Lead Executive)
- Associate Medical Director - Primary Care
- Assistant Director of Primary Care

The following In Attendance Members have also been identified to serve on the Committee:

- Head of GMS/Deputy
- Head of Dental and Optometry/Deputy
- Primary Care Manager (Community Pharmacy)/Deputy
- Locality Development Manager from the applicable locality

Further membership is dependent upon the decisions which need to be made and these are determined by relevant Primary Care Contract guidance and regulation. The Community Health Council, Local Medical Committee and Community Pharmacy Wales are commonly invited as non-voting members to give patient or contractor opinion. The County Director, Dental Practice Adviser or Associate Medical Director (Dental) may also be invited to provide further local or clinically specific information.

Meetings

During 2018/19, Primary Care Applications Committee meetings were held on a bi-monthly basis or whenever there were contracting decisions to be made.

As the Primary Care Applications Committee is directly accountable to the Board for its performance, it provides an assurance to the Board through a formal written update report which is received at the subsequent Board meeting. A full set of the papers for each Committee meeting is routinely made available on line from the Health Board's website.

During 2018/19, the Committee met on the following seven occasions and was quorate at each; two of which were extra-ordinary meetings:

- 30 April 2018 (Extra-ordinary)
- 10 May 2018
- 4 July 2018
- 4 September 2018
- 23 October 2018 (Extra-ordinary)
- 6 December 2018
- 21 February 2019

Areas of Responsibility
In discharging its duties, the Primary Care Applications Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its Terms of Reference:

Assurance
At its meeting on 27th March 2018, the Committee received the PCAC Terms of Reference for review. Members agreed to create an additional Sub-Committee, separate to the current GMS Sustainability Panel, entitled Vacant Practice Panel (VPP), and to remove its membership from PCAC's terms of reference and include within separate terms of reference for the VPP. It was further agreed to simplify the membership for the Pharmacy and Dental Application Panels and attend to a number of minor amendments. The revised Terms of Reference were re-presented to the Committee on 10th May 2018 for onward submission to the Board on 31st May 2018.

Also at its meeting on 27th March 2018, the outcome from the Committee's self-assessment of effectiveness exercise was presented and further analysis of the data was suggested to produce a composite outcome report for the next Committee meeting on 10th May 2018. This was received and themes drawn out and cross-referenced to other Board level Committees. Discussion took place in respect of GMS awareness training for PCAC Members and it was suggested this could be extended to the wider Board membership to provide an understanding of the contractual issues discussed at the Committee. Members noted that a training programme had been developed for a Board Seminar session and that a suitable date for this would be identified.

At its meeting on 10th May 2018, the Committee received the Primary Care Applications Committee Annual Report 2017/18 and approved it for onward submission to the Board on 30th May 2018 subject to a number of minor amendments to membership and the inclusion of a numbers of applications received throughout the year.

- **General Medical Services (GMS) contractual changes in accordance with the NHS (General Medical Services Contracts) (Wales) Regulations 2004**

At its 4th July 2018 meeting, the Committee received a report on the review of Health Board Managed Practices, and Members noted that their number was set to increase by a further two Practices by the end of August 2018. Members recognised the demands placed on the Health Board's Primary Care team by managing the direct delivery of general medical services for circa 32,000 patients with no additional resources in place. The report therefore articulated some of the issues regarding Managed Practices and suggested an alternative proposal to managing these. Members acknowledged that consideration of the proposal was not within the Committee's Terms of Reference, however it was agreed that, as the proposal concerns changes to service management, as opposed to changing the service provision, consultation should not be required. The Committee recognised the pressures on both the service and the Health Board's Primary Care team, and suggested the need for the report to be seen in the context of the Health Board's wider risks to ensure it is considered in the whole and not simply as a primary care issue.

At the meeting on 4th July 2018, the Committee was provided with an update on Ash Grove Medical Centre, Llanelli, since the Health Board received their notice of intent to return their GMS Contract as of 31st August 2018. Members were reminded of the background to the contract return and the current position within the Practice where staff are continuing to populate the GP rota, post September 2018. Members were also advised that interviews for the vacant Practice Manager post were scheduled for 5th July 2018. It was noted that a budget had been agreed with finance colleagues for the Practice and that a risk assessment has been

undertaken on taking over the lease for the building. Although early conversations had been held with the Llanelli cluster regarding any potential support that could be provided, it was noted that whilst there is a willingness to assist, no capacity was available. It was recognised that patients of the Practice are keen for continuous engagement and Members acknowledged the public criticism that can be received when letters to patients are unable to provide anything definitive or positive. An updated media statement was therefore prepared, and engagement continued with MPs and AMs together with the convening of a public event. The Committee noted the update, and acknowledged the need to discuss the workload issues in managing this at wider Executive Team level with others from the County and Triumvirate Team. A further update at the meeting on 4th September 2018 confirmed that Ash Grove Medical Centre, Llanelli, became the Health Board's fifth Managed Practice as of 1st September 2018. Members noted that the GMS team remained positive about the future of this Practice, with the appointment of a very experienced Practice Manager and a full clinical rota in place for the whole of September 2018. Members were informed that the current premises are large with ample spare capacity to provide the opportunity for more integrated working with community services and teams. Members noted the update and commended the work of the GMS team in supporting a smooth transition from independent contractor to Managed Practice status.

Also at its meeting on 4th July 2018, the Committee received an update on Tenby Surgery since the Health Board received their notice of intent to return their GMS Contract as of 31st July 2018. Members commended the creditable work undertaken by the Practice in changing their model, and acknowledged their commitment to keeping the Practice operational, however, were informed of a number of emerging anecdotal concerns regarding clinical governance following the Health Board's undertaking of a routine visit as part of due diligence. It was noted that the Primary Care team was working to address these concerns with a series of Practice visits commencing 9th July 2018. It was confirmed that the Pembrokeshire County Team is fully engaged and keen to create an environment to work together on a sustainable model for the future. Members were reminded of previous discussion on the fragility of service provision within Hywel Dda which may require the Health Board to be brave in its response, and where support from the Independent Members serving on the Committee for more innovative types of opportunity would be welcomed at the Board. The Committee received a further update on Tenby Surgery at its meeting on 4th September 2018. It was noted that Tenby Surgery had become a Managed Practice on 1st August 2018, under a newly appointed Practice Manager, to continue to deliver General Medical Services for the Tenby population. Members were informed that whilst the clinical services were largely locum led, the Health Board was considering the options available in terms of clinical leadership. Members noted there is now the opportunity to work more innovatively with local community services, particularly in terms of using the combined premises in a more integrated way to introduce a more sustainable and holistic service for the patients of Tenby. Members again noted the update and commended the staff involved for a smooth and positive transition from independent contractor to managed practice status.

At the 4th September 2018 meeting, the Committee received an update on the Health Board's Managed Practices and noted the recent addition of a further two Practices and the additional risks these bring. Members commended the work of the Health Board's wider GMS team in supporting these Managed Practices; however expressed concern at the absence of a viable plan for their future. Members were assured that discussions are on-going with individual clusters on how to support the Practices involved. Recognising that the issues of Managed Practices are an issue for the whole Health Board, not only the Primary Care team, it was agreed that there was a need to look at a more integrated way of working with the community teams involved, recognising the current fragility within primary care. In a further update received at the Committee meeting on 21st February 2019, Members were advised that a baseline assessment of Health Board Managed Practices had been developed, in discussion

with other Health Boards across Wales. Members were also advised that an informal cap on locum costs had been applied across all Managed Practices, reducing the expenditure to a maximum of £400 per session; this has aligned the costs attributed to locum GPs working in Managed Practices to other Health Board Managed Practices in Wales. Advice was being sought from Procurement colleagues to establish the principle for seeking Expressions of Interest in returning Managed Practices back to Independent Contractor status. It was agreed that an update paper would be considered at the April 2019 PCAC meeting. Members noted that Meddygfa Minafon continued to experience recruitment challenges with work ongoing to link recruitment to Ashgrove Surgery to hopefully improve the position with regard to increasing the availability of salaried GPs. Members were advised that there is a regular locum commitment at the Practice alongside two salaried GPs and that feedback from the locums on their experience of working in the Practice is positive.

It was noted that data presented on the patient list sizes for Managed Practices shows a deteriorating position for four out of the five, however Members were assured that this information was out of date and was in fact reflective of the point in time when the Practices came into Health Board management, which is normally reflective of some patient movement due to anticipated anxieties regarding service change. Through the recently established Managed Practices Practice Managers Forum, a commitment has been given to developing a piece of work around patient satisfaction, which will be reported back to a future meeting of PCAC.

At its extra-ordinary meeting on 23rd October 2018, the Committee received a progress report on Ashleigh Surgery Cardigan, since the practice returned their GMS Contract to the Health Board on 14th August 2018. Members were reminded that at the PCAC meeting on 4th July 2018, the Committee received the recommendation from the Vacant Practice Panel to consider dispersal of patients recognising that the majority would go to Feidrfair Surgery based in Cardigan Health Centre and Newport Surgery. It was agreed however that the GMS team should be allowed further time to explore solutions to the issues raised relating to premises, TUPE and public engagement, and to ensure sustainability of healthcare provision to Cardigan residents. The extra-ordinary PCAC meeting was therefore convened on 23rd October 2018 to receive an update on the resolution of these issues, prior to a decision being made. Members were reminded that the Committee had previously raised concerns about the ability of Cardigan Health Centre to accommodate the additional dispersed patients as an interim solution until the practice re-located to the new Cardigan Integrated Care Centre in October 2019. It was confirmed that the GMS team had visited the Practice to discuss the options involved and had been assured that the additional patients could be managed via a re-organising of internal clinics and their current resources. It was suggested that the Ceredigion County Team monitors this throughout the transition process and until the Practice moves premises.

The Committee was informed that that the issue of TUPE is not the responsibility of the Health Board, nor could the Health Board offer advice to Practices and their staff, and that each Practice had been urged to seek independent legal advice on this matter. The Committee was assured that Ashleigh Surgery had been advised to take specialist HR advice and the GMS team would expect practice staff to seek support from their respective Union representatives. It was acknowledged that there could potentially be a role for NHS Wales Shared Services Partnership (NWSSP) to provide support to Practices in regard to HR issues which would require LMC and GPC Wales approval. The Committee received assurance that there had been continuous engagement with the patients involved via letters, emails and telephone calls. Patients had also been provided with a helpline number to contact if they had any concerns. The Committee noted that the Community Health Council (CHC) had requested dispersal be formally actioned following the patient engagement event scheduled for 20th November 2018 whilst acknowledging the impact this delay may have on planning and implementation. The

Committee agreed to support dispersal in principle, subject to the public engagement event on 20th November 2018. At the 6th December 2018 meeting, the Committee received an update noting that approximately 175 patients had attended the Ashleigh Surgery Patient Engagement Event**.** Members were asked to note that patients would be allocated to the Practice nearest to their home address; however it had not been possible to communicate this at the event, as it remained subject to discussion with the CHC at that point in time. Members were further advised that the CHC Executive had met and now confirmed that they believed that the Health Board had demonstrated the level of engagement which they would expect to see with this patient population. However, it was noted that the CHC would want to see ongoing patient engagement and an assessment of access to services. Members noted the recommendation and agreed that the dispersal be progressed. Members also noted that the Panel agreed to undertake the actions that the CHC had requested.

Members received an update on the Contract termination by Ashleigh Surgery at its meeting on 21st February 2019. It was noted that the transition arrangements were in train with members of the Primary Care team at the Practice to assist in the final stages of winding down the business and ensuring the smooth transition of patient services. Members acknowledged that whilst this dispersal affected a smaller number of patients, in most instances they were being allocated to Practices that had already recently accepted new patients as part of the Teifi Practice dispersal. It was noted that there remained a small number of patients who remain dissatisfied with the Practices that they have been allocated to. Members noted that Cardigan Health Centre had been offered some additional space at Cardigan Hospital at the outset of the process due to building constraints ahead of the new Cardigan development being completed, but that this offer had been declined. Members discussed the ability and potential concerns around Cardigan Health Centre dealing with the impact of new patient registrations. It was noted that here had been a number of meetings held with the Practice where they have offered the assurance of their ongoing sustainability; however it was felt that there would need to be the offer of ongoing support made to ensure that this remained the position. Members were advised that the new premises would offer much better provision for the population and that the Project Board was working hard to secure any additional space required for the Practice. It was acknowledged that Cardigan Health Centre operate very differently from Ashleigh Surgery and that appointment systems, etc., could prove to be difficult for patients to accept initially on transition. Members acknowledged the need to support Cardigan Health Centre with any concerns raised in relation to this. The thanks extended to the Primary Care team as part of the management of the Teifi Practice dispersal was reiterated in relation to Ashleigh Surgery.

At its 6th December 2018 meeting, the Committee received an update on progress of the list dispersal of Teifi Surgery. Members were advised on the impact of the dispersal, the actuality of the patient numbers and how the distribution has been agreed. It was noted that the discussion around premises for community services, in particular in Llandysul, remained work in progress and was being led by the Ceredigion County. Members were advised that a Working Group had been established with the GMS team and the Practices significantly affected by the dispersal. Members were also advised that this is assisting with a number of the more challenging areas. It was noted that the overall success of this dispersal would be down to the Practices and their teams, and therefore support was being provided to ensure a smooth transition for all concerned. Members were concerned over some potential delays in the electronic data transfer, and whilst recognising that this area of work falls to NHS Wales Informatics Service (NWIS) to deliver, it was felt that there needed to be a full report on the potential issues with data migration and data transfer albeit recognising that this was not a matter for PCAC discussion. It was suggested that a paper be prepared for the IM&T Sub-Committee. Members received a further update regarding Teifi Surgery at its meeting on 21st February 2019. Members were advised that the patient list dispersal took place on 1st February 2019 following the cessation of the GMS Contract. Five of the Practices taking

substantial numbers of new patients evoked the British Medical Association (BMA) Guidance on sustainability by temporarily suspending new patient registrations to allow them time to take stock and stabilise their service model. A reflective session with lessons learnt with all affected Practices and key stakeholders was planned for April 2019 to identify where changes could be made to the process for any future Contract terminations and associated list dispersals. It was agreed that the outcome of the session would be brought back to a future PCAC meeting. It was noted that overall the feedback from Practice Managers has mainly been positive and Members recognised the considerable work that had been undertaken by the team in preparedness for the transitional arrangements, acknowledging that there had been a lot of difficult conversations to have whilst maintaining resilience. Credit was given to the Primary Care team in recognition of this work.

Members were provided with an update on the planned merger between Goodwick and Fishguard Surgeries at the meeting on 21st February 2019. Members were advised that the Memorandum of Understanding previously put in place had supported the establishment of positive working relationships and also supported the transitional arrangements. It was noted that a date for the open evening had been circulated to celebrate the merger of Fishguard and Goodwick Surgeries, and for patients, key stakeholders, etc., to visit the newly extended and refurbished premises.

At its extra-ordinary meeting held on 30th April 2018, Members were appraised of the work of the Health Board's GMS team had undertaken in conjunction with Argyle Surgery in regard to opportunities and solutions to support both the immediate situation, and the need for sustainability in the longer term, with regard to their previously considered application to close their branch surgery in St Clements. Members noted that the Health Board was still considering a number of options going forward on which it would be imperative to receive the public's support on whichever decision is made. The CHC welcomed their involvement in this once further information was available. The LMC's feedback was presented directing that the Health Board consider a package of proactive sustainability measures, including the investment of additional Health Board resources, to support the development of a new model of provision in Neyland and the wider Cleddau estuary area, to support the Practices' transition to a new model and reduce the risk to both the practices and the Health Board. The Committee approved the closure of St Clements branch of Argyle Surgery subject to it remaining open and staffed to an agreed level until transition could take place which should be no later than 1st September 2018. It was also agreed for discussions to take place on establishing a new model with Neyland & Johnston Surgery for the provision of a service by the end of August 2018.

The Committee received an update on GMS provision in the Neyland area at its meeting on 4th July 2018. Members noted that discussions had now progressed to the point of drafting a Memorandum of Understanding (MOU) for the transfer of these patients, by which time Neyland & Johnston Surgery were confident they would have recruited a further GP and strengthened their clinical team. Members also noted the likelihood of Argyle Medical Group submitting a boundary change application to draw back their boundary to the river Cleddau which would require the Committee's approval. The Committee received a further update on GMS provision in the Neyland area at its meeting on 4th September 2018, following Neyland & Johnston Surgery's proposal to take-on the provision of GMS services for those patients currently registered with Argyle Surgery resident in the area north of the river Cleddau from 1 November 2018. Members noted this represented the first such patient transfer following a branch surgery closure in Wales, and that given this represents a perceived service change for the patients involved, further public events would be held. It was confirmed that Argyle Surgery would not be considering any further contractual changes until the branch surgery closure had become embedded, and the Committee noted the update report.

At its meeting on 6th December 2018, the Committee discussed the List Closure Application from Robert Street Surgery, Milford Haven. The Committee noted that Robert Street Surgery is co-located with Barlow House Surgery within the same building. Members were advised that a meeting had been held with the senior partner to discuss the application and the pressures experienced by the Practice, including sustainability issues due to an unfilled GP vacancy with one of the current GPs also on a year's maternity leave, leading to an acute problem with access to GP appointments. Members were reminded that there had been historical difficulties within the geographical area. Robert Street Surgery had started to use the GP Hub to assist with support in managing patient triage and was considering expanding their engagement from three to five days. It was noted that the Practice has an ambition to become a Training Practice and until recently, had started to show signs of working with other Practices in the area through developing a Paramedic Home Visiting Service supported through the Pacesetter programme. Members were advised that the Practice has not submitted a Sustainability Application and have declined a Sustainability visit although would receive their scheduled quality visit. Members noted that the Practice appeared to have an unusual appointment system which appeared to be impacting on patient access, resulting in an increase in patient complaints. Although the Practice has been feeling the pressure of its current vacancies, the partners have been stepping up their commitment to support the salaried GPs.

In considering the application, Members noted that whilst the Practice was starting to take steps to address some of the causes of the pressures they were experiencing, it was considered that they had not pursued all options and that the rigidity of the appointment system was causing additional difficulties. Members were advised that the team was not aware if any discussion had taken place at Cluster level to consider local support for the current pressures and that there had previously been limited interest in both Practices merging to assist with sustainability. Members noted that the CHC felt that it would be premature to look at a list closure when there were other options which could be explored. It was also noted that a further change, added to recent changes within the area, would not be helpful to patients. Members agreed that the list closure application should be declined and that the recommendations in the report would be supported.

At its meeting on 6th December 2018, the Committee welcomed Dr Dave Wilson from Argyle Surgery Pembroke Dock to the meeting, to discuss a Boundary Change Application. Members noted that there had been longstanding discussions around this issue and recognised that there had now been a conclusion to the reallocation of St Clements patients to Neyland and Johnstone Surgery as part of the branch surgery closure. Members were advised that as part of that process, Argyle Surgery had indicated that they would seek a boundary change once the transition was concluded. It was noted that any children born to patients currently registered but living outside of the revised practice area would still be registered at the Practice.

Members noted that the Practice is the sole provider of General Medical Services to a quarter of the county in South Pembrokeshire, and that the area is geographically challenging when undertaking home visits. It was further noted that the boundary change would allow a focus on patients where the GP Practice is situated, limiting travel time and improving efficiency. Members were advised that the area which the Argyle Medical Practice had requested to be excluded is already served by other GP Practices. It was recognised that there were a number of patients whom had been caught up in the switch over to Neyland and Johnstone Surgery but that the Practice was willing to be flexible to consider those patients on a case by case basis to ensure patient care was safeguarded. It was also noted that neighbouring Practices had been contacted and that there appeared to be no controversy from them in regard to this proposal. Members noted that there were no areas of dispute and the Committee was asked to agree the

boundary change with a formal letter of confirmation to be sent to the Practice.

In total, 8 GMS contractual changes were considered by the Primary Care Applications Committee during 2018/19 (compared to 14 in the previous year).

- **General Medical Services Vacant Practices in accordance with WHC (2006) 063:**

The Committee received the following outcomes from the Vacant Practice Panel meetings:

10 May 2018

- The Committee received the outcome from the Tenby Surgery Vacant Practice Panel held to consider the options available since the Practice handed in its notice to terminate on 31st July 2018. The Panel recommended that in the immediacy, the Health Board takes this on as a Health Board Managed Practice to sustain services for patients in the area, but continues to focus on what could be a more sustainable independent contractor model in the future, with a review of the situation in six months' time. It was agreed that an update report would be received at the next PCAC meeting in July 2018.

- The Committee received the outcome from the Ash Grove Medical Centre Vacant Practice Panel held to consider the options available. The Panel recognised the need to move quickly to stabilise services for Llanelli given the previous unsettled 12 months and recommended the Health Board take this on as a Managed Practice, again with a six month review date in place, and without losing any momentum to develop a more robust solution for the area in future. Members discussed the options available to the Health Board to build confidence in those who might be interested in taking on another Practice, which included making contact with organisations such as Business Wales who work with small to medium enterprises and where there could be transferability in terms of the development of specific packages of support to GP Practices. The Committee approved making Ash Grove Medical Centre a Managed Practice from 1st September 2018 with a review after six months, and until such time as the Committee has approved an alternative geographical based model of the area.

4 September 2018

- The Committee welcomed Drs Beth Williams, Teifi Surgery, and Sonia Rooke, Llynyfran Surgery, to share their innovative vision for the future of GMS in the Llandysul area. Both GPs expressed concern regarding the sustainability of the other GP practices within the South Ceredigion and Teifi cluster particularly as two Practices were due to close in early 2019, and were assured that the Committee would be considering the receiving Practices' needs and concerns about future fragility when making its decision on the Teifi Surgery Vacant Practice Panel's recommendation. Members noted that the Vacant Practice Panel's (VPP) recommendation to disperse Teifi's list to neighbouring GP Practices, with the understanding that Llynyfran would be receiving most of the patients involved, was considered the only safe and viable option for both Teifi patients and the Health Board. The Committee acknowledged its responsibility to make a decision on the vacancy based on the review of the options by the VPP, recognising that a decision to disperse would not be actioned until a public engagement event was held in early October 2018, and that dispersal would not take place until 31st January 2019. On this basis, the Committee approved the recommendation to disperse the list, subject to a report to the Committee in November 2018 to include feedback from the public engagement event and on the GMS team's discussions with the receiving Practices.

- The Committee received the recommendation from the VPP's consideration of Ashleigh

Surgery, acknowledging that the Practice's notice to terminate their Contract had only been served two weeks previously. Concerns were expressed in regard to the sustainability of healthcare provision to Cardigan residents in the interim period given the lack of scope to extend the current premises of the neighbouring Feidrfair Surgery based in the existing Cardigan Health Centre to accommodate additional patients from Ashleigh Surgery, and the fact that the new Cardigan Hospital/Healthcare Centre would not be ready for occupation until November 2019. However, in the long term, the amalgamation of the two Cardigan surgeries into one based at the new Cardigan Hospital site would provide one centre for the provision of all general medical services for Cardigan residents which remains the vision for the area. Concerns were also expressed regarding potential TUPE issues given previous challenges in similar situations, with the GMS team seeking further legal advice on this matter. Members were informed that discussions had already taken place with the Cluster on how to manage the list dispersal for patients of Ashleigh Surgery which had resulted in some positive offers of support. The Committee noted that although the recommendation is to disperse the Ashleigh Surgery patient list, the GMS team need time to explore solutions to the issues raised, and supported their request for this before a final decision is made which would take place at the extra-ordinary PCAC meeting in October 2018. The Committee therefore agreed a dispersal in principle, and to delay a final decision until the GMS team could undertake the further work involved.

In total, recommendations of 4 Vacant Practice Panels were considered by the Primary Care Applications Committee during 2018/19 (compared to 2 in the previous year).

- **General Medical Services Sustainability Applications made in accordance with the Local Sustainability Assessment Process:**

At its meeting on 27th March 2018, the Committee received an update on the sustainability status of GMS within Hywel Dda, outlining the current sustainability issues together with a Managed Practice update. Members were pleased to note there were no list closures at this point in time, suggesting the actions taken by the Health Board to maintain this position are having a positive effect; the Committee's thanks were extended to the wider Primary Care team. Members were reminded of the Cabinet Secretary's directive to seek a fundamental shift of services from secondary to primary care and it was acknowledged that these would need to be identified and resourced appropriately.

At its meeting on 10th May 2018, Members were advised that the heat map of GP Practices had recently been reviewed, reducing the scores of two of the Practices previously classified as at risk. Given the anticipation that the final GMS Contract detail for 2018/19 would not include the requirement for practices to provide sustainability scores in future, the Health Board will consider new ways to continue with this approach in order to derive as accurate as picture as possible.

At its meeting on 4th July 2018, the Committee was presented with the GMS Sustainability Update Report, demonstrating that 55% of Hywel Dda GP Practices had been classified as being challenged, however there were no closed lists in place at that point in time. Members noted the status of the South Ceredigion Practice Contract, where discussions remained ongoing with a month's grace being granted to consider the support and solutions that could be put in place to provide them with the confidence to continue with their Contract. It was noted that a similar situation had occurred in North Ceredigion where a federation approach had been established in response.

At its meeting on 6th December 2018, the Committee received an update on the position with

regard to Health Board Managed Practices and the two GMS Contract resignations in South Ceredigion. Two formal applications for sustainability support (Avenue Villa and Cardigan Health Centre) were received and considered in line with the nationally agreed process. It was noted that the Health Board had five Managed Practices and eight Practices identified as being of "high risk". Members noted that consideration was being given as to how Practices could be proactively supported to prevent further destabilisation and a package of support developed. In addition, it was noted that one list closure application had been received also for consideration at the 6th December 2018 meeting. It was noted that there remained a variance across Wales in terms of the number of Health Board Managed Practices and the number of sustainability pressures reported and applications for support received. Members noted that currently Betsi Cadwaladr University Health Board (BCUHB) had the highest level of Managed Practices; and that this potentially reflects similar challenges within HDdUHB in terms of rurality of the Health Board and the consequential impact on Practices in relation to recruitment and retention. It was noted that Meddygfa Minafon is now the longest standing Health Board Managed Practice and an update on progress was requested for a future meeting. Members were advised that a paper had already been prepared for consideration, in the first instance, by the Executive Team. Members noted that Solva Practice had won the Royal College of General Practitioners (RCGP) award for Practice of the Year.

At its meeting on 21st February 2019, Members noted the Practices that were currently considered as being of concern for a variety of reasons and it was agreed to bring back a number of the issues to a future meeting for further consideration.

In total, 2 sustainability applications were received by the Primary Care Applications Committee during 2018/19 (compared to 3 the previous year).

- **Community Pharmacy contractual changes in accordance with NHS (Pharmaceutical Services) (Wales) Regulations 2013:**

At its meeting on 6th December 2018, Members noted the change of ownership of the NHS Pharmacy Contract from Borth Pharmacy Limited to IMG Jones.

In total, 1 Community Pharmacy contractual change (change of ownership) was considered by the Primary Care Applications Committee during 2018/19 (compared to 6 in the previous year):

- **General Dental Services contractual changes in accordance with the National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006 and the National Health Service (General Dental Services Agreements) (Wales) Regulations 2006:**

At its meeting on 4th July 2018, the Committee was provided with an update on the process for tendering for new GDS Contracts to commence on 1 June 2018, chosen mainly in areas with low access and high deprivation and poor access for urgent out of hours services. Out of the 12 lots, seven had been awarded to existing providers, however there had been challenges in awarding the remaining five. Members were assured that feedback had been taken from previous tender exercises for this year's round. Members acknowledged the slippage involved given the Health Board's inability to award all the Contracts in this financial year's interim plan to discharge its funds and that consideration would now be given to a more innovative approach to attract in practitioners by understanding the enablers involved, with a further report to be submitted to the 4th September 2018 Committee meeting.

Also at its meeting on 4th July 2018, the Committee was provided with an update on the

Orthodontic Plan as the current Contract ends on 31 March 2019. Members noted that the Health Board would be re-tendering for specialist orthodontic services and would undertake work to understand the needs of the population and to develop an appropriate specification. A report would be presented to the next Committee meeting outlining the areas that could be included within the specification together with the benefits and risks identified. The Committee's view would be sought on whether the scope is correct, acknowledging that determination of the specification is not within the Committee's Terms of Reference.

At its meeting on 4th September 2018, the Committee received an update on the challenges faced by the dental commissioning team including the need to spend within this year any unspent monies from the previous year, and the need to break even by year end with no further unspent monies. Members acknowledged the Committee's responsibility to ensure Contracts are in place to meet the dental needs of the population, and the Committee's role to consider only the contractual aspect of the report, with the Planning Sub-Committee under BPPAC considering any planning aspects.

Also at its meeting of 4th September 2018, the Committee received an update regarding Phase 1 of the Dental Reform Programme for the period 1 November 2017 to 31 March 2018, and a review of the Quarter 1 data collection. Members were informed that Welsh Government had instructed all Health Boards to increase the number of practices participating in Contract reform from 1 October 2018 to 10%. Members noted the summary within the report of all the Contract changes made. Concerns were expressed that two thirds of the practices had not met their targets to date and queries were raised on how this would affect the future provision of general dental services. Members were assured that the dental commissioning team would be meeting with the Practices involved to address concerns regarding their performance, and that where possible, Practices would be supported to increase their service delivery rather than taking monies back prematurely. The Committee recognised that Contract reform has many benefits both for patients and the Health Board.

The Committee received the Health Board's response to the Social Care and Sports Committee Inquiry into Dental Services for information at its 4th September 2018 meeting.

In total, 3 Dental contractual and/or service changes were considered by the Primary Care Applications Committee during 2018/19 (compared to 7 in the previous year).

Workplan for 2018/19

The core purpose of the Primary Care Applications Committee is to consider Contract changes, many of which cannot be predicted and developed into an annual work programme. Core standing agenda items are therefore included on a work plan template and agenda items added as meetings progress throughout the year and presented at each Committee.

Key Risks and Issues/Matters of Concern raised by the Committee to the Board during 2018/19 included:

- Sustainability issues within GMS
- Challenges within Health Board Managed Practices and the impact this is having on the Health Board's GMS team

Matters Requiring Board Level Consideration or Approval

- PCAC revised Terms of Reference

Argymhelliad / Recommendation

The Board is asked to endorse the Primary Care Application Committee Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Committee meetings 2018/19
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Primary Care Applications Committee (via Chair's Action)

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not Applicable
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable

Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	University Partnership Board Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor John Gammon, Chair, University Partnership Board
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sarah Jennings Director of Partnerships and Corporate Services

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the draft University Partnership Board Annual Report for 2018/19 to the Board.

The University Partnership Board Annual Report provides assurance in respect of the work that has been undertaken by the Committee during 2018/19, and outlines how the University Partnership Board has complied with the key responsibilities delegated by the University Health Board through the Terms of Reference set.

Cefndir / Background

Hywel Dda University Health Board's Standing Orders and the Terms of Reference for the University Partnership Board require the submission of an Annual Report to the Board to summarise the University Partnership Board's work during the year and to identify how it has fulfilled the duties required of it.

The purpose of the University Partnership Board, as expressed in its Terms of Reference, is:

- To drive and monitor developments in agreed Priority Areas under the umbrella of the University Partnership Board Strategy.
- To monitor progress against the plans developed by the Priority Area leads and ensure that the University Health Board is meeting the criteria to maintain its University status against which it will be judged by Welsh Government.
- To assess the current position of the University Health Board, identify gaps and opportunities, and ensure links are made to maximise the effectiveness of developments to improve the health of its population and the quality and effectiveness of its services (including those delivered jointly with partners).
- To advise the University Health Board to ensure it is sighted on major innovations, with the guiding principles of a clear strategy; clear governance and performance management; and being mindful of budget constraints. Issues of relevance to the University Health Board will include rurality, frailty, links with partners, legislation and work with related initiatives.
- To assure the University Health Board that a plan is in place to continue to meet the criteria for university status.

- To assure the University Health Board that the work of the University Partnership Board, through partnership working with the Universities, is leading to continual improvement in the quality of care being provided and patient outcomes.
- To assure the University Health Board that the organisation is compliant with research governance statutory requirements, and that the Board is meeting its contractual requirements with regard to research and development;
- To receive the Research & Development Annual Report for approval prior to submission to Health and Care Research Wales.

Asesiad / Assessment

The University Partnership Board has been established under Board delegation with the Health Board approving Terms of Reference for the University Partnership Board at its Board meeting on 29th March 2018.

This Annual Report outlines how the University Partnership Board Committee has complied with the duties set through its Terms of Reference, and also identifies key actions to address developments.

Constitution
There is a core membership of the Committee which is comprised of:

- Independent Member (Chair)
- Independent Member (Vice-Chair)
- 2 Independent Members
- University Health Board Chair
- University Health Board Chief Executive
- Director of Partnerships & Corporate Services (Lead Director)
- Director of Research & Development
- Director of Public Health
- Director of Workforce & Organisational Development (Executive Lead for Aberystwyth University)
- Director of Planning, Performance & Commissioning
- Director of Therapies and Health Sciences
- Director of Nursing, Quality and Patient Experience (Executive Lead for University of Wales Trinity Saint David University)
- Medical Director and Director of Clinical Strategy (Executive Lead for Swansea University)
- 3 x Aberystwyth University Representatives
- 3 x University of Wales Trinity Saint David University Representatives
- 3 x Swansea University Representatives
- 1 x Further Education Representative (Pembrokeshire College)

Meetings
During 2018/19, University Partnership Board Committee meetings were held on a quarterly basis and were quorate at each,

As the University Partnership Board Committee is directly accountable to the Board for its performance, it provides an assurance to the Board through a formal written update report which is received at the subsequent Board meeting. A full set of the papers for each Committee meeting is routinely made available on line from the Health Board's website.

During 2018/19, the Committee met on the following occasions and was quorate at each.

- 16th May 2018
- 2nd August 2018
- 21st November 2018
- 12th February 2019

The University Partnership Board provided four update reports to the University Health Board during 2017/18 at the following Public Board meetings:

- 31st May 2018
- 27th September 2018
- 29th November 2018
- 28th March 2019

Sub-Committees
Two Sub-Committees currently report to the University Partnership Board:

- Research & Development Sub-Committee
- Collaborative Institute Sub-Committee

The Sub-Committees meet quarterly and produce a written update report for the University Partnership Board following each Sub-Committee meeting. These update reports detail the key actions, issues and risks discussed, and are the subject of debate and discussion at each University Partnership Board meeting.

Research & Development Sub-Committee
The principal duties of the Research & Development (R&D) Sub-Committee are to:

- Ensure R&D is appropriately resourced and that resources are channelled to local and national R&D priorities in the health community.
- Report to relevant agencies such as Health and Care Research Wales, Welsh Government, through the approval of the R&D Annual Return, Mid-Year Return, Annual Plan and Spending Plan.
- Receive and comment on financial, performance management and data reports submitted to Health and Care Research Wales.
- Review new research applications pertaining to a member's specialist field / management responsibilities when requested by the R&D Manager.
- Promote increased staff involvement in research activity, including facilitating access to relevant training to enhance research capacity and capability.
- Encourage multi-disciplinary and multi-agency R&D, including patient/public involvement where appropriate.
- Report on R&D activity to relevant health community committees and the Health Board via the R&D Director or their nominated person.

Research & Development Sub-Committee meetings are held on a quarterly basis and during 2018/19 the Sub-Committee met on the following four occasions:

- 21st May 2018
- 13th August 2018
- 12th November 2018
- 11th February 2019

See Appendix 1 *(to be attached following approval at UPB meeting on 29th May 2019)* for the Research & Development Sub-Committee Annual Report 2018/19

Collaborative Institute Sub-Committee

The key objectives of the Collaborative Institute Sub-Committee are to:

- To identify ways to maximise resources, that promote innovation in skills and workforce development aligned to the priorities of each organisation.
- To develop and foster the delivery of collaborative learning environments that promotes interdisciplinary practice, knowledge and understanding.
- To challenge assumptions about how health and social care is delivered, who delivers it and where it takes place.
- To establish processes and where appropriate policies, that facilitate strategic collaborative recruitment and support innovative and creative schemes that develop new, advanced and extended roles.
- To further develop existing simulation and clinical skills facilities to underpin the drive for multi-professional education and training and provide an environment for talent and skills development.
- To initiate and evaluate creative skills training schemes for the unregistered health care workforce.
- To develop integrated education schemes for advanced and changing professional roles which are responsive to service changes, that enable health and social care provision to be both sustainable and prudent.
- To support the delivery of the Health Board Education Strategy.
- To propose models that will facilitate 'collaborative practice development' working across professions, promoting team based education and training and inter professional dependence.

A key principle of the Collaborative Institute is to maximise upon the opportunities to collaborate, as a virtual institute with virtual and physical outcomes.

The future of the Collaborative Institute Sub-Committee is being discussed with the aim of standing this down. Since the formation of Health Education and Improvement Wales (HEIW) there are new forums which may be more effective and prevent duplication.

Areas of Responsibility

In discharging its duties, the University Partnership Board Committee has undertaken work during 2018/19 against the following areas of responsibility in relation to its Terms of Reference:

- **Governance**

Outcome of the Self-Assessment of Performance Questionnaire 2017/18

It was noted that only half of the UPB membership had responded to the exercise, and although the analysis appeared to provide a positive outcome, some comments received suggest Members do not understand how the UPB disseminates information across the Health Board.

A number of useful comments were made from the Self-Assessment process:

- changes to the membership going forward – it was noted that this would be reviewed.
- lack of regular attendance from University partners at UPB meetings.

It was added that there is an opportunity to do things differently now the UPB has been established and its progress has been recognised by Welsh Government. All these have been addressed throughout the year.

Strategy

Members received updates on the following missions for Year 2 of the UPB Strategy in each of the meetings held across 2018-19:

University
• 1a - to explore the benefits of, and approaches to, utilising electronic patient centred technology, designed to enable proactive self-management of chronic conditions i.e. COPD and enable the provision of real time data for the medical practitioner.
• 1b - to develop a simulated education programme framework encompassing initially clinical skills and then broaden to include all aspects of an individual's care pathway.

Health
• 2a - to create a comprehensive framework enabling evidence-based decision making to influence the approval and introduction of new clinical interventions.
• 2bi - to investigate the effectiveness of PocketMedic, a Technology Enabled Care Service (TECS), utilising self-determination theory to increase self-management knowledge and motivation in patients with COPD: a mixed method analysis.
• 2bii - reduction in the prevalence of pre-diabetes following one-to-one consultation delivered through general practice

Board
• 3a - to test a model of remote pulmonary rehabilitation, and analyse benefits of current model and scaling up of provision.
• 3b - To work with University and Health Board partners to develop an evaluation framework to enable piloted primary care initiatives to be assessed; enabling the evidencing of impact, underpinning research and efficiency, and provision for questioning suitability for wider utilisation and adoption

The Chair advised that as current milestones are being reached in the majority of missions, and as there were no further comments from Members, the Committee could be assured that progress was on track.

In the meeting held on the 16th May 2018, Members were informed that the University Partnership Board Strategy had been updated to reflect the feedback received from University colleagues. The revised version was circulated to Members following the meeting.

During the meeting, the work undertaken by Universities on the translational element of patient pathways and patient experience was referred to, and that it should be possible to provide a comprehensive narrative on this work. Members were reminded of presentations given on UWTSD's activities and proposed the option to link up with the Dean of Swansea College of Art at the UWTSD. The Centre for Health and Ageing was also discussed and how this is a positive initiative.

A brief discussion was had on recognising this important area for the UPB Strategy, and it was suggested that more information would be required from University partners on their work and on how the University Health Board can support them to achieve this. It was noted that one of the tasks of the new Hub Administrator would be to carry out an inventory of all activities to provide an overview of the work currently being undertaken by University of Wales Trinity St David.

In relation to the study which comprises a health care application allowing patients to track and manage their chronic obstructive pulmonary disease (COPD), it was advised in the 16th May 2018 meeting that following its review at a panel to consider sponsorship the previous week, focus groups would now be established.

It was cautioned against this becoming a one off study into the disease and that working collaboratively on developing programmes of enquiry could prove very beneficial. It was noted that the Computer Science Department intended to work on this study. UWTSD are undertaking a digital project that could also be linked to this.

A discussion was had on possible gaps in the roles of the R&D Sub-Committee members – it was agreed that this be taken forward by Dr Seale. Members were informed that the Collaborative Institute for Learning and Development is in the early stages of progressing a simulated education programme framework, and that there is an opportunity to link in with Swansea University's Health and Well Being Academy at the Institute of Life Sciences in Llanelli.

Similar discussions had taken place with the Institute of Life Sciences (ILS) and University of Wales Trinity St David to establish a skills network.

Following discussions at the recent Effective Clinical Practice Sub-Committee (ECPSC) meeting, it had been agreed for a workshop to take place in September 2018 to establish reporting lines up to Quality, Safety & Experience Assurance Committee (QSEAC) and that the Sub-Committee Terms of Reference (ToRs) would be revised to reflect this. In the November 2018 meeting, the outcomes from this workshop were provided, including:

- a review group to be set up to assess data when introducing new processes.
- a document to be provided noting the thematic headings of expertise and Universities to populate these

Whilst no assurance could be taken on the evidence of progress to date, Members remained pleased with the trajectory proposed, recognising further discussions would be required.

It was agreed that updates would be received on selected research presented at the UPB Innovation and Practice Conference July 2017.

In respect of the Remote Pulmonary Rehabilitation Model, two hub and spoke site rehabilitation programmes for pulmonary rehabilitation have been complete. The location of the hub site for these rehabilitation programmes was Glangwili General Hospital (GGH), with the spoke site, Tregaron Community Hall. Initial feedback from patients had been very positive and the next stage of the project would be the utilisation of community venues as opposed to Health Board locations.

In respect of the development of an evaluation tool, Members were reminded that this project had been discussed at the previous UPB meeting in February 2018. Discussions to be had with Mr Colin Eaketts, Welsh Government and other Health Boards to provide the national perspective on evaluation tools.

In the meeting held on the 2nd August 2018, it was noted that current milestones were being reached in the majority of missions and progress on track.

The Evaluation Model was an important element of the workshop on 12th February 2019. A brief presentation was provided on the workshop followed by facilitated group work.

Colleagues were given the opportunity to work together on the development of tangible and clear plans for the next three years to support and deliver elements of the 20 year Health Strategy that was recently approved.

There were four tables provided for the group work, and four topics for the session:

- Education and Training
- Research and Evaluation
- Innovation/New Models of Care
- Prevention and Population Health

Members were advised that the focus for 2019-20 would be to demonstrate the impact and outcome of the Strategy while ensuring its fluidity.

Service Developments – University Health Board

A positive presentation was given on Research, Development & Innovation in Hywel Dda University Health Board, advising of the requirement to determine the work each University partner will undertake. The numerous programmes currently being undertaken by the Health Board were also highlighted as well as the external partnerships that the Health Board is involved with. The Research and Innovative Practice Conference held in July 2017 was noted as being beneficial in highlighting the work each University partner does. It was noted that following the Transforming Clinical Services consultation there would be a strategy that would focus on the wellbeing of the population for the next 20 years as well as the plans for the next 10 years for clinical services and the social model of health and care. Ms Sarah Jennings advised of her recent to Bilbao where lessons learnt would be shared with the Board and incorporated into future plans.

Ms Jennings presented an insight into the opportunities for working in partnership with Institut Bonanova that had arisen following a recent trip to Bilbao.

In the meeting held on the 12th November 2018, a presentation was given by Dr Phil Kloer on the Transforming Clinical Services Strategy Consultation's Closing Report. Dr Kloer ran through all recommendations and noted that we need to recognise our role and to look at not only patients' Health & Wellbeing but also to look at Environmental Health. A reference was made to the opportunity of using Hubs in rural areas and members were advised that Hub systems are currently working well within other organisations. Dr Kloer advised Board Members that further development of all recommendations into the draft Health and Care Strategy would be considered at the Public Health Board meeting on 29th November 2018.

Academic Developments – Universities

- **Apprenticeships**

An update was provided in the 2nd August 2018 meeting, on Hywel Dda UHB's work to progress its apprenticeship work programme through the 'Hywel Dda Apprentice Academy'. A digital framework at degree level was authorised by the Welsh Government to be provided by the University of Wales Trinity St David and Swansea Universities. It was noted that the work placed learning portfolio for University of Wales Trinity St David had significantly increased.

A further update was provided in the meeting held on the 12th November 2018.

- **Rural Education Medical Students & GPs**

In the 2nd August 2018 meeting, the Rural Education, Medical Students & GPs report advised that following the Cabinet Secretary for Health and Social Care's announcement on 6th July 2018, an additional 20 medical student places have been approved from 2019. WG are aiming to increase Welsh students onto these courses and the Health Board will play an important role in providing placements for them. It was asked that the Health Board be innovative in establishing different ways to support students to train locally which may encourage them to take up permanent posts within the locality once qualified. It was noted that there are 6 Academic GP Fellowship scheme students covering the West Wales region and one student accepted a partnership with a practice in Hywel Dda, with the fellowship providing them with the opportunity to gain knowledge and experience in medical education and research. A report highlighting the next steps for the Health Board on widening access to training would be presented to the next UPB meeting.

- **Student Placements**

It was noted in the 2nd August 2018 meeting that the Health Board would be instrumental in providing medical and nursing student placements from University partners and helping to train locally in terms of implementing the new models of care for TCS. Members supported the suggestion to establish a Task & Finish Group to progress and enhance these placements and to meet the needs of all UPB partners.

In the meeting held on the 12th November 2018, a paper was provided for information. It was noted that the Health Board would need to raise its student footprint and Swansea University were in talks to create a hub in Aberystwyth. Ensuring students return to work within the Health Board was another aim. An update was given on the number of students currently engaged in placements – 2 students were on 13 week placements and a further 6 would be placed in Pembrokeshire the following year. Members were informed of the benefit that the partnerships with Universities are having on the Health Board

- **Academic Developments – University of Wales Trinity Saint David (UWTSD)**

During the 2nd August 2018 meeting, a report outlining the University's focus on 4 areas within health was provided. For the previous two years, the University had advertised a post for two MPhil/PhD studentships to undertake health services research & implementation of policy and advised that a further advertisement would be placed soon. The University will also explore proactive measures to increase research developments with University partners and develop a holistic learning environment for healthcare students. The contract for teacher training had been increased, and will include a whole lifestyle approach for education and well-being.

With reference to the Assistive Technologies Innovation Centre (ATiC), the University advised of the potential for collaborative working with the Health Board and how to progress any innovations emanating from the ACCELERATE work. Further discussions to be had to determine a way forward.

The Chair reminded Members that this agenda item provides all partner Universities with the opportunity to influence the UPB's agenda going forward.

Other Significant Business:

Rural Health & Care Wales (RHCW)

- In the May 16th 2018 meeting an update was provided that meetings were due to take place with HEIW and Prof. Elizabeth Treasure, Vice-Chancellor, Aberystwyth University. This provided a clear focus for the UPB.
- The Rural Health and Care Wales (RHCW) conference took place at the Royal Welsh showground in Builth Wells on 13th November 2018.
- An update was provided on Rural Health & Care Wales in the 12th November 2018 meeting, noting progress and work undertaken.

Discussion Items

A discussion was held in the 16th May 2018 meeting on the Hywel Dda Community Health Council report raising awareness of urgent care services amongst students. It was noted that the University Health Board should consider its engagement with students and look at how this could be undertaken more collaboratively in future to improve communication with the student population across the 3 counties.

Assurance Items

Sub-Committees

- **Research & Development Sub-Committee**

  Regular written update reports from Research & Development Sub-Committee meetings have been received by the University Partnership Board during 2018/19, highlighting the key areas of work scrutinised by the Sub-Committee. The Research & Development Sub-Committee Annual Report 2017/18 was presented to the University Partnership Board at its meeting on 16th May 2018 which was endorsed by Members. Also in August 2018, the Research & Development Sub-Committee Terms of Reference were approved and ratified via Chair's Action.

  In the 16th May 2018 meeting, the UPB approved the R&D Narrative Annual Return 2017-18 and also approved the Intellectual Property Policy.

  In the 12th November 2018 meeting, it was agreed that a clear plan for the management and support of active research clinicians to be set up.

- **Collaborative Institute Sub-Committee**

  Regular written update reports from Collaborative Institute Sub-Committee meetings have been received by the University Partnership Board since its establishment in July 2017, highlighting the key areas of work scrutinised by the Sub-Committee. The aims of the Collaborative Institute were discussed, which are to utilise the current skills and excellence in each organisation in terms of education, training and research; to further enhance health outcomes; to support the need for a changing workforce; and to improve the quality of life of the patients and population served by Hywel Dda.

  During the 2nd August 2018 meeting, it was advised that Mrs Angie Oliver had held discussions on the progress of the Sub-Committee, proposing that a regional approach is required. No Sub-Committee meeting was held prior to the November 2018 UPB meeting.

Information Items

With regard to the capture of research capability and activity across the University Health Board, it was suggested that a strategy for managing research, to include a flow diagram, be considered at the next UPB meeting in conjunction with the Hub Administrator.

In the 12th November 2018 meeting, Ms Jennings and the Chair both confirmed that they had each visited all Universities within the region.

Following the Health Board's recent advert for Deputy Director of Research and Innovation, the appointment of Mr Leighton Phillips had been made to this role.

Key Risks and Issues/Matters of Concern raised by the Committee to the Board during 2018/19 included:

- An urgent risk was noted – the concern that a number of active Research Clinicians are being lost which has a productivity risk. The Chair noted that Professor Keir Lewis had also written to him outlining his concern at this particular risk. In his letter, he requested that the Board look at 2 issues:
  - Research should be offered in Consultant's Job Descriptions, as an SPA, and supported by the R&D Director at annual appraisals.
  - The Nursing Managers give assurance that new Specialist Nurses have research put into their Job Descriptions, and all Specialist Nurses have protected Study Leave for a two day course, and be encouraged to attend workshops provided by Debbie Fenlon (Professor of Nursing)

Matters Requiring Board Level Consideration or Approval during 2018/19

- The University Partnership Board's Annual Report to Board 2018/19.
- The University Partnership Board's revised Terms of Reference.

Argymhelliad / Recommendation

The Board is asked to endorse the University Partnership Board Annual Report 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas, papers and minutes of the Committee meetings 2018/19.
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Governance, Leadership & Accountability Standard
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Board is asked to consider the attached Governance, Leadership and Accountability (GLA) Standard, which supports the Annual Governance Statement, and sets out expectations of health organisations for working within a legal and regulatory framework.

A summary of the Health Board's actions to demonstrate that it operates in accordance with both the GLA Standard and the wider standards framework is integral to the Annual Governance Statement. The self-assessment of the Governance, Leadership and Accountability (GLA) Standard should lead to the production of a development plan.

Cefndir / Background

The attached Governance, Leadership and Accountability Standard is one of the required elements underpinning the compilation of the Annual Governance Statement and contributes to the end of year processes. A draft of the completed standard, providing the opportunity for comment and amendment, was circulated to all Board Members, with any amendments received being incorporated into the final version which is now being presented.

Asesiad / Assessment

The Governance, Leadership and Accountability (GLA) Standard sets out the expectations of healthcare organisations for working within a legal and regulatory framework, and organisations are expected to consider the following criteria for meeting the standard:

- Demonstrating effective leadership by setting direction, igniting passion, pace and drive and developing people.
- Strategy is set with a focus on outcomes and choices based on evidence and people insight with an approach of collaboration building on common purpose.
- 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.

- Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models and manage performance and value for money.
- Foster a culture of learning and self-awareness and personal & professional integrity.

The Health Board's self-assessment considered all the questions as set out in the Welsh Government's supporting guidance in relation to the standard criteria, has been completed in terms of the current position and cross referenced where possible to the assessment against all other Health & Care standards. It should be noted that, although overall collation has been undertaken centrally by the governance team, Executive Directors were identified as leads for certain elements of the standard, providing the review and approval of the content.

The self-assessment identified areas where reasonable progress continues to be made, with some aspects of good practice identified, whilst also recognising that further development is required in other spheres.

Argymhelliad / Recommendation

The Board is asked to approve the completed GLA Standard, noting that work will continue in line with the Governance Enabling Plan.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Assurance reports to Committees and Board aligned to relevant standards. Triangulation with Fundamentals of Care audit.
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Board Secretary Independent Members of the Board Executive Directors

Parties / Committees consulted prior to University Health Board:	Internal Audit Audit & Risk Assurance Committee

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

In relation to the standard criteria below (in bold) the following key questions need to be considered:

Health services demonstrate effective leadership by setting direction, igniting passion, pace and drive, and developing people			
		Executive Lead	**Position**
1	Have you identified and set objectives for your organisation/ service which take values and behaviours into account?	Chief Executive Officer	In November 2018, the Board approved its *Health and Care Strategy – A Healthier Mid and West Wales: Our future generations living well*, which was developed based on the 11 clinical recommendations that emerged from the University Health Board's (UHB) public consultation 'Our Big NHS Change' The strategy describes the UHB's: • 20 year vision for the population health outcome for current and future generations; and • 10 year health and care strategy This strategy provides a long term vision that underpins the UHB's short and medium term planning over the coming months and years. During 2018/19, the UHB has been developing its strategy and the 2019/20 Annual Plan demonstrates how the UHB intends to begin delivery of the recommendations, with a particular emphasis on the shift from hospital focused care to population health, community and primary focused care. This will be supported by the resources approved from the Transformation Fund, together with those bids awaiting approval by Welsh Government (WG). To deliver the Health and Care Strategy, the UHB needs to make changes to the way in which it delivers its services, which means it needs a flexible and adaptable workforce which is competent, confident and engaged. The UHB strives to be an employer of choice and the health and well-being of its staff is paramount. Hywel Dda's Values and Behaviours Framework has now been in place for more than two years. The values were developed to support the organisational mission and vision. The values are the driving change of organisational culture and bring a consistent level of leadership to Hywel Dda. This is being reinforced by our organisational development strategy and the introduction of the Senior Leadership Programme and Aspiring medical Leaders course, both of which were launched in 2018/19. This shift in cultural change and leadership capabilities will impact positively in employee experience and increase staff engagement. It is recognised that higher levels of staff engagement impacts positively on quality, financial, performance and patient outcomes.

			The UHB have three value statements which are: • Working together, working as one to be the best we can be. • Putting people at the heart of everything we do. • Striving to deliver and develop excellent services. In addition to the organisation's value statements, there are nine personal values within the Values and Behaviours Framework which represent the personal values expected of staff on a day to day basis: • Dignity, respect and fairness. • Integrity, honesty and openness. • Caring, kindness and compassion. These nine personal values have been underpinned by three behavioural frameworks which define the types of behaviours that should be demonstrated on a daily basis to embed the values. These step up in categories, as follows: • Core behaviours – for all staff throughout the UHB. • Advanced behaviours – for all staff working up into leadership roles. • Excellence behaviours – for all leadership and senior roles. These behavioural frameworks have been added and measured through the annual Personal Appraisal Development Review (PADR) process for all staff, as well as following part of our recruitment process for all new employees.
2	Do you have mechanisms and systems of assurance in place to ensure your organisation operates in accordance with the Health and Care	Director of Nursing, Quality & Patient Experience	All SBAR reports that are presented to the Board and Committees are aligned to the Health and Care Standards (HCS). A template identifying appropriate links to committees/sub-committees has been compiled and will support the methodology in use for the self-assessment by Internal Audit. Internal Audit undertook a review of the self-assessment of the HCS completed by the UHB during 2018. The Internal Audit Review considered the processes that were in place for the preparation and completion of the self-assessments for HCS. It also considered how the standards are embedded in the organisation at all levels. Following this self-assessment, Internal Audit awarded a reasonable assurance rating in 2018.

	Standards?		An Integrated Impact Assessment (IIA) Tool, which incorporates the HCS, was developed in 2016/2017; following approval by the Executive Team in March 2017 this was rolled out for use in papers submitted to the Board and its Committees from April 2017. The IIA has been further developed to support the new 'check and challenge' process approved by the Board in March 2019. The Quality, Safety and Experience Assurance Committee (QSEAC) continues to receive a report on Healthcare Inspectorate Wales (HIW) and Community Health Council (CHC) inspection activity. The reports are written to reflect the relevant Health Care Standards, which will support embedding the standards into practice. The reports will identify any areas that require immediate assurance as well as noting full findings. Action plans are formulated by service areas, and monitored through the Executive Performance Reviews. Any incidents in respect of Ionising Radiation (Medical Exposure) (IR (ME)) Regulations are also reported to QSEAC, and assurance is given when investigations have been completed in relation to these reports. The UHB tracks all inspections and reviews undertaken by HIW to ensure that all recommendations are implemented within the UHB. Progress on implementing recommendations from any external review is reported through the UHB's Committee structure. The UHB's Audit Tracker maintains a record of progress and is regularly presented to the Audit and Risk Assurance Committee (ARAC). QSEAC also receive the HIW, CHC and peer review elements of the UHB's Central Tracker which will provides the Committee with a status report on the number of recommendations that are outstanding.
3	Has your Board undertaken an assessment of its effectiveness and developed a prioritised action plan in response?	Board Secretary	Over the last few years, there have been a number of commissioned external reviews which have considered the effectiveness of the Board and its arrangements. These have included an External Review of Governance Arrangements as well two WG commissioned external reviews, a zero based review of Hywel Dda UHB's acute cost base and a review of its financial arrangements. The UHB developed improvement plans following each review and almost all of the recommendations have been implemented. In addition, the Wales Audit Office (WAO) undertakes an assessment of the UHB's governance arrangements, financial management and the effective use of its resources on an annual basis. In January 2019, the Board received the WAO Final Structured Assessment 2018 report (SA18). WAO

			concluded that the UHB continues to strengthen governance and management arrangements, however there is recognition that some weaknesses remain in quality and safety governance arrangements, more needs to be done to streamline the organisational structure to support implementation of the new strategy, and the efficiency of both resources and assets in the short to medium term could be further improved. There were two recommendations made specifically around Board effectiveness, one of which related to the level and quality of information enabling Independent Members to make well-informed decisions, and the other was to improve the effectiveness of committees by allowing time on the agenda for reflection. The management response to the SA18 was presented to ARAC in February 2019, along with the outstanding recommendations from SA17. ARAC will continue to monitor progress on implementing recommendations from both reports. In September 2017, the Board approved the proposed approach to, and content of, the Board Development Programme which takes into account the recommendations made in the review of financial governance. The 3 stage 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 for them to improve individual and collective performance. Stages 2 and 3 of the programme have been undertaken during 2019/20. Sessions for Executive Directors have included the following areas: Executive Director Performance Management Framework; Myers Briggs Step 2; Leadership Diagnostics and Coaching; Leadership Well-being and Resilience; Team Stock Take; Executive Coaching Round 2; Action Learning; Working in Integrated Partnership for Transformation; Leadership Diagnostics and Team Climate, Values & Behaviours. Independent Members' sessions have covered the following subjects: Integrated Governance; New Member Induction; Committees Self-Effectiveness Feedback; Myers Briggs Step 2; Chairing Effective Sub-Committees; Team Stock Take; Scrutiny in Turnaround (KPMG); Risk Profiling & Tolerance and New Induction Programme. The above sessions have been supplemented by Joint Board Development Sessions which have focused on the following topics: Financial Governance and Assurance; Working Together Better; Board to Floor walkabouts; Compassionate Leadership; High Performing Organisation; Bespoke support; Financial Modelling & Simulation; and Myers Briggs Board Member Mapping.

			To complement the local provision, Board Members have also participated in the national available development through Academi Wales. In addition, Board Members have participated in a number of development sessions through the Board Seminar programme. The combination of Board OD sessions and Board Seminars has 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 to adequately assess organisational performance and the quality and safety of services. In accordance with Standing Orders, all Board Committees undertake an end of year self-assessment exercise. Findings are reported back to the Committees and an action plan will be developed in 2019/20 to address common themes from all self-assessments, as well as the Board Members survey of board members across Health Boards and NHS Trusts conducted by WAO. In addition to the above, ARAC holds annual private meetings with its external and internal auditors. No issues were raised in 2018/19 in respect of the effectiveness of the Board, although there was recognition that the Board needed to have a stronger focus on quality and safety.
4	Have you established effective reporting structures for all services?	Board Secretary	The current Board and Committee structure was approved by the Board in May 2015 as part of the recommendations from the External Governance Review. All Terms of Reference for the Committees and Sub-Committees structure are reviewed at least annually and all Committees/Sub-Committees and groups work to these. During 2017/18, the Board and Committee structure was further strengthened by adding clear reporting structures for both strategic and operational delivery to support the existing assurance Committee structure. In September 2017, the Board approved the Standard Operating Procedure for the Management of Board and Committees (including the Governance Wiring Diagram). In March 2018, the Standing Orders and Standing Financial Instructions were reviewed and agreed by Board; these have been reviewed in preparation for presentation to the Board in May 2019. Following presentation to ARAC, in September 2018 the Scheme of Delegation was approved by Board, as was a detailed Scheme of Delegation for Board, Committees and Officers which provides clarity on the responsibilities of Executive Directors, their Directorates and Committees. The detailed electronic Scheme of Delegation encompasses all delegations including Standing Orders, Standing Financial Instructions, financial delegations, legislative compliance, other delegations and

			responsibilities, both at delegated lead and operational responsibility level. This has been kept under review, and further expanded through Directorate delegations. In addition to the above, the UHB has refreshed its internal performance review process and the new Performance Management Assurance Framework commenced in May 2018. The objective of the Quadruple Aim Performance Management & Assurance Framework (PMAF) is to ensure that information is available which enables the UHB and senior management teams to understand, monitor and assess the UHB's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. The PMAF also incorporates how we track our performance and delivery against the UHB's Mission Statement, our strategic objectives and our values. It is recognised that there is further work to be undertaken in relation to reviewing reporting structures, with particular reference to QSEAC, to ensure that good governance is embedded throughout the UHB and that further work is required in relation to the Sub-Committees of the Board's Assurance Committees. This will be an area of focus for 2019/20, following receipt of the WAO review of local arrangements. Further work is also required to strengthen primary care reporting to the Business Planning and Performance Assurance Committee (BPPAC).
5	Do you have effective leadership, direction and decision making within your organisation/ service?	Chief Executive Officer	There is an expectation that all Executive Directors will demonstrate effective leadership in accordance with their portfolios and through their lines of accountability. To achieve our organisational vision, the UHB has been developing a culture of engagement, openness and honesty in which all elements of the workforce are encouraged to be innovative. Central to this is the need for clear and supportive leadership, including robust and empowering clinical leadership and staff engagement, and clear schemes of delegation. 2018/19 brought an improved level of stability to the Executive Team. Although there were changes in respect of Executive Directors and Independent Members, the UHB did not have any significant gaps and had interim arrangements in place prior to appointing to vacant posts. All Executive Directors participate in a consistent framework for Executive Objective setting and development, which helps to focus on key priorities and achieve more integrated team work. Executive Directors have been undertaking leadership diagnostics to deepen their understanding

			of themselves and others in the team, all of which helps to strengthen team performance and consequently organisational leadership for improvement. The UHB has a Board-approved comprehensive Board Development Programme designed to provide ongoing development to support the Board. 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 2018/19, the Board and Executive Directors took part in 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, and when new members are appointed and new chairs of committees are put in place. A programme of organisational development is currently in place to develop the Independent Members, as well as strengthen the Board as a whole, supported by regular six-monthly reviews on an individual basis. Independent Members have been complimentary regarding the training and development opportunities in place, although scope to make use of visits to departments and wards to develop their knowledge was highlighted during recent appraisals. Plans are in place to address this feedback, including the involvement of Independent Members in the Chair's Employee of the Month visits. (WAO SA18). A new Executive Performance Development Framework was implemented in 2018/19, wherein all members of the Executive Team had new objectives agreed; delivery of which was monitored by the Chief Executive Officer (CEO). These objectives provided clarity with regard to executive roles and responsibilities, were directly linked to objectives set out in the 2018/19 operational plan and promoted joint working. Executive Directors shared these with their direct reports and the totality of the objectives and how they interrelate have also been shared across the Executive Team and Board. The executive objectives have also encouraged wider involvement in operational issues, than has previously been the case (WAO SA18). Regular review of progress has been undertaken with each Director throughout the year.

			The UHB has implemented an organisational structure which is designed to be clinically-led; however, WAO found that directorate medical leads and GP cluster leads were not as involved as they might be in day-to-day management, due to their own clinical workload and trying to maintain fragile clinical services. Clinical Executive Team meetings were established, however medical staff struggled to attend, therefore they were put on hold. In 2017/18, the UHB put in place a substantive programme of organisational development following receipt of funding from WG, however WAO reported in SA18 that progress had been slow. During 2018/19, a number of steps have been taken to further develop Medical Leaders across the UHB. A Medical Leadership Forum has been established, co-chaired by the Medical Director and Director of Operations, with membership comprised of Hospital Directors; GP Cluster/Locality Leads and Assistant Medical Directors. The purpose of this forum is to develop the capability of our most senior medics to collectively and effectively address issues relating to professional development and services affecting the whole system. The Aspiring Medical Leaders Programme was launched in November 2018 to develop a community of Medical Leaders from the various sites, specialities and including primary care. These Medical Leaders have critical leadership roles in supporting the transformation and delivery of clinical services. Cohort 1 with 20 participants is underway with Cohort 2 commencing in May 2019. The System level Leadership Improvement Programme was launched in Autumn 2018 for 16 of our Senior Operational Leaders including General Managers; Heads of Nursing; Heads of Therapies; GP Cluster Leads and Hospital Directors. Cohort 1 completes in July 2019, with Cohort 2 commencing in June 2019 and running into the spring of 2020. The programme intention is to create a body of leaders capable of leading sustained improvement in services and systems. The programme offers opportunities to address complex service challenges and also a pipeline for succession. WAO reported in SA18 that there had been strong medical leadership in the Transforming Clinical Services (TCS) Programme, with the Medical Director responsible for developing the UHB's clinical strategy. The clinical directors and lead clinicians have also been at the forefront of the consultation exercise, with positive involvement from a wider range of other health professionals.

			The UHB recognises that high quality leadership is crucial to the achievement of organisational objectives and to ensure sustainability and future development. The UHB has a strong commitment to leadership development and acknowledges its role to increase the capability of current leaders and to develop future leaders. In September 2017, the Board reaffirmed its commitment to the UHB's Values and Behaviours Framework for staff. The Values Framework underpins leadership and effective management at all levels and a revised suite of leadership and management development programmes has been developed to support the delivery of a values based, compassionate leadership culture. The programmes are intended to develop leaders who engage staff and encourage innovation, and support the ongoing development of skilled effective leaders and managers who drive continual improvement through engagement. The programmes focus on the 'how' as well as the 'what'. Schedule 1 of the Standing Orders details the Scheme of Delegation for the Board, Committees and Officers. Committees' revised Terms of Reference details the responsibilities and accountability of the Committees/Sub-Committees/Groups.
6	What levels of delegation have been agreed? Do they provide a robust framework for accountability?	Board Secretary	In March 2018, the Standing Orders and Standing Financial Instructions were reviewed and agreed by Board, and will be presented to the Board in May 2019 following the annual review. In September 2018, the Scheme of Delegation was approved, as was a detailed Scheme of Delegation for Board, Committees and Officers which provides clarity on the responsibilities of Executive Directors. The detailed electronic scheme of delegation encompasses all delegations including Standing Orders, Standing Financial Instructions, financial delegations, legislative compliance, other delegations and responsibilities, both at delegated lead and operational delegation responsibility level. This has been kept under review, and further expanded through Directorate delegations. The Board has a Committee Structure in place to provide assurance to the Board. Terms of Reference have been reviewed and agreed for all Committees, and were approved by the Board as part of the review of Standing Orders in March 2018. SA2018 reflected that the UHB has an effective system of internal control to support Board assurance. WAO found that some aspects of governance are stable and well-organised, but others need to be further developed particularly in relation to quality and safety arrangements.

			During 2018/19, the UHB refreshed its internal performance review process and introduced the new Performance Management Assurance Framework (PMAF). This is currently under review to align with delivery of objectives. The Quadruple Aim PMAF will ensure that information is available which enables the UHB and senior management teams to understand, monitor and assess the UHB's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. The Board received an updated and detailed Governance Wiring Diagram in September 2017 which provided a clear map of the Committees, Sub-Committees and Groups which underpin the three arms of the UHB's governance structure – Assurance arm; Operational Delivery & Performance Management arm; Strategy Development arm. It also described the relationships with each other, the connectivity between them, and key partnerships. The Governance Wiring Diagram provided assurance to the Board that there is a clear line of reporting for all identified Committees, Sub-Committees and Groups and that they have purposeful roles and responsibilities which support the UHB's governance structure. This Governance Wiring Diagram remains under regular review. To support the Scheme of Delegation a Corporate Scheme of Financial Delegation provides clarity for the Health Board on financial limits and approvals. The summarised scheme was presented to the Finance Committee in September 2018. Budgets have been aligned to Directorates and accountability letters sent from the Chief Executive to all budget managers detailing their responsibilities. During 2018/19, a restructuring of the Finance Directorate has taken place, thereby strengthening support to Directorates through Business Partnering. This will help deliver increased accountability in 2019/20 as the model is embedded.
7	How do you communicate organisation/service priorities effectively through the organisation, ensuring that these are delivered at	Director of Partnerships and Corporate Services	There is an expectation that all Executive Directors will disseminate information in accordance with their portfolios and through their lines of accountability. The UHB holds its Board meetings, with these now being webcast live to increase reach, in public to improve openness and transparency about the business of the organisation. In accordance with Standing Orders, the role of the Board is to: • Set the organisation's strategic direction.

	pace?		• Establish and uphold the organisation's governance and accountability framework, including its values and standards of behaviour. • Ensure delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity. The Board's agendas follow a set format which ensures that strategic decisions and issues are considered, and quality, safety and performance is reported and discussed by the Board. Following every Board meeting, an update is cascaded through 'Team Brief' to managers and staff of the UHB to communicate the Board's decisions and discussions to staff. This is circulated via global e-mail to staff, with managers expected to brief their staff through the Team Briefing process. Board decisions are also disseminated through the work of the Sub-Committees and respective meeting structures. Whenever the UHB undertake engagement or consultation activities, one of the important first steps is to identify who it needs to work with through a robust stakeholder mapping and analysis process. Engagement activities are planned using the most appropriate methods. The UHB's engagement activities and public consultations are communicated to staff through a number of methods including 'Global bulletins', intranet pages, surveys and questionnaires and drop-in events. Staff are encouraged to become members of our Siarad Iechyd/Talking Health involvement and engagement scheme which provides members with up-to-date information and opportunities to shape health services. Members receive information and can support the UHB through several methods including providing feedback via surveys, participation in engagement activities such as focus groups, world cafe events, etc, and test patient information documents to see if they are user-friendly. The UHB developed and implemented its PMAF in 2018/19 to enable the Executive Team to enhance its understanding, monitoring and assessment of the UHB'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 2018/19. The PMAF will be strengthened further in 2019/20 following feedback from WAO SA18. The Annual Plan 2018/19 was underpinned by a number of enabling plans to translate actions and behaviours into delivery. These plans were developed by clinical and service leads with Executive sign off and were the subject of quarterly monitoring through the committee structure of the Board and reporting to Welsh Government.

8	Have you identified risks and barriers to achieving these objectives?	Board Secretary	In 2018/19, the UHB further developed its Board Assurance Framework (BAF) and Corporate Risk Register (CRR). The BAF was refreshed and risks were aligned/identified to the existing strategic objectives 9 and 10 agreed by the Board in March 2016 (as strategic objectives 1 – 8 were under review as part of the Health and Care Strategy). The BAF was received by the Board in September 2018 and January 2019, and will continue to be received by the Board twice a year. SA18 concluded that the UHB has a well-developed BAF in place which will be refreshed as new strategic objectives are developed and that it is supported by a well-documented CRR, which was refreshed and updated following a Board Development Session in August 2018. The content of the CRR is agreed by the Executive Team and includes significant risks to achieving the organisation's strategic objectives and significant operational risks which could cause substantial harm, loss or damage to the UHB and require oversight by the Board. Directorates across the organisation continue to identify, articulate, and manage/mitigate risks that affect the day to day operations of the UHB. Each Directorate has a risk register which is fed by department/service risk registers. 2019/20 will see further development of directorate and service risk registers to ensure that they reflect risks to achieving their directorate and service objectives and compliance with legislation/standards.
9	How do you identify, assess and manage your risks?	Board Secretary	As set out in the UHB's Risk Management Framework, the UHB follows the 3 line of defence model whereby the first line of defence relates to the functions that own and manage risk. 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 UHB's wider governance framework. All three lines need to work interdependently to be effective. Roles and responsibilities are set out in the Risk Management Framework, making it clear that risk ownership and management sits with management and staff. There are 3 types of risks within the UHB. These are strategic (principal), operational and project risks and are managed through 3 different processes, which are mutually complimentary. In respect of strategic risk management, the Board agreed the structure and process for the Board Assurance Framework in September 2018 - BAF Process App1(page 7).

			Principal risks are generally identified in a top down and bottom up approach, whereby the Executive Lead for each strategic objective, proactively identifies risks that could affect delivery of the strategic objectives and any significant operational risks, from their directorate risk register, that needed oversight by the Board. These risks were then assessed and analysed, taking into account the controls that were already in place and the assurance on their effectiveness, and appropriate actions were planned to address any gaps in both controls and assurances. The content of the BAF/CRR is considered and agreed by the Executive Team. The risks on the BAF/CRR are aligned to a Board Committee, responsible for monitoring and reviewing the management of the risks on behalf of the Board at alternate meetings. Where the Committee are not assured that risks are being managed effectively, it will seek further assurances at the following meeting. The Board receives updates on this process via the Committee Update Reports, and considers the BAF/CRR twice yearly. In respect of operational risks, this is predominantly achieved through a bottom up approach whereby service areas are responsible for identifying, assessing and managing risks and maintaining their own risk registers. Where these affect the Directorate achieving its objectives, day to day operations or compliance, these will be escalated for Directorate oversight.
10	Do you have a risk framework and a system of assurance?	Board Secretary	In September 2017, the Board approved the Risk Management Framework which detailed the 3 lines of defence model in respect of risk management. The first line of defence is where operational management have ownership, responsibility and accountability for directly assessing, controlling and managing/mitigating risks. The second line of defence consists of activities covered by several components of internal governance, i.e., specialist risk management functions such as corporate risk management, health and safety, quality, counter-fraud, business continuity, etc), which monitors and facilitates the implementation of effective risk management practices by operational management and assists the risk owners in reporting adequate risk related information up and down the organisation. The third line of defence is provided by Internal Audit which provides an independent assessment on how the UHB assesses and manages its risk and the effectiveness of the first and second lines of defence. Success of the 3 lines of defence model is reliant on all 3 lines working effectively with each other. The Risk Management Framework also detailed the risk architecture of the organisation clarifying the roles and responsibilities for risk management, as well as the reporting and communication mechanisms throughout the organisation.

			The UHB has further developed the BAF in 2018/19. This was reviewed and discussed by the Board in its Seminar in August 2018 and formally presented to the Board Meeting in Public in September 2018. The BAF sets out the risks to achieving strategic objectives, the internal controls for mitigating those risks and the assurances the Board needs to know that controls are effective and risks are being managed. The BAF process was also set out to the Board in September 2018 which documented the 3 stage process of mapping and assessing assurances related to the principal risks. The WAO SA18 was relatively positive in its report, in that it assessed that the UHB has a well-developed BAF in place and had addressed its previous recommendation that further work was required to embed the revised risk management framework. WAO also stated that the UHB had an effective system of internal control to support board assurance, and found that some aspects of governance are stable and well-organised, although others needed to be further developed particularly in relation to quality and safety arrangements. WAO also advised in SA18 that the UHB had a robust process for tracking recommendations by all regulators, not just those identified by External and Internal Audit, which they identified as good practice. The tracker is regularly reported to ARAC and executive officers are held to account for the pace of delivery, with detailed progress updates reported back to ARAC at regular intervals. During 2018/19 ARAC approved an escalation process for late or non-delivery of recommendations which facilitated focus on addressing outstanding recommendations, with progress monitoring now delegated to the performance reviews. The Legislative Assurance Framework (LAF) has been reviewed in 2018/19 with an assurance report presented to ARAC as part of end of year reporting. The statutory obligations of UHB are wide ranging and complex, therefore in order to provide the Board, via ARAC, with a level of assurance of compliance, the LAF has been reviewed focusing on those matters that present the highest risk in terms of likelihood and impact of non-compliance. Where an assurance rating of ‘limited’ or ‘no assurance’ has been given, Services were asked to undertake a risk assessment for these areas (if not already in place) in order that the impacts are understood and the planned actions detail the risk management plan and mitigation in place. Documenting and understanding of the level of risk ensures will help to inform UHB’s annual prioritisation process going forward. These will also be included in the performance management reviews undertaken with services.

			A register of Ministerial Directions is maintained and compliance is reported to ARAC annually as part of end of year reporting. A Decision Tracker from Board and Committees in place to ensure actions from meetings are logged and detailed, these are RAG rated. A log of Welsh Health Circulars (WHCs) is maintained and progress on implementation/compliance is reported through the Board's Committee and Sub-Committee structure. This is also presented to ARAC as part of the end of year reporting.
11	How do you gain assurance about your organisation/ service?	Board Secretary Director of Nursing, Quality and Patient Experience	The UHB gains both positive and negative assurance from a number of internal and external sources of assurance. Where positive assurance is gained, this provides the organisation with the opportunity to share good practice, however where negative assurance is identified, the Board expects management to take appropriate action to reduce the risks. SA18 reported that in respect of embedding a sound system of assurance, some aspects of governance are stable and well-organised, however others needed to be further developed particularly around quality and safety arrangements. Most assurance is gained from internal sources such as the Integrated Performance Assurance Report (IPAR) which is presented on a bi-monthly basis to the BPPAC and the Board, self-assessment processes such as the Health and Care Standards, reports to Committees and the Board, and monitoring and scrutiny of risks through the Board and Committee structure. SA18 reported that the IPAR had been further developed as an interactive tool which ensures areas of underperformance are more prominent and recognised the continual improvement being made by the UHB to focus on patient experience and outcomes. Further work to be undertaken on the quality dashboard in 2019/20. Executive Performance Reviews were introduced in 2018/19 as part of the PMAF, chaired by the CEO, and currently cover performance, workforce, quality and safety, risk and assurance, finance and delivery against plans. These are under review following feedback from WAO in SA18. Internal Audit is classed as an internal source of assurance which provides the UHB with an honest and independent opinion of its systems and processes. The UHB agree the Internal Audit Plan in advance with Internal Audit and reports are presented to ARAC throughout the year.

			Recommendations are taken forward by management and progress is tracked via the UHB Audit Tracker. Clinical Audit reports are received by various committees and groups within the clinical services and governance structures. All clinical audits are expected to have an action plan for improvement. These are submitted to the Clinical Audit Department and progress updates are expected. Whole hospital audit meetings are held to highlight the learning involved and share best practice. The UHB implemented a forward Clinical Audit Programme in 2018/19. This pre-planned list of audits is intended to address the highest priority audit projects with a "risk based" approach to Clinical Audit and matching the programme to available resources. An annual report will be presented to ARAC in August 2019. There is an established process for the reporting of mandatory national audits. When a national audit report is published this triggers the process whereby services are asked to complete an assurance form outlining the report recommendations and subsequent action plan. This plan is signed by senior service leads and a representative of the Medical Director and then submitted to Welsh Government. A new process for non-participation in mandatory audits was developed and implemented in 2018/19 and services now undertake a risk assessment relating to non-participation, in line with their service's other risks. Non-compliance is reported through individual specialty risk registers. However, it is recognised through the work of ARAC that further work is required to increase participation and learning from these audits. In addition, the HCS Fundamentals of Care audits, which are undertaken on an annual basis, will support UHB assurance mechanisms. The results from these audits are presented to the Board and QSEAC. Information from complaints, compliments, patient surveys and patient stories, can provide the UHB with information which will support assurance mechanisms. The UHB developed the Quality Improvement Strategic Framework which was formally launched in March 2019. Throughout 2018/19, formalised Board to Floor walkabouts were undertaken. These included executive and independent members and staff from the Assurance, Safety and Improvement (ASI) team. The walkabouts have been well received from clinical staff. There is on-going evaluation of the programme and themes and trends are being reported to QSEAC. A planned programme of IM site visits is also being developed and rolled out.

			Although the quality dashboard continues to be developed for use by QSEAC members, there are dashboards in place at operational level, which Heads of Nursing and other identified staff use, to oversee the management of incidents, and concerns. External assurance is gained from outside organisations. WAO undertake a review of the UHB's governance and financial management arrangements. The SA18 followed similar themes to previous years' work in respect of the focus on reviewing the UHB's corporate governance and financial management arrangements and progress made in addressing the recommendations made in the previous assessment, whilst broadening the scope to include commentary on arrangements relating to procurement, asset management and improving efficiency and productivity. The SA18 was reported to the Board in January 2019, with the management response presented to ARAC in February 2019. The Committee will monitor progress against the recommendations throughout 2019/20. The UHB also agreed an Annual Audit Plan with the WAO, who are the UHB's official external auditor. Progress against this Plan is routinely reported to ARAC, with final reports and the management responses developed to address the recommendations, presented throughout the year. Progress on implementing recommendations is undertaken via the UHB's Committee structure and the Executive Performance Reviews, and is tracked via the UHB Audit Tracker. ARAC approved a new escalation process in June 2018, and now invite Executive Directors to account for late or non-delivery of recommendations. SA18 reported that the UHB has a robust process in place for tracking recommendations by all regulators, and has identified this as an area of good practice. External reviews by organisations such as HIW or the CHC will also provide rich information to advise on how the UHB is performing and provide further assurance mechanisms. HIW assesses the health services provided by the UHB to check whether standards are being met. HIW undertake inspections of hospitals, mental health and learning disabilities facilities, GP practices and dental services, and monitor compliance on the use of ionising radiation. All HIW reports and other external reviews are presented to QSEAC. Management responses are subsequently developed to address recommendations and delivery of these is now monitored through the Executive Performance Reviews.

			The UHB also gains assurance from its management responses to the Public Service Ombudsman for Wales (PSOW) S16 and S21 reports, Coroner Regulation 28 reports into unexpected deaths and the Welsh Risk Pool (WRP) claims reviews which demonstrate that the UHB is addressing the causes and issues of incidents that have led to complaints and claims. The UHB maintains a Legislative Assurance Framework which lists the key legislative and regulatory requirements, as well as the accreditations and inspections, which the UHB is subject to. An Assurance Report is presented annually to ARAC. This has been developed in 2018/19 to ensure it aligns to the UHB's risk management process and informs the development of the Internal Audit Plan going forward.
12	Have you mapped out your sources of assurance to build an assurance framework?	Board Secretary	The BAF was received by the Board in September 2018 and January 2019, detailing the information that the Board relies on to gain assurance on the effectiveness of the controls it has in place in respect of managing principal risks (risks that could affect delivery of the strategic objectives of the UHB). When the Board approved the refreshed BAF in September 2018, it also approved the 3 stage process for mapping and assessing assurances which enables the Board identify whether there are any gaps in assurance. WAO SA18 reported that the UHB had a well-developed BAF.
13	How do you use internal and clinical audit mechanisms to provide assurance?	Board Secretary Medical Director Director of Nursing, Quality and Patient Experience	An Internal Audit Plan is agreed annually and monitored by ARAC. The UHB uses a risk based approach to develop the Plan and this is undertaken in conjunction with the Chair of ARAC, ARAC Members and the Executive Directors. Internal Audit is also requested to undertake specific pieces of work related to risk areas that are identified within the financial year. Internal Audit reports and management responses are presented to ARAC. Recommendations are taken forward by management and progress is tracked via the UHB Audit Tracker which is reported to ARAC on a regular basis. The introduction of Team Central, which is an electronic tracking system, specifically for Internal Audit reports, will strengthen assurance on the timely implementation of recommendations.

			The UHB has developed a forward plan of Clinical Audits for 2018/2019. The plan was compiled by asking the senior committees within the already established UHB governance structure to provide a list of high priority projects, focusing on key risks, areas of concern and where possible, linked to the strategic objectives. The plan was approved by ARAC in August 2018. It is recognised that this programme will require improvements in the future and with increased engagement, led by the Clinical Audit Department and Senior Committees, the programme will build in quality in subsequent years. It remains a concern for the UHB that the Clinical Audit Department and the services carrying out the projects continue to face resource challenges which impact on the organisation's ability to participate fully with mandatory national audits and key local audits. The developing work streams around the forward clinical audit programme have led to improvements in this area and the UHB has seen some increase in compliance within key projects. Clinical Audit has been highlighted as an area of concern from ARAC to the Board with progress being regularly monitored in the 2018/19 financial year. There is a governance structure in place for reporting clinical audit; Effective Clinical Practice Sub-Committee, QSEAC, other specialty/directorate specific governance committees. A Clinical Audit Group has been approved as a reporting group to the Effective Clinical Practice Sub-Committee. This group's primary focus will be on providing further assurance that there is a robust clinical audit function within the organisation. Whole Hospital Audit meetings are held regularly on all sites to highlight the learning from these. In 2018/19 a total of 19 of these events were held with 79 audits presented and discussed. It is recognised that work is needed to be undertaken to strengthen the role and governance of the ECPSC and this work will be led by the Medical Director. ARAC maintains an oversight of the work undertaken by Clinical Audit in order to be able to provide assurance to the Board and to discharge the Committee's duty in accordance with the Audit Committee Handbook. Due to resource pressures within operational teams for data collection and implementation of audit outcomes the UHB did not participate in all mandatory audit projects for 2018/19. Reported compliance with a number of these projects increased during this time period from 26 to 28 and the number of projects without any participation from the UHB was reduced. Whilst this is a positive trend, the programme consists of 34 unique and variable projects which require continuous monitoring and support. Participation in the national clinical audit programme is a risk on the risk register. Reports on compliance with the national programme are to be presented at ARAC in April and August 2019.

14	Have you discussed, agreed and communicated clear values and behaviours for your organisation/service?	Director of Workforce and OD	In July 2016, the Board approved the UHB's Values and Behaviours Framework for staff. http://www.wales.nhs.uk/sitesplus/documents/862/Item13BoardSBARReportTemplateValuesFinal.pdf. To ensure the UHB makes a difference and performs to its optimum, three organisational value statements wrap around the individual personal values. These being:- • To always put people at the heart of everything we do; • To work together to be the best we can be; • Strive to deliver and develop excellent services. In September 2017, the Board reaffirmed their commitment to the Values and Behaviour Framework, when they were presented with an annual update in the implementation of the Values and Behaviours Framework and how they have been brought to life within the organisation. The report demonstrated the work that had been undertaken since July 2016 to implement the values and behaviours throughout the organisation and how success has been measured. However there is also a growing evidence base which is showing that there are improved staff behaviours/ engagement, although it is difficult to solely attribute this to the values being implemented. There will be ongoing reviews to review the project to implement of the Values and Behaviours Framework, although embedding the framework will be a continuous process. The Organisational Development (OD) team, leading on cultural change, have developed a values session which showcases the values and asks the team/department or service what the values look like for them. A values charter has been designed with staff contributing and agreeing on the types of behaviours they expect from that team. These sessions are being conducted across the organisation and have resulted in some significant improvements in staff engagement. The leadership module of leading people also has a values session which outlines the need for consistent behaviours and the need for leaders to role model organisational values.
15	How do you constantly communicate the values and	Director of Workforce and OD	Information on the Values and Behaviours Framework of the UHB is available on both the staff intranet and public website. A staff information booklet is also available. This is integral to the UHB's induction and is included in all managerial and team development programmes. The UHB has a twitter account linked to the UHB values where staff and members of the public can comment on

	behaviours to staff and the maintenance of high standards and codes of conduct?		when our staff have lived up to our values. The Values and Behaviours Framework is part of the annual PADR process whereby managers and staff members review where they have met the organisation's values and behaviours during their day to day work. The UHB is working towards a culture of open consistent reflection where employees are encouraged to reflect and discuss their behaviours in line with organisational values and the associated behavioural frameworks. The building of psychological safety will support employees to appropriately challenge any improper behaviours at any level. The UHB is in the early stages of introducing values-based recruitment and has used values-based exercises as part of its Health Care Support Worker Bank, Student Nurse recruitment, Overseas recruitment, and Executive Director recruitment processes. The values continue to be showcased in the Chair's employee/team of the month awards which are shared on social media and global e-mails. Any applications for the award need to demonstrate how the recipient has demonstrated the values in their work. The OD department has designed new values workshops that have been run now for a number of wards and services throughout the organisation. The team has facilitated these sessions for teams in Special Care Baby Unit (SCBU), Nutrition and Dietetics, Children's Play Specialists, Estates, Pharmacy, Research and Development and many more. The sessions conclude with the team developing and agreeing a list of values behaviours for their department or ward, which are then drawn into a values pledge that they will adopt and which will support the amending of the organisational values. The feedback for the sessions has been excellent and the OD department have many more to complete for 2019/20. The Standards of Behaviour Policy enables the UHB to ensure that its employees and Independent Members practice the highest standards of conduct and behaviour. Regular reminders are issued to staff to declare interests, gifts, hospitality, honoraria and sponsorship which always reference the wider policy. Recognising that further work is needed to be undertaken to communicate the key elements of this policy to the wider workforce, standards of behaviour now features routinely at both corporate induction and Managers Passport/Plus programmes. Other initiatives to communicate acceptable standards of behaviour include a poster introduced for ward areas, reminders via payslip

			information, and targeting of specific groups of staff, i.e. Finance, Procurement, Safeguarding, etc. Work has taken place during 2018/19 to enable the electronic completion of declaration forms and all declarations are now publicly available from the UHB's website. Work is also ongoing in conjunction with Betsi Cadwaladr University Health Board on a 'Once for Wales' basis to link the declaring of interests, gifts, hospitality, honoraria and sponsorship to the UHB's Electronic Staff Record (ESR) system to enable more easily identifiable information and reports. The UHB's Standards of Behaviour Policy will also undergo a wholesale review in May 2019 as part of an all Wales approach. Board to Floor walkabouts have been initiated within the UHB and will be further embedded during 2019/20. Walkabouts have enabled Independent Members and executive officers to undertake visits to specific departments and clinical areas. These visits demonstrate the increasing focus by Independent Members on the need to triangulate sources of assurance, and feedback to date has suggested that the visits have proved useful in providing triangulation for Board members on the key quality and safety challenges that the UHB faces. Walkabouts, together with other safety initiatives, demonstrate strong commitment of senior leadership to a culture that encourages safety, as well as a tool to connect senior leaders with people working on the front line, both as a way to educate senior leadership about safety issues and to signal to front-line workers the senior leaders' commitment to creating a culture of safety. Visits have taken place in a number of wards and units across the UHB and feedback has been provided to QSEAC. As part of Independent Members ongoing development, a programme of site visits will be initiated in 2019/20, to improve engagement with and strengthen understanding of the services within the UHB's acute hospitals, community services and mental health and learning disabilities services.
16	How do you know your staff are aware of the vision and values of the organisation and the high standards of behaviour and codes of conduct expected	Director of Workforce and OD	Following the launch of the Values and Behaviours Framework in July 2016, the organisation has continued to embed them into the organisation. The organisation has continued to communicate them through – • A communication campaign to ensure the organisational values are embedded across the UHB; and • Drafting of suitable values based questions for recruitment practices for both core and leadership roles.

	of them?		The Corporate Induction for all new starters continues to include a session on our organisational values and why they are so important. It outlines what the values are and what behaviours underpin these values. Induction also includes information on the PADR process and how employees are measured using the values when they complete their yearly review. September 2017 saw the Board reaffirm their commitment to the Values and Behaviour Framework, when they were presented with an annual update in the ongoing implementation of the Values and Behavioural Framework and how they have been brought to life within the organisation. It was recognised that behaviours of leaders are integral to the embedment of the values. The leaders in Hywel Dda should not only be ensuring that all team members are behaving to expectations but should be role models within the organisation. It has been recognised that there are some inconsistencies within the leadership in the organisation and there is a need for uniformity. The need for further skills regarding effective appropriate leadership styles have led to the team designing and facilitating modules on living the values, effective communication, conflict management and compassionate leadership. The UHB's leadership development programmes are now focused on both operational and effective people skills to ensure compassionate leaders who role model and challenge where the values are contradicted in any way. The new leadership programmes – Managers Passport and Passport Plus are designed to highlight accepted behaviours and build a psychological safe culture; a culture where employees can speak out and challenge any behaviour that is not deemed appropriate according to the values. The organisational values are now part of the PADR process where employees are expected to review both past performance in their roles and also how they have embodied and lived the values through their associated behaviours. The PADR conversation is only part of an open reflection and feedback culture where employees are encouraged to reflect on themselves and how they are performing within the role and any future aspirations. This culture is supported through high levels of psychological safety and effective leadership performance management with efficient feedback methods such as supervisions, 121's and regular, meaningful PADR's. The UHB has achieved a combined compliance rate of 78% as up to March 2019 which is a vast improvement from 2017/18.

			The Corporate Induction also includes an introduction to the Standards of Behaviour Policy and sets out the expectations of the UHB in respect to the standards of conduct and behaviour. The policy ensures that there are arrangements in place to support staff to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific guidance for the appropriate declarations of interests and acceptance/refusal and recording of offers of gifts, hospitality, honoraria and sponsorship. All new starters to the UHB, and all existing staff who change roles, are issued with Contracts of Employment within 8 weeks of their start date. When staff are asked to sign their Contract of Employment, which is a legal requirement, they are also asked to confirm their requirement to abide by the UHB's Standards of Behaviour Policy. Other initiatives to communicate acceptable standards of behaviour are also regularly progressed (see 15 above).
17	Does your Board actively monitor standards of behaviour throughout the organisation? (This could be via the Audit and Risk Committee, complaints; disciplinary action; or the PADR process)	Board Secretary	An annual compliance report for standards of behaviour is presented to ARAC. This report, presented in March 2018 and April 2019, provided an update on the adequacy of arrangement in place for declaring, registering and handling gifts, hospitality and sponsorship. The report also advised on the work undertaken since the WAO survey on the management of interests, gifts, hospitality, honoraria and sponsorship at the UHB in early 2016. The Committee reviewed the adequacy of the arrangements currently in place for the register of interest and the hospitality and gifts register, and noted the proposed steps to improve the adequacy of these arrangements. In 2018/19, further development has been undertaken to increase the number of gifts, hospitality, honoraria and sponsorship registered by further promotion of the Standards of Behaviour Policy, and by the introduction of more user friendly electronic declaration forms. The Improving Experience Sub-Committee (IESC) monitors complaints on behalf of QSEAC, and would identify any issues of poor standards of behaviour, with complaints performance a bi-annual discussion item on the Board's agenda. Any trends or areas of concern are reported through to the relevant Associate Medical Director (Workforce) or the Assistant Director of Nursing (Practice). For 2019/20, a Listening and Learning from Events Working Group will be established which will report to the IESC on lessons learnt assurance, monitoring of corporate level actions plans from concerns, and external reports.

			The HCS - Fundamentals of Care (FOC) audits, which are undertaken on an annual basis, will support UHB assurance mechanisms. The results from these audits are presented to the Board and QSEAC. Since 2015, the FOC annual audit has been undertaken using the Health and Care Standards which provide the framework for how services are organised, managed and delivered. Feedback from patients, family and carers show that, in the vast majority of cases, the UHB does get their care right and they rated their overall satisfaction as 93% (RAG rating of green for fifth year but a 1% decrease on last year's position). Staff were also asked to rate their overall satisfaction with the care provided to patients and relatives, staff gave the organisation a satisfaction rating of 81%, (RAG rating of amber but an increase of 1% on last year's position) for this question however when staff were asked to rate their overall satisfaction with the organisation, staff gave the organisation a satisfaction rating of 73% (RAG rating of amber but an increase of 1% on last year's position). The audit provided QSEAC with assurance that the care delivered by the UHB continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement which are being addressed by the organisation. Information regarding individual performance, arising from the concerns process, is submitted for discussion as part of appraisal and revalidation processes. The Workforce & OD Sub-Committee monitors PADRs and disciplinary cases and this is also a regular feature of the Board performance report. PADR levels are also monitored at the Executive Performance Reviews. The OD Department continue to gain feedback from leavers through the exit interview process and questionnaire, where feedback is sought on behavioural standards. This feedback is analysed and any areas of concern investigated and appropriate interventions supplied to support the relevant individuals/teams. Interviews that have being completed by the OD department in the last 18 months show that a high proportion of leavers were aware of the values, with approximately 80% of respondents answering positively. In accordance with the All Wales Disciplinary Policy, the In-Committee Board is provided with a regular update on all employment suspensions, highlighting cases where the suspension has exceeded a period of four months and including details of suspensions lifted or closed since the

			previous report. In addition, employee relations activity, which includes all disciplinary cases, is regularly reported to Workforce & OD Sub-Committee. Disciplinary trends are also examined, analysed and reported to Workforce & OD Sub-Committee.
18	How do you actively promote, embed and robustly support high professional standards and quality requirements and challenge poor behaviour?	Director of Workforce and OD Medical Director Director of Nursing, Quality and Patient Experience	There is an expectation that Executive Directors, e.g. Director of Nursing, Quality and Patient Experience, Medical Director and Director of Therapies and Health Sciences will enact these principles in accordance with their portfolios and through their lines of accountability. Registration is confirmed at the point of recruitment and monitored by line managers, whilst arrangements are in place to ensure that all registered nurses and consultants revalidate. For nursing and midwifery staff, the individual, professionally focussed reflective discussions that underpin the revalidation process is reported as being a positive, individual reminder of the professional standard expected of every registrant. A PADR process is in place and PADR compliance is monitored at Board and BPPAC. As at Month 12 of 2018/19, PADR compliance was 78% (IPAR Month 12) which demonstrates a positive trend in this area. Overall, PADR performance improved by 15.63% over the last 12 months with the main reasons for this increase being the review of service/team compliance rates within the performance monitoring process and the ongoing building of a culture wherein leaders recognise the benefits of the PADR process. There remains ongoing focus through training and support mechanisms via the Workforce & OD teams, but improvement is still failing to meet required targets. Respective Codes of Practice are referenced in appropriate workforce policies i.e. All Wales Disciplinary Policy. The standards require a nurse or midwife to declare that they have practiced for 450 hours during the last three years and followed requirements on Continuing Professional Development (CPD) and practice related feedback. They are expected to have indemnity insurance and be of good health and character. Revalidation also requires nurses and midwives to have a professional discussion with another registrant about their practice, and obtain confirmation from a third party that they have met the revalidation standards. It is expected in the majority of cases that the professional discussion and confirmation takes place during the registrant's Personal Appraisal and Development Review, and be undertaken by the line manager. PADRs are central to the nurse and midwifery revalidation process. Monthly meetings of the Senior Nursing and Midwifery Team (SNMT) discuss a range of local and national professionally focussed issues and this agenda is

			cascaded through professional forums held regularly with nurse leaders within each service. Medical staff are required to undertake annual appraisal and five year revalidation in line with UK legislation. The UHB has a dedicated team to monitor and coordinate this process, with independent screening to identify and flag up issues of concern with the General Medical Council (GMC) and to take action accordingly. Appraisal rates are monitored monthly through the Performance and Revalidation Panel, chaired by the Deputy Medical Director, and action taken to address any issues which arise. The second five year cycle commenced in April 2018 and the same process will be followed. All revalidation of the medical workforce continues to be managed and monitored by the Medical Directorate and monthly exception reporting is acted upon at monthly revalidation meetings. As at March 2019, medical appraisal remains above target at 95% (IPAR Month 12) which demonstrates a positive improvement in this area. The OD Department is working to develop a culture of psychological safety within the organisation, where employees are encouraged and empowered to speak out against poor behaviours. The Department will be looking at various means of confidential communication so that staff who fear repercussions feel more comfortable in raising issues. The UHB actively promotes a 'See Something, Say Something' programme to encourage all staff to feel empowered to challenge poor practise and conduct. All managers are encouraged to address shortcomings in behaviour and performance. Managers receive training in addressing poor performance through the Managers Passport programme. Managers are closely supported by the Operational Workforce team in addressing performance issues. In addition, the development of the medical management model and infrastructure within the UHB has helped to ensure a more robust approach to addressing shortcomings relating to medical staff performance whether relating to clinical performance or behaviour. In addition, the Workforce Department place strong emphasis on problem solving at an early stage and encourages early resolution wherever possible. Managers, including Senior Clinical Managers are being strongly encouraged to address shortcomings as soon as they present. Training is also being provided for senior staff. Reviewing complaints can also provide the UHB with a mechanism for challenging poor behaviours.

			During the year, significant work has been undertaken on improving reporting, including establishing a quality dashboard, escalation processes, and strengthening the Datix system to provide better reporting mechanisms. Monitoring reports are provided to services to ensure earlier identification of emerging themes/trends and any concerns regarding the management of investigations. This work will be further strengthened by the establishment of the Listening and Learning From Events Group. The sharing of patient stories at Board and at Sub-Committees is an additional step in the feedback process which can lead to reflection of practices and suggestions for improvement. Patient stories are also shared at departmental and service level for reflection and discussion about lessons learnt and at internal/external training events. A new patient experience charter and associated programme will be implemented in 2019/20. This will include the introduction of a new patient experience system and roll out of the friends and family test to all services. This will result in improved level of feedback on experiences of services users, family and friends and will enable the measurement and evaluation of feedback on individual service areas.
19	Do your service priorities, values and behaviours influence your staff development programmes?	Director of Workforce and OD	The UHB's core values are embedded within all developmental programmes and induction. Currently some appointments are using values based questions. This will be further explored and expanded so that all staff will be recruited and trained in line with the UHB's core values. The Managers Passport and Passport Plus leadership programmes have the core values running through all sessions. The modules of: • Managing Services • Managing People • Managing Yourself Have been designed with service priorities, patient feedback and organisational values throughout all of them. There are direct links to research that outlines how compassionate, values led leadership directly impacts patients safety. The programmes have been continually tweaked from feedback from attendees to ensure they are meaningful and continue to provide added value for leaders across the organisation.

20	Does your organisation publish a statement in your Annual Report/ Quality Statement on the adequacy of its arrangements for safeguarding high standards?	Director of Nursing, Quality & Patient Experience	The UHB publishes annually the Annual Quality Statement (AQS) and the 2018/2019 Statement was submitted in draft to the April 2019 meeting of QSEAC. Minor amendments are to be made following the Committee and this will be published, in line with guidance, following presentation to the Board on 29th May 2019 and accessed via the UHB's website. An Extraordinary Public Board meeting will be held prior to publication to support formal sign off by the UHB prior to publication. The final AQS will be presented at the UHB's Annual General Meeting (AGM) in July 2019. The AQS provides an opportunity for the organisation to let its local population know in an open and honest way what it is doing to ensure all its services are meeting local need and reaching high standards. It brings together, each year, a summary highlighting how the organisation is striving to continuously improve the quality of all the services it provides and commissions in order to drive both improvements in population health and the quality and safety of healthcare services. The UHB has launched its Quality Improvement Strategic Framework in March 2019, with the first cohort starting in June 2019. The quality dashboard is being further developed, this dashboard has identified key quality indicators, which will support triangulation of data and support the development of next year's AQS.
21	Does the culture of your organisation support the personal responsibility of individuals in the maintenance of high standards?	Director of Workforce and OD Director of Nursing, Quality & Patient Experience	The values are now embedded into all development programmes which begin to shape our culture. The culture expected in the organisation is one where poor standards are not accepted and employees are encouraged to celebrate successes and speak out where standards have not been met. The values sessions and leadership programmes outline the need for individual responsibility of the culture desired at the UHB. It is the responsibility of everyone to influence the culture and to challenge appropriately when poor standards or inappropriate behaviours are witnessed that damage the UHB's culture. Compassionate leadership is vital to build the correct level of psychological safety for individuals to challenge. The need for leaders to role model and demonstrate organisational values and behaviours is paramount to achieving this.

			The UHB has a Whistle-Blowing Policy in place for staff to raise concerns, which can be accessed via the UHB staff intranet. The UHB actively encourages staff to report incidents through Datix for investigation. Since 2018 Datix incident reporting training has been included on the Staff Induction Programme. Incident investigation training is now also provided on the Managers Passport Programme. The UHB continues to work hard to ensure the timely management of incidents. The performance against the 60 working day target for investigation and closure of serious incidents reported to WG has improved, however, there are some areas were further work is required. A targeted approach has been implemented to support areas of poor compliance. A process for setting up Control Groups has been established for incidents and events which meet certain criteria. There is also a panel, chaired by the Executive Director of Nursing, Quality and Patient Experience, with the Medical Director and the Executive Director for Therapies and Health Sciences also in attendance. Services with poor compliance against the 60 day closure target for Serious incidents (SI) are asked to attend and explain the reasons for poor compliance. Action plans are devised and monitored through this panel. Training in relation to the quality of investigations has been given to staff within the ASI team. These training sessions were led by Delivery Unit and WRP. There has been a vast improvement in the quality of SI investigations and this has been recognised and acknowledged by WG. A quality and safety newsletter has also been developed.
22	Is this supported by induction, training, and personal appraisal?	Director of Workforce and OD	The Values and Behaviour Framework is now embedded within all developmental programmes and induction. Going forward, all staff will be recruited and trained against these core values. The PADR documentation has been amended to incorporate the UHB values so that the conversations during PADR focus on the behaviours required ensuring the values are demonstrated in every area of work. Performance monitoring of PADRs/medical appraisals improved during 2018/2019 and is evidenced on ESR. A new values PADR was developed in December 2017 and this new documentation combined with leadership and bespoke PADR training has seen a hugely improved position of 76.04% compliance for non-medical appraisals and 95% for medical appraisals which gave the organisation a combined compliance rate of 78% up to March 2019 and was reported to WG as part

			of Tier 1 targets.
23	What corporate policies exist within your organisation / service to guide your staff and others on how you do business?	Director of Partnerships and Corporate Services Board Secretary	All written control documents are developed/reviewed in accordance with the UHB Written Control Document Policy. This policy describes the policy development/review process, ensuring that all documents are in line with current legislation, guidance and evidence. Once approved the documents are circulated via the global email and are accessible on the policy pages of the staff intranet and UHB website. All corporate written control documents are approved through an agreed scheme of delegation and are published on the UHB website. http://www.wales.nhs.uk/sitesplus/862/page/58594. The Standards of Behaviour Policy sets out the expectations required and provides supporting guidance in order that all employees and Independent Members are supported in delivering this requirement. The Health Board's Standards of Behaviour Policy will undergo a wholesale review in May 2019, as part of an all Wales approach. The revised Standard Operating Procedure Setting out the Requirements and Standards for the Management of Board and Committees, approved by Board in September 2017, sets out best practice for the management of Board and Committee meetings and the production of Board and Committee papers. An accompanying toolkit provides guidance to staff on this best practice. This Standard Operating Procedure and Toolkit is kept under regular review. The UHB Standing Orders and Standing Financial Instructions and Standing Orders and Terms of Reference for the Joint Committees of the Board such as Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and NHS Wales Shared Services Partnership (NWSSP) are reviewed by Board and were presented to the March 2018 meeting for approval. A Framework for Partnership Governance was approved by the Board in March 2017 to ensure there are effective arrangements in place for the governance of partnerships. This is reviewed annually. The Integrated Impact Assessment Tool which was approved by Board in March 2017 ensures that our plans, programmes and initiatives are cognisant of equality issues, and also assess the impact these have on health inequalities and adherence to prudent healthcare principles. As part of the

			portfolio management approach to deliver the health and care strategy, a supportive Check and Challenge process will be in place, which provides assurance that the delivery of any projects, service changes and pathway re-design meets the UHB's priorities, is consistent with the principles set out within '*A Healthier Mid and West Wales: Our future generations living well'*, and fully aligned across the portfolio. The approach will also provide a supportive space to test and challenge the proposals to ensure that they are delivering truly aspirational and transformational change. The approach will also ensure that the programme or project can progress more confidently to the next stage of development, implementation or realisation. The approach is not designed to be linear, but rather will allow for a cyclical view, recognising the inter-relationship between key elements and principles. The approach will check and challenge against the Health Board's key priority areas: a. Health and Wellbeing Framework b. Framework for Continuous Engagement c. Equality, Diversity and Inclusion d. Evidence based innovation, research and benchmarking e. *A Healthier Mid and West Wales* Design Principles f. Clinical Input g. Quality/Patient Care h. Applying the Teulu Jones Lens i. NHS Wales Planning Framework j. Workforce supply and feasibility k. Finance/Affordability (including Turnaround and Value Based Health Care) l. Legal Impacts m. Risk The approach will develop as the portfolio of programmes develops. It will be continually reviewed and will allow flexibility to facilitate meaningful conversations which are both challenging and supportive, in order to deliver the best and most transformational proposals for the Health Board. The approach to Check and Challenge is fully aligned to the Health Board's Integrated Impact Assessment and as part of the ongoing review of the approach, opportunities to amalgamate into a single process and mainstream across the Health Board will be explored.
24	How do your corporate policies	Director of Partnerships and	To function safely and effectively the UHB needs to work within a framework of agreed written control documentation. The UHB approved policy 190 - Written Control Document Policy, provides a robust

	uphold the values of your organisation/ service?	Corporate Services	and clear governance framework surrounding the system to manage written control documentation. This system includes the organisational arrangements, the governance, assurance and accountability for the development, review and implementation of all written control documentation (ensuring that they are developed in line with current legislation, guidance and evidence) and helps to achieve compliance with corporate and clinical governance standards. This document differs significantly to the previous version, particularly in relation to the involvement of key stakeholders, decentralisation of the approval process and the associated responsibility of 'groups' for the quality assurance of the document. As part of the implementation, help guides and flow charts to support authors in the development/review process of written control documentation have been created. Annual summary reports detailing the status of relevant written control documentation. The reports will also include information on: • Any new documentation currently in development; • Any documents which have been removed from the internet during the financial year; • Details of documentation highlighted as requiring review in light of the revised Data Protection Act/General Data Protection Regulations 2016 or any subsequent legislation to the same effect; • Information on relevant written control documentation highlighted as part of the cleansing exercise of the intranet which have been uploaded onto various library pages. A Privacy Impact Assessment Policy is currently being drafted by the Information Governance Manager which will detail the new regulations and the process for undertaking privacy impact assessments for all new/revised written control documentation.
25	Do you use patient/user feedback in staff and organisation reviews?	Director of Partnerships and Corporate Services	Information received via patient/user feedback is recorded and any themes/trends are reported to the services involved or to individual mangers, where individual staff are involved. Details of claims/complaints are also recorded against individual staff, where appropriate, and this information is provided to individuals to assist with the revalidation and appraisal process. Any thematic or organisational wide reviews take account of any issues recorded on the risk management system, as a result of the feedback obtained, including compliments, claims, complaints.

			The sharing of patient stories at Board and at Sub-Committees is an additional step in the feedback process which can lead to reflection of practices and suggestions for improvement. Patient stories are also shared at departmental and service level for reflection and discussion about lessons learnt and at internal/external training events. The introduction of a new patient experience system, including friends and family and strengthened surveys and “Care to Share” sessions in clinical areas will greatly enhance the level and quality of patient experience feedback, allow improved triangulation of data, and identification of any emerging themes/trends. The UHB has a statutory duty to continuously engage and consult around any changes to health services. The TCS programme is clinically–led, so the UHB has worked with hundreds of doctors, nurses, therapists and other healthcare professionals to design and test new models of care fit for our current and future generations. The UHB’s public engagement “The Big Conversation” took place from June to September 2017 and involved engaging with around 4,000 members of the public, staff and stakeholders about the UHB’s health and care services. The findings from engagement were used to design options. This process was clinically-led through the Options Development Advisory Group (ODAG) which was tasked with developing and co-designing options to be tested and challenged by a wide number of stakeholders at workshops and check and challenge sessions. A fictional family “Teulu Jones” was developed to test scenarios and help challenge the UHB’s ideas and models. Formal consultation “Our Big NHS Change” took place for 12 weeks between 19 April 2018 and 12 May 2018. There was an unprecedented level of activity throughout the consultation period and this included: - 17 public drop-in events reaching over 1,400 people - 44 staff events involving over 1,100 staff members - 77 activities / meetings with community groups involving over 1,300 attendees - 17 independently run public workshops reaching 241 people - 7 independently run staff workshops with 43 people A particular emphasis was placed on seldom heard voices and targeted activity was undertaken with key groups – this accounted for approximately 45 activities.

			A diverse range of activities included face to face meetings, existing groups, poster campaigns, press releases and an unprecedented level of digital communication. The feedback was independently analysed and a series of conscientious consideration sessions including clinicians, wider staff and stakeholders were used to help understand the outcome of the formal public consultation and the significance of key emerging themes. The outcomes of these sessions were used to determine the final clinical recommendations. This has been a co-designed approach and the UHB has responded openly and dynamically to change and challenge throughout this process. The UHB has strengthened its commitment to continuous engagement and the Joint Framework for Continuous Engagement and Consultation developed by the UHB and CHC was signed off at Board in January 2019. In addition to the phenomenal amount of work undertaken throughout the consultation period, the UHB continued to support continuous engagement in practice around key projects including Cylch Caron Integrated Resource Centre, and the Cardigan Integrated Care Project The Siarad Iechyd/Talking Health involvement and engagement scheme continues to provide members with up-to-date information and opportunities to shape our services. Members receiving information can support the UHB through activities including feedback via surveys, participation in engagement activities such as focus groups, world café events, online events as well as testing information documents to see if they are user friendly.

	Strategy is set with a focus on outcomes, and choices based on evidence and people insight. The approach is through collaboration building on common purpose.		
		Executive Lead	**Position**
26	Do you consider the Citizen Centred Governance Principles in developing the	Director of Planning, Performance & Commissioning	Whilst not explicitly mentioned in the Annual Plan 2017/18 and 2018/19, the Citizen Centred Governance Principles were implicit through our plans and its underpinning enabling plans. The 2019/20 Annual Plan recognises that it is a continuing journey to ensure that our governance processes are aligned to the WG's Citizen Centred Governance Principles.

	organisation's strategic planning process (IMTPs)?		Work has also been undertaken through the Board's development programme in terms of refreshing understanding of the principles. This has been further supported with target training awareness-raising sessions with the CHC, groups and individual officers within the UHB. The Citizen Centred Governance Principles are reflected in the management of individual change processes and is particularly important in the development of the UHB's TCS programme. The first stage of this being the Transforming Mental Health Services strategy which was approved by Board in January 2018 and with the Board approved *Health and Care Strategy: A Healthier Mid and West Wales* in November 2019.
27	How do you ensure prudent healthcare principles are embedded in your strategies and plans?	Director of Planning, Performance & Commissioning	The Bevan Commission defines prudent healthcare as *'healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients.'* The Board Paper in January 2016 'Embedding Prudent Healthcare in Hywel Dda' stated that the UHB was committed to embedding the four principles into its planning as well as day-to-day delivery of healthcare. The Board encourages the principles of prudent healthcare in all activities rather that this being seen as a separate stand-alone plan. The principles of prudent healthcare form the basis of our TCS Programme, which directly informs our work to ensure all of our health and care services are fit for the future and are *Safe, Sustainable, Accessible and Kind*. This is now the underlying philosophy of the 2019/20 Annual Plan, developed through 2018/19, and building upon the previous years' endeavours on the same. Furthermore, the UHB has begun developing its Value Based Healthcare approach. Whilst acknowledging that Value Based Health Care (VBHC) is at a relatively early stage of development in the UHB, *A Healthier Wales* alongside our own clinical strategy, *A Healthier Mid and West Wales*, provide both a clarifying context and strategic direction for the developing work programme in this area. The noted Zero Based Review highlighted significant efficiency opportunities for the UHB. A VBHC approach can support exploration here in several ways.

			For example, it has been acknowledged that workforce review and changes will be necessary to ensure safe and sustainable services in the future, the technical aspects of the financial approach to value are perfectly placed to support the contrasting of different grades or professions of staff when redesigning both the who and the how our services are provided. In reviewing services themselves, a VBHC approach contrasts the desirable clinical and patient outcomes with the cost of achieving those outcomes. In doing so the VBHC approach can deliver both visibility and a consistent currency for all the activities in a pathway, allowing technical efficiency comparisons between organisations, sites or clinical teams but also allocatively reviewing where resources are best deployed in a pathway. This is particularly crucial if ambitions to move resources into primary, community and preventative healthcare are to be realised. Beyond this, there are planning and monitoring opportunities in designing and following up any resultant changes as we move into redesigned future service models. Priority pathways have already been identified through high level reviews that explored and triangulated existing data covering activity, quality and cost measures. In moving to a more detailed exploration of these, VBHC will be a core component of our approach, and is fully consistent with the vision of prudent health care in NHS Wales.
28	How do you ensure that your strategies and plans contribute to the strategic vision for health services in Wales?	Director of Planning, Performance & Commissioning	Whilst it was agreed the UHB would produce an Annual Plan for 2018/19, this has nevertheless been produced to comply with the NHS Planning Guidance Framework and therefore follows the prescribed structure and content for IMTPs. Within the context of an Annual Plan, the UHB has addressed the strategic vision demonstrating how plans and actions align to duties, legislation and national programmes, the development of regional planning and the key delivery metrics of Welsh Government i.e. NHS Wales Outcomes Framework. Both the Annual Plan 2017/2018 and 2018/2019, as well as the 2019/20 Annual Plan developed during 2018/19, ensure that the UHB values and mission statements are at the core of what we do. The UHB values, through a comprehensive organisational development strategy which is already underway, are becoming firmly embedded in the way it conducts its day-to-day business. The UHB's mission statement has also informed the *Health and Care Strategy* and in particular our intention to develop services that are 'Safe, Sustainable, Accessible and Kind' for today's patients and for future generations, and is as follows:

			• Prevention and early years intervention is the key to our long term mission to provide the best health care to our population and this will be further strengthened by our continued collaboration and partnership working with other organisations, stakeholders and the public • We will be proactive in our support for our local population, particularly those living with health issues, and carers who support them • If you think you have a health problem, rapid diagnosis will be in place so that you can get the treatment you need, if you need it or move on with your day-to-day life • We will be an efficient organisation that does not expect you to travel unduly or wait unreasonably; is consistent, safe and of high quality, and, has a culture of transparency and learning when things go wrong Similarly, the enabling plans to the Annual Plans 2017/2018 and 2018/2019 also demonstrated contribution to national strategy in workforce, informatics, capital, quality, finance and performance agendas. These were all subject to performance monitoring throughout 2017/2018. The Annual Plan 2018/2019 continued the UHB's journey to becoming a population health organisation focused on keeping people well, developing services in local communities and ensuring our hospital services are safe, sustainable, accessible and kind as well as efficient in their running. Regional working is a strong theme in our Plan and is reflected in the key collaborative arrangements with neighbouring health boards, universities and local authorities.
29	How do you ensure you work in constructive partnership to develop policies and strategies on cross cutting issues and deliver the best outcomes for people?	Director of Partnerships and Corporate Services	The UHB recognises the importance of regional and partnership working and can evidence this through the high profile collaboratives which are a central part of the UHB's strategy to maximise opportunities and address a number of our key regional challenges. The relationship between Hywel Dda UHB and Swansea Bay University Health Board (SBUHB) has strengthened, through the mechanisms and opportunities provided by ARCH and the Joint Regional Planning and Delivery Committee (JRPDC). The Annual Plan 2019/20 sets out planned regional developments to deliver improvements in immediate priority areas, many linked to the UHB's Planned Care Action Plan, subject to resource and capacity (endoscopy; catheter laboratories; orthopaedics; vascular, dermatology; ophthalmology; cellular pathology; neurology; interventional radiology; cardiology; digitalisation of services and hyper acute stroke unit (HASU). In addition, a joint Board

			to Board meeting has been held between both organisations. As part of the Mid Wales Joint Committee for Health and Care, which leads on the implementation of the findings and recommendations of the Mid Wales Healthcare Study, the UHB worked in partnership to deliver the Mid Wales programme during 2018/19 and will continue to do so through 2019/20 This will include development of integrated community focussed ophthalmic and respiratory services across mid Wales, a multi-agency dementia care service through joint working with social care, voluntary services and other agencies, improve access to community based oncology services, reviewing the colorectal pathway, implementation of the Telemedicine Strategy and development of the Bro Ddyfi integrated Health and Care facility to improve access to health and social care, well-being, prevention and health promotion services. The UHB has made significant progress to develop the integration of service planning and delivery at a locality level which was a key area of focus for 2018/19. Working with partners in primary care, there are plans in place for each of our 7 GP Clusters. The Integrated Care Fund (ICF) has funded frailty work in Ceredigion and has funded an End of Life project working in partnership with third sector in Pembrokeshire. The UHB also has a Regional Plan in collaboration with Local Authority colleagues. The UHB is also a statutory member of the West Wales Regional Partnership Board (RPB) established under part 9 of the Social Services and Well-Being (Wales) Act 2014, and is working in partnership with local authorities, independent and third sector organisations. The UHB was an active partner in the production of the West Wales Area Plan which was published in March 2018 and during 2018/19 the RPB submitted a successful bid to WG to secure transformation funding to accelerate the pace and scale of change in health and social care integration. The Well-Being of Future Generations (Wales) Act 2015 places a well-being duty on specified public bodies to act jointly within established statutory Public Services Boards (PSBs). The UHB is a statutory member represented on the three PSBs within the Hywel Dda region, and on all appropriate sub-groups. Each PSB must improve the economic, social, environmental and cultural well-being of its area by contributing to the achievement of the well-being goals identified within the Act. The PSB Well-being Plans set out the well-being objectives and priorities of the PSB and reflect the aspiration of PSB members to add value through collaboration. Work is currently underway to ensure these are

			integrated within existing UHB's frameworks for delivery and governance. The UHB approved and has published its Well-Being Statement and Objectives in March 2017 and the organisational objectives were maintained in 2018/19. The University Partnership Board (UPB) assures the UHB that the work of the UPB, through partnership working with the Universities, is leading to continual improvement in the quality of care being provided and patient outcomes. Year 2 of the UPB Strategy has identified key priorities which will be met through specific missions; these are the basis for collaborative developments and a focus for reporting within the active partnership. This year has seen the university partners contribute to the Health and Care Strategy and their detailed responses will form a three year work programme that starts to deliver on the ambitions of that plan in a range of ways. This will be across workforce, training, research, innovation and the full range of wider benefits that universities can bring with an emphasis on making real impact on the lives of our population. This is further strengthened by the implementation of the Well-Being of Future Generations (Wales) Act 2015. The Sustainable Development principle is in the process of becoming embedded across the organisation, which in itself will provide focus toward collaboration within partnerships maximising the sustainability of benefits to individuals. Recognising that the UHB will need to work increasingly in partnership to deliver its strategic aims, objectives and priorities, the Board approved an approach to strengthening partnership arrangements with the West Wales RPB. This will see the establishment of a new Integrated Executive Group to support joint working and integrated at an operation level and oversee the delivery of regional strategies. In addition, the RPB will establish a Regional Leadership Group comprising the four statutory Chief Executives, Chair of the Health Board and Cabinet Members for Social Services from the three local authorities. This will provide strategic advice and support in relation to setting an overall vision for the integration of health, care and support in the region, agreeing objectives in support of the vision, and ensuring appropriate links with other local and regional transformation programmes.

30	Do you know about all partner organisations/ networks?	Director of Partnerships and Corporate Services	Through statutory membership of the three PSBs within the Hywel Dda region and the relevant sub-groups, there is the ability to demonstrate the wide range of interaction and links with many partner organisations. With representation from leaders of national and local public sector organisations and the third sector, there is a common duty to meet the well-being needs of the population collaboratively. Partnerships that the UHB actively participates in have been mapped and the Partnership Governance Framework and Toolkit was approved in September 2017. The partnerships, which vary in size and purpose, with representation from across sectors and at a national, regional and local level, have been registered by UHB partnership leads. This information populates a partnership register, through completion of a partnership registration form, the purpose of which is to record key details of partnerships, particularly those which meet the UHB's 'significant' definition i.e: • How strongly the partnership supports delivery of the UHB's key/strategic objectives, priorities or statutory obligations; • The amount of resources the UHB contributes to the partnership; and • The levels of liability consequent on any serious failures within the partnership, particularly from a delivery or liability perspective. This enables the UHB to demonstrate an awareness of its key commitments, and evidence the performance and risk management arrangements it has in place for each partnership. Whilst the UHB will have governance and reporting arrangements in place for its main partners, it has not mapped out all its partnerships' networks. Each registered partnership was reviewed in September/October 2018 and will continue to be reviewed annually with new partnerships added, details updated and partnerships where UHB has disengaged; recorded and removed from the register.
31	Do you identify and engage with stakeholders and have formal processes in place	Director of Partnerships and Corporate Services	The role of the UHB's Stakeholder Reference Group (SRG) is to provide early engagement and involvement in the determination of the UHB's overall strategic direction, provide advice to the UHB on specific service improvement proposals prior to formal consultation and feedback to the UHB on the impact of the UHB's operations on the communities it serves.

	to capture feedback from stakeholders to inform future strategic planning?		The membership is drawn from within the area served by the UHB, and ensures involvement from a range of bodies and groups operating within the communities services by the UHB. Membership includes representation from the Armed Forces, Bevan Advocate, carers, County Equality Group Chairs, Dyfed Powys Police, Fire and Rescue Service, Health and Social Well-Being Partnerships/Public Service Boards, UHB Public Health, Housing Associations, Community Health Council, Independent Sector, Mental Health, Senior Officers of Directors in Social Care/Social Service Carmarthenshire, Ceredigion and Pembrokeshire Local Authorities, Sensory Impairment, Third Sector (Ceredigion Association of Voluntary Organisations, Carmarthenshire Association or Voluntary Services and Pembrokeshire Association of Voluntary Services), Town and Community Councils, Well-being of Future Generations and Children and Young People Partnership, Welsh Ambulance Services NHS Trust and a patient representative. The SRG is an important advisory group of the UHB. SRG is one of the key forums used to share early service change plans, with a voice at Board on key issues that stakeholders wish to raise, the services that need to be improved, as well as an opportunity to shape the way the UHB delivers its services. Over the past year the SRG has played a key role in the work of both the TCS and TMH programmes of work. For the next year, the focus of this group will predominantly focus on the Health and Care Strategy programme of work.
32	Do you involve patients/service users and staff and focus on their needs and experiences, putting them at the heart of strategic plans?	Director of Partnerships and Corporate Services	Hywel Dda's Big NHS Change Consultation used a mix of engagement methods to elicit views from the population it serves which includes citizens, patients, service users, carers, staff, third sector, and partners. This includes attendance at existing meetings, community groups and setting up specific activities to meet different needs. These programmes of work are strategic approaches to how the UHB can develop services to better meet the needs of the population it serves with co-production integral to how they operate. The UHB has strengthened its commitment to continuous engagement and the Joint Framework for Continuous Engagement and Consultation developed by the UHB and CHC was signed off at Board in January 2019.
33	How do you ensure	Director of	The Annual Plan 2018/19 and its underpinning enabling plans set out deliverables and milestones

	that everyone involved in the delivery chain understands each other's roles and responsibilities and how together they can deliver the best possible outcomes?	Planning, Performance & Commissioning	through detailed actions, timescales and measures of success. This remains true for the Annual Plan 2019/20 and is being developed through the Integrated Planning Assurance Report (IPLAR) which provides assurance on the planning cycle process and products. PSBs provide the leadership to meeting county-wide Well-Being Objectives. Through co-ordination of representation at a senior level and those supporting the underpinning thematic groups, information is shared and actions taken within the UHB. Governance is in place to provide assurance to the Board regarding integrated delivery and development. Recognising that the UHB will need to work increasingly in partnership to deliver its strategic aims, objectives and priorities, the Board approved an approach to strengthening partnership arrangements with the West Wales RPB. This will see the establishment of a new Integrated Executive Group to support joint working and integrated at an operation level and oversee the delivery of regional strategies. In addition, the RPB will establish a Regional Leadership Group comprising the four statutory Chief Executives, Chair of the UHB and Cabinet Members for Social Services from the three local authorities. This will provide strategic advice and support in relation to setting an overall vision for the integration of health, care and support in the region, agreeing objectives in support of the vision, and ensuring appropriate links with other local and regional transformation programmes. The Scheme of Delegation for Board, Committees and Officers details responsibilities and accountability, and was reviewed and updated in January 2017 to reflect recent changes in Executive portfolios. There have been a number of OCPs in Directorates within the UHB which clarified the roles and responsibilities for delivery. In 2018/19, the UHB further developed an interactive Scheme of Delegation to clarify delegated responsibility, authority and accountability within the organisation. This is supported by ensuring that all enabling and action plans have an assigned Executive lead both for their development and their monitoring through the Committee structure of the UHB.
34	How do you ensure your business planning	Director of Planning, Performance &	Board Committee work plans, particularly BPPAC, are aligned to the planning cycle and ensures both the delivery of agreed plans, and the development and prioritisation of deliverables for the Annual Plan.

	procedures effectively prioritise key deliverables to meet your strategic objectives?	Commissioning	The UHB established a new Planning Sub-Committee which reports directly to BPPAC. The role of the Sub Committee is to ensure the UHB develops its Integrated Medium Term Plan (IMTP)/Annual Plan in line with latest NHS Wales Planning Guidance and to advise and guide the UHB's planning arrangements and implementation of major change (one year, medium and longer terms plans). The Planning Sub Committee has also been established to: provide assurance to BPPAC that the planning cycle is being taken forward and implemented in accordance with the UHB and Welsh Government requirements; guidance and timescales; ensure the development of, and quality assure all Together For Health delivery plans; ensuring their alignment with the UHB's strategy and priorities; and ensuring their alignment to the planning cycle; have an overview of on-going regional planning work and the impact on local planning, including strengthening of the commissioning of these services, determining local targets, and repatriation opportunities; ensure that risks relating to planning are being effectively managed across the whole of the UHB's activities; receive updates from CHC Service Planning Committee; and agree issues to be escalated to BPPAC with recommendations for action. One of the roles of the Capital, Estates and IM&T Sub-Committee is to prioritise recommendations for discretionary capital sums and All Wales Capital Schemes and investment proposals, in response to an assessment of the organisation's risks, and to support the UHB's service strategy (including delivery plans) and vision for healthcare and its strategic objectives including, performance and financial improvement and is managed through the Board committee structure. The Executive Team oversees implementation arrangements for the vision, goals and priorities set by the Board, which can then be signed off by relevant committees, and the development of strategic change/business cases that have been signed off by the Board, ensuring robust appraisal processes are in place and utilised.
35	How do you plan and prioritise resources and evaluate your performance	Director of Planning, Performance & Commissioning	The Annual Plans and their underpinning enabling plans set out deliverables and milestones through detailed actions, timescales and measures of success for both 2018/2019 and 2019/20, each with an assigned Executive lead. During 2018/19, the UHB monitored these on a quarterly basis through appropriate governance structures and reporting to WG.

	against strategic goals and delivery plans?		The BAF identified the significant risks which could prevent the UHB from delivering its strategic objectives and details the required actions to address any gaps in controls such as the need for any additional resources. BPPAC is responsible for monitoring and scrutinising on overall performance and delivery against UHB plans and objectives. These include the delivery of Tier 1 targets and the financial control giving early warning on potential performance issues and making recommendations for action to continuously improve the performance and the financial position of the organisation and, as required, focus in detail on specific issues where performance is showing deterioration or there are issues of concern. In 2018/19, the UHB further developed an interactive scheme of delegation to clarify delegated responsibility, authority and accountability within the organisation.
36	Do your objectives have specified and measurable outcomes and do you monitor against them?	Director of Planning, Performance & Commissioning	The UHB's Annual Plan 2018/19 included specific and measurable outcomes, which have been monitored through action plans and through BPPAC. This is the same for the 2019/20 Annual Plan. Performance objectives are monitored through regular performance review meetings and through the Board Committee structure, and in moving forward in 2019/20 Annual Plan actions will be proactively managed through this mechanism. In 2018/19, the Director of Public Health undertook a review of the UHB's strategic objectives with the aim of developing cross-cutting programmes of work that will implement the objectives and instigate a whole system change. The Board approved the Health and Care Strategy in November 2018, which describes the long term vision for the population health outcomes for current and future generations and the UHB's 10 year health and care strategy. This will be further developed into the UHB's short and medium term planning in 2019/20 and beyond.
37	Are you clear about what evidence you need to demonstrate the	Director of Planning, Performance & Commissioning	The Board agreed in January 2017 that strategic objective reporting arrangements needed to be strengthened and refined to include a clear and detailed narrative on progress against delivery of the strategic objectives, supported by the BAF which would detail the principal risks to achieving objectives, and how gaps in controls and assurance would be addressed.

	success of a strategy, and how you will collect this? (outcome focus)		One of the reasons why the UHB has not been in the position to produce an IMTP has been the lack of a clear, sustainable Clinical Services Strategy. The Health and Care Strategy has now been approved following extensive public consultation and the delivery and governance mechanisms have been agreed by Board in March 2019. The advanced part of the TCS programme was concluded in January 2018 when the Board approved the TMH strategy. Planning and delivery for this has been included in the 2019/20 Annual Plan. The 2019/20 Annual Plan demonstrates how the UHB intends to begin delivery of the *A Healthier Mid and West Wales: Our future generations living well*, with a particular emphasis on the shift from hospital focused care to population health, community and primary focused care. This will be supported by the resources approved from the Transformation Fund, together with those bids hopefully still to be approved by WG.
38	What accountability arrangements exist for partnerships and networks?	Director of Partnerships and Corporate Services	Partnership and network arrangements are supported by the development of formal partnership governance arrangements, Memorandums of Understanding e.g. UPB; Section 33 of the NHS (Wales) Act 2006 Partnership Agreements with Local Authorities e.g. Carmarthenshire and Pembrokeshire Integrated Provision of Community Equipment Services and Terms of Reference for partnership working Committees/Groups e.g. Carmarthenshire Integrated Services Board. A Partnership Governance Framework and Toolkit has been developed which facilitated a review of the UHB's partnership and network arrangements. The Framework ensures that accountability is clear in regard to partnership reporting through the UHB's own corporate governance arrangements, which is particularly important where partnerships are focused on some of our most vulnerable groups, and where there needs to be even more trust and confidence in the arrangements in place. The Framework was approved by the Board in September 2017 and is reviewed annually to ensure it is current and up to date. In March 2019, the Board received a paper setting out the plans to strengthen the governance arrangements of the West Wales RPB to ensure there is a shared approach going forward. In addition there will be an integrated Executive Team meeting established which will further strengthen partnerships working between the health Board and local authorities.

39	Are you compliant with local compact arrangements between the NHS and Third Sector?	Director of Partnerships and Corporate Services	The Three County Compact has now been absorbed into the work with each Public Services Board. The UHB led the way in co-designing with the third sector 'The Third Sector Role in Health and Social Care (2013)'. This took the Compacts to another level and embedded best practice in all our work with the third sector across the whole UHB. The ethos of the Compact is actively demonstrated through partnership working and has influenced development of the Partnership Governance Framework. Co-producing future models of care and service provision with third sector partners is a continued commitment of the UHB as well as in its joint working with PSBs and the West Wales RPB.
40	Do you communicate evidence and research to teams that develop strategy?	Medical Director	The Research and Delivery Strategy sets out the way in which clinical research and development (R&D) activities will be prioritised, supported and integrated into everyday clinical practice, and describes how the clinical research infrastructure will be developed and maintained to ensure capacity and capability to deliver R&D across the UHB. Nursing and Midwifery has its own underpinning R&D strategy, approved through QSEAC, whilst the Directorate also use evidence at professional meetings to base clinical developments/practice. A new R&D enabling plan has been developed as part of the 2019/20 Annual Plan with new objectives that are designed to further develop R&D and innovation during the next year. The UPB is a formal, partnership arrangement between the UHB and its University partners. It is a creative hub, and will drive and monitor developments in three domains: Research, Innovation, Translation and Adoption, Workforce and Organisational Development and Collaborative Partnerships. An Organisational Development Innovation Hub has been developed and was launched on 8th July 2018. This concept is designed to bring people with different expertise together, to develop and drive new ways of thinking and reflect 'prudent' ideas. It aims to identify research and development opportunities locally and regionally, and where appropriate internationally to maximise health impact and critically contribute to service sustainability. The Hwyl Hub consists of a physical and virtual hub (designed to encourage learning, creativity, fun, innovation and service improvement).

41	Do you communicate this to your teams delivering the service?	Medical Director	The purpose of the R&D Sub-Committee is to promote and support involvement in high quality healthcare research, to promote evidence-based healthcare, to build research capacity and to foster a research culture and promote the dissemination of research findings in order to contribute to clinical effectiveness and evidence-based healthcare delivery. The R&D budget is ring fenced and allocated on a formula, based on activity i.e. The numbers of patients recruited into clinical trials. The UHB has seen a decrease in its annual funding allocation for R&D in 2019/20 and this will mean restructuring resources to accommodate. Hwyl Hub is a light, open, modern and creative space where individuals, teams from across the UHB and partner organisations can come together to work collaboratively on innovation projects and research and development. Hwyl Hub is a place for people who are looking for an inspiring environment, helping them to develop innovative ideas in a space that promotes new and different ways of thinking and working, where new concepts can emerge and flourish. It will also be a resource to support team development and group learning.

Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models, and manage performance and value for money			
		Executive Lead	**Position**
42	How do you ensure your organisation/ service is always learning and look for creative ways and innovation to improve the delivery of services?	Director of Planning, Performance & Commissioning	The UHB will seek to maximise opportunities from commissioning, collaboration and innovation, including working with: • Powys and Betsi Cadwaladr University Health Boards to implement more sustainable solutions for Bronglais Hospital through the Mid Wales Joint Health and Social Care Committee; • Swansea Bay UHB (SBUHB) and Swansea University to improve sustainability of our services through networking solutions for a population of over a million – A Regional Collaboration for Health (ARCH) - as well as improving access to more specialist services and the development health and well-being and the development of local skills and talent for the future workforce; • A greater regional operational delivery focus is now being providing through the JRPDC

			which is Hywel Dda UHB and SBUHB, also attended by the Director General; • Universities developing more innovative clinical practice like that of Mental Health and the Trieste model, as well as more innovative workforce solutions involving international training and recruitment which we are growing in Withybush, and also new bespoke clinical roles that fit rural service delivery such as Physician's Assistants and Advanced Practitioners. This has not been incorporated into the approved Transforming Mental Health Strategy; • The Swansea Bay City Deal working in collaboration with local authorities on economic regeneration, digitisation and education and training initiatives. Towards the end of 2017, the UHB was successful in being awarded seven Bevan Exemplar projects. These projects, together with previous Bevan Exemplars provide a platform for the creation of the community of innovators and the basis for the UHB's Innovation Hub that was launched in 2018. Through sponsorship by the Bevan Commission the process for development of a UHB Innovation Hub was commenced in 2017/18 led by the Assistant Director of OD and the Head of Service Improvement and Transformation. A site has been secured for the Hub at the Beacon Centre in Llanelli which provides a resource centre for improvement and innovation materials and information and an environment for staff to meet. Throughout 2017/18, the UHB took forward an ambitious TCS Strategic Programme. The programme had a key focus on redesigning health and care services with the aim of delivering care closer to home, and reducing the demand impact on secondary care, and thereby enabling people to be seen and treated in the most appropriate place by the appropriately skilled professional. The programme resulted in the development of a long-term strategy – Health and Care Strategy – *A Healthier Mid and West Wales: Our future generations living well* – which was approved by the Board in November 2018. The Turnaround Programme was established in 2017 to provide a robust process for the delivery of savings as part of ensuring the Health Board meets its statutory duty to break-even over a three-year rolling basis. Activity focuses on: • Corporate Savings plans including workforce, medicines management and non-pay procurement; • Directorate Holding to Account meetings; and

			• 60 Day Cycles. The 60 day cycles provide a creative and innovative space focusing on pan organisation opportunities in order to ensure patient focused benefits as well as savings are achieved. They provide an environment in which the Turnaround Team can positively engage across the organisation. The 2018/19 themes were: • Continuing Healthcare; • Operational Effectiveness; • Outpatient Redesign; • Theatres; • Patient communication; • Travel & Subsistence; • Roster Efficiency; • Ophthalmology pathway. As part of the process for reviewing what has been successful in the past year, a review of the overall approach to Turnaround continues. A new programme structure is being worked through but essentially will include 10 Executive Director led delivery programmes that build on the current Turnaround 60 Day Cycle model. A review of the 60 day cycle and Holding to Account (HTA) meetings will also be undertaken as part of providing a response to the WAO structured assessment. The Quality Improvement Strategic Framework was approved by the Board in July 2018 and was launched to the whole Health Board in April 2019. A collaborative steering group chaired by the Director of Nursing, Quality & Patient Experience and the Director of Workforce and OD has been established to oversee and monitor the implementation of the collaborative approach. The first collaborative cohort will commence in June 2019, it is anticipated that 10 teams of 8 staff will attend and will on 10 projects aligned to at least one of the 'quality goals' identified in the Strategy. To support these teams, 10 collaborative coaches have been identified to provide expert support to the improvement teams on the programme. These coaches come from the UHB's improvement resource and from collaborative working with 1000 Lives and Swansea University.
43	How do you ensure	Director of Public	The strategic objectives are based on a Health Needs Assessment (HNA) which has been produced

	you work from evidence?	Health/Medical Director	by the Public Health Directorate to provide evidence about the population of Hywel Dda in order to plan services and address health inequalities amongst our local communities. The purpose of the HNA is to gather the information required to bring about changes beneficial to the health of the population and draws upon epidemiological, comparative and corporate information. The Board is committed to population health led organisation that promotes good health, prevents illness and better manages disease. In January 2019, the Board approved its Health and Wellbeing Framework - *Our Future Generations: Living Well*. This builds upon and supplements UHB's Health and Care Strategy, *A Healthier Mid and West Wales*, approved by Board in November 2018, and designed to help us focus on our long-term ambitions to deliver better health and wellbeing for all. The framework's implementation will be fundamental to the success of the strategy, and will help drive and align our short and medium term planning to deliver our vision for the future. The UHB has strengthened its commitment to continuous engagement and the Joint Framework for Continuous Engagement and Consultation developed by the UHB and CHC was signed off at Board in January 2019. This has been designed to ensure a coherent, consistent approach towards co-production and service change around health (and in the future social care, or any other integrated service with other public sector partners) that is fit for the future and takes into account the duties of both the CHC and Health Board. Ensuring robust evaluation is undertaken in respect of new projects or pilots is crucial in terms of making informed decisions regarding the mainstreaming of effective services and decommissioning services that are not shown to be ineffective or of low value. We should be taking an outcome focussed approach in all that we do and consider opportunities to work alongside our partners particularly our academic institutions to maximise local research and the development of evidence that supports community development and locally-based action. The UHB employs a Clinical Effectiveness Co-ordinator who ensures that all new National Institute for Health and Care Excellence (NICE) and other guidelines are distributed to the relevant operational management teams throughout the organisation. Each team then considers the guidelines and develops action plans. Compliance with NICE guidelines is reported to the Effective Clinical Practice Sub Committee (ECPSC). .

			Work has continued during 2018/19 to embed the process for providing assurance on compliance with standards. During 2019/20 there will be a greater emphasis on the compliance with standards and guidelines with proposal for a revised system and a dedicated group under ECPSC to provide additional focus and assurance. During the development of the Health and Care Strategy, the Health Board worked with local, national and international partners to learn key lessons from service transformation in other areas, and the UHB is currently working with The Advisory Board Company (a Global Healthcare network) to establish key connections internationally. Additionally, our work has taken into account key sources of information from the likes of The Health Foundation, The Kings Fund and The Welsh NHS Confederation, and all of this work presents us with the evidence-base that has directly informing our design principles around how we deliver health and care services that are fit for the future. The UHB uses the Institute for Healthcare Improvement (IHI) model for improvement to underpin all its improvement activities and training.
44	How do you empower your staff to innovate and learn to improve quality and service delivery?	Director of Nursing, Quality and Patient Experience	During 2018/19, the Director of Nursing, Quality and Patient Experience has continued to lead on the work that was undertaken during 2017/18. A formalised Ward to Board programme continues which gives staff the opportunity to discuss quality and experience issues and improvement opportunities directly with Board Members. The further development of a quality dashboard will allow QSEAC and also staff within service areas to have an overview of quality information. In developing the dashboard, consideration has been given to quality indicators which are reported to WG, key quality indicators which will support and inform patient safety and the quality improvement strategy for the UHB. It is further intended to triangulate information that could support identifying 'hot spot' areas across the Hywel Dda. Significant progress has been made through working with service areas, IT and the Performance Team; as this dashboard develops front line clinicians will be better able to interrogate and manage quality related issues. The UHB Quality Improvement Strategy has been developed through consultation with staff and service teams. The document describes how the UHB will adopt a collaborative approach to build quality improvement capability and capacity across its workforce. This process supports and

			encourages staff to suggest ideas for quality and service improvement which are supported both during and after the training period. The collaborative training will align with and underpin the UHB's leadership development programmes. The strategy was approved by the Board in July 2018. A collaborative steering group chaired by the Director of Nursing, Quality and Patient Experience and the Director of Workforce and OD has been established to oversee and monitor the implementation of the collaborative approach. The first collaborative cohort will commence in June 2019, it is anticipated that 10 teams of 8 staff will attend and will on 10 projects aligned to at least one of the Quality Goals identified in the Strategy. To support these teams 10 collaborative coaches have been identified to provide expert support to the improvement teams on the programme. These coaches come from the UHB's improvement resource and from collaborative working with 1000 Lives and Swansea University. In addition to what is integral to the portfolio of the Director of Workforce & OD, the Medical Director/Director of Clinical Strategy provides the lead for innovation. Through sponsorship by the Bevan Commission the process for development of a UHB Innovation Hub was commenced in 2017/18 led by the Assistant Director of OD and the Head of Service Improvement and Transformation. A site has been secured for the Hub at the Beacon Centre in Llanelli which provides a resource centre for improvement and innovation materials and information and an environment for staff to meet. The Hwyl Hub is a light, open, modern and creative space where individuals, teams from across the UHB and partner organisations can come together to work collaboratively on innovation projects and research & development. The UHB successfully achieved support for 7 Bevan Exemplar Programmes during the year, within services including Organisational Development, Chronic Conditions & Primary Care. Through these programmes staff are provided with support and advice on improvement methodology and techniques. Expertise in relation to the promotion of quality improvement methodology has been enhanced during the year through the sponsorship and successful completion of the first All Wales Institute of Healthcare Improvement (IHI) Advisor Programme by the Assistant Director of Quality Improvement, the Head of Quality Improvement and the Head of Service and Transformation. The UHB now has 3 expert improvement advisors to support and advise staff on improvement activity design and implementation. As part of the programme 3 projects were undertaken with service teams on

			Inpatient Falls, Improvement of Inpatient Mobility and Outpatient Improvement. These projects were undertaken using a team approach providing the opportunity to share and disseminate improvement techniques and methodologies. The projects have been presented at The All Wales IHI Graduation Event. The management and leadership programmes delivered throughout the year have included Quality and Service Improvement training. Sessions are actively linked to development work within individual service manager's portfolios. Improving Quality Together (IQT) training has also been provided to individual staff outside of these programmes, resulting in over 60 staff having now attended and working on individual improvement projects. Operational teams have further developed service level governance structures, where quality and service improvement activities undertaken and needed are discussed and planned. The Quality Improvement team attend the acute site Triumvirate Governance meetings to support and advise on the outcomes of these activities. These activities include inpatient falls reduction, Sepsis bundle compliance, Hospital Acquired Thrombosis prevention processes, pressure damage prevention, Acute Kidney Injury prevention processes. A proof of concept project 'breaking the cycle' was commenced in early 2018 as part of the Turnaround programme, with a specific focus on the quality and improvement of patient experience. The Service Improvement and Transformation Team and the Quality Improvement Team have been working with the Scheduled and Unscheduled Care teams, encouraging staff to share their views and ideas on how services can be improved. Workshops and meetings have been regularly held with different groups of staff across UHB sites to work through identified issues using the service improvement methodology and actively encourage innovative ideas. The team are visible and receptive to individual or team approaches, to listen, support and empower staff across the UHB to take forward their ideas for service improvement and transformation.
45	How do you identify and share best practice and benchmark?	Executive Directors shared responsibility throughout	There are a number of All Wales Peer groups and network meetings where best practice is identified. The UHB will be actively engaging the revised All Wales Peer Review process through the Quality Improvement Strategic Framework, so that the outcome of reviews informs quality improvement priorities and activities.

		respective portfolios	WAO reports benchmark the UHB against best practice and other health organisations. Reports are presented to ARAC and published on the UHB's website. HCS Fundamentals of Care (FOC) audits continue to be undertaken annually across the organisation. The findings are reported to Board and QSEAC and outcomes are fed back through clinical nursing networks. Action plans are developed in order to improve on individual clinical areas performance by the responsible clinical teams. A full review of savings opportunities based on an analysis of the Efficiency Framework was undertaken in December/January 2019. Initial findings were presented to both the Executive Team and the Finance Committee, who have endorsed the proposed direction of travel. Work is now progressing to translate these opportunities into deliverable savings plans both in the short and medium term. A local Value Based Healthcare Steering Group (the VBHC Group) has been established as a sub-group of the Executive Team to support the identification and delivery of opportunities to deliver better value based healthcare within the health board. The inaugural meeting took place on 8th January 2019. This group complements the work of the already established regional VBHC Steering Group, and will routinely consider • Technical Efficiency and Allocative Efficiency opportunities • Finance Delivery Unit / NHS Efficiency Group outputs • Key Turnaround efficiency programmes planned for 2019/20 Value posts have been appointed to, with Finance support secured for a 9 month secondment from a recognised expert in the field. In line with the review of the Turnaround Programme, it is proposed that identification of best practice and benchmarking should be led by the VBHC Group in 2019/20. The Service Improvement & Transformation team encourage staff to share examples of good practice and where possible present and share their experience and learning at various meetings including Outpatient and Follow up meetings, Watchtower and site specific weekly meetings. The

			team work closely with the1000 Lives Programme and will direct and share good practice case studies across unscheduled and scheduled care teams. An Organisational Development Innovation Hub has been developed and was launched on 8th July 2018. This concept is designed to bring people with different expertise together, to develop and drive new ways of thinking and reflect 'prudent' ideas. It aims to identify research and development opportunities locally and regionally, and where appropriate internationally to maximise health impact and critically contribute to service sustainability. The Hwyl Hub consists of a physical and virtual hub (designed to encourage learning, creativity, fun, innovation and service improvement). Individuals, teams from across the UHB and partner organisations can come together to work collaboratively on innovation projects and research & development.
46	How is this communicated throughout the organisation?	Executive Directors shared responsibility throughout respective portfolios	Clinical audit learning is shared through Whole Hospital Audit meetings. National Clinical Audit action plans are being shared with key governance groups to help ensure that learning is carried out appropriately. The implementation of assurance processes around this are continually monitored and are being improved upon. The work undertaken by both the practice development and Service Improvement teams is also used to identify and disseminate best practice. HCS Fundamentals of Care (FOC) audits continue to be undertaken annually across the organisation. The findings are reported to Board and QESAC and outcomes are feedback through clinical nursing networks. Action plans are developed in order to improve on performance individual clinical areas by the responsible clinical teams. The Turnaround Programme Group is responsible for the following: • Seeking assurance from groups taking forward schemes that this is being undertaken in a timely way and that there are no internal barriers to progress. • Identifying, with suitable advice where required from experts, who should be tasked with addressing opportunities not currently being progressed. • Cross-referencing schemes to Turnaround projects to ensure no duplication of effort or conversely potential lost opportunities.

			• Quantifying opportunities where possible and those with the biggest gains will be prioritised in respect of providing additional support for delivery in conjunction with the PMO, Transformation, Turnaround and or Service Improvement Teams. • Establishing suitable mechanisms so that staff throughout the organisation are able to highlight opportunities for consideration. This could be in the format of global e-mails to all staff or the requirement for specific consideration on other appropriate groups' agendas similar to the requirement to review risks. In line with the proposed review of the Turnaround process it is likely that these functions will be discharged differently in 2019/20 with the VBHC Group focusing on the identification of best practice opportunities and benchmarking.
47	Have you got a clear methodology to prioritise work streams to deliver targets? Does this relate to resource allocation?	Director of Planning, Performance & Commissioning/ Director of Finance	The Executive Team has been the key forum for prioritisation decisions. In January 2018, the Terms of Reference of the Executive Team were reviewed to reflect a new and more focused approach. The Terms of Reference defined the purpose of the Executive Team was to: • Ensure oversight and co-ordination of the overall management of the UHB, ensuring efficient, effective and appropriate planning, operation and monitoring of internal and external business and relationships. • Oversee implementation arrangements for the vision, goals and priorities set by the Board, which can then be signed off by relevant committees, and incorporated into personal objectives as appropriate. • Oversee the development of strategic change/business cases that have been signed off by the Board, ensuring robust appraisal processes are in place and utilised. The Executive Team has a weekly meeting cycle that includes regular meetings with clinical leaders across the organisation, Clinical Executive Meetings and meetings in respect of the Turnaround Programme. In addition, as part of the Planning Cycle during 2018/19, Chief Executive review panels were held with each of the UHB's triumvirates and key service delivery departments, to ensure departmental plans are appropriately prioritised to meet UHB targets.

			The UHB has developed an Infrastructure & Investment Enabling Plan which aligns to the Annual Plan and the Health and Care Strategy. In addition, the developments within the Infrastructure Investment Plan have key strategic alignment with national policies and drivers and are the subject to prioritisation through the UHB's capital management process. In January 2018, the CEO introduced a formal (monthly) Turnaround meeting to hold Directors to account for the planning, implementation and delivery of in year cost improvement programmes. In September 2018, the UHB established a monthly Finance Committee to scrutinise and provide oversight of the UHB's financial performance and delivery against the UHB financial plans. The current UHB governance structure is able to fulfil both the internal and external assurance requirements for the Turnaround Programme in line with the 3 lines of defence model set out in the UHB's Risk Management Framework. A proposal to use the Turnaround Executive Team as a Programme Board is being worked through. In 2018/19, the UHB built on work undertaken in 2017/18 but with an increased focus on efficiency and productivity – length of stay bed day reduction, low acuity medically fit model, outpatients and theatres. The UHB is also moving to implementing evidence based pathways that will offer increased value in orthopaedics, ophthalmology etc. In part this is by pulling forward opportunities identified through the TCS process as they arise. The Service Improvement and Transformation team support the Turnaround programme, ensuring that teams are supported to take forward ideas that can contribute to efficiency savings and improve delivery. Priority is given to those areas with the greatest impact. In 2019/20, a number of Director-led Turnaround Delivery Programmes will be established. These will be supported by Turnaround Improvement Groups, which will use a rapid improvement methodology to support a stepped approach to delivery. The Turnaround Delivery Programmes are aligned to year 1 of the Health and Care Strategy implementation, increasing focus on transformation and efficiencies, and moving the organisation from Turnaround to Transformation. A stronger project management methodology has been introduced in 2019/20, including the requirement for Directorates to complete a Project Initiation Document (PID) for each savings scheme, with clear objectives and associated measurements for success. Schemes will be considered at HTA meetings and signed off at Executive Team. This will assist in the allocation of

			resources. During 2019/20 we will continue to focus on efficiency and productivity with the implementation of the Efficiency Framework set out by the NHS Wales Efficiency, Healthcare Value and Improvement Group and the opportunities identified in the UHB's Efficiencies and Opportunities group. There will be an increased focus on value, which will include identifying work which is of low clinical value or impact, tackling clinical variation etc.
48	Do you use feedback from patients/service users/carers to innovate and change delivery?	Director of Nursing, Quality and Patient Experience	As above re: TCS. (Section 25). Hywel Dda's Big NHS Change Consultation used a mix of engagement methods to elicit views from the population it serves which includes citizens, patients, service users, carers, staff, third sector, and partners. This includes attendance at existing meetings, community groups and setting up specific activities to meet different needs. These programmes of work are strategic approaches to how the UHB can develop services that better meet the needs of the population it serves with co-production integral to how they operate. The UHB has strengthened our commitment to continuous engagement and the Joint Framework for Continuous Engagement and Consultation developed by the UHB and CHC was signed off at Board in January 2019. Patient feedback is included in the annual FOC Audits. Themes arising from patient feedback, including audits, 'The Big Thank You, Friends and Family Test' is included in reports to directorates and through the governance committee structure. The IESC reports to QSEAC on all matters relating to concerns, Putting Things Right and the patient experience. Each Directorate has governance/ lessons learnt arrangements to review and respond to feedback. Feedback from the 'Big Thank You' on-line system is also provided to clinical teams. The sharing of patient stories at Board and its Committees is an additional step in the feedback process which can lead to reflection of practices and suggestions for improvement. Patient stories are also shared at departmental and service level for reflection and discussion about lessons learnt and at internal/external training events.

			The Listening and Learning from Events Group which will be established in 2019/20 will provide a strong mechanism for identification of emerging themes and risks and will feed into the quality improvement and annual planning process.
49	How do you ensure an understanding of the governance and compliance requirements of regulatory bodies and use feedback from auditors/regulators to inform and improve your business planning processes and procedures?	Board Secretary	External and Internal Audit reports are presented to ARAC. Management responses are developed to address recommendations from auditors and regulators. The UHB is also subject to announced and unannounced inspections from its key regulator HIW, and other organisations such as the CHC, Royal Colleges, and WG who often provide feedback on areas of improvement. Management responses are informed by services and specialist functions within the UHB. Issues and risks raised within audits and inspections that require investment or additional resources are recorded on a strategic log and fed into the planning processes within the UHB along with a range of information from other sources, including estate appraisals (which includes statutory health and safety compliance, environmental compliance audits), risk assessments, testing and site operational feedback. Progress on delivery of recommendations is monitored through the UHB's Executive Performance Reviews and Committee structure; ARAC holding an overview position, with the UHB's Audit Tracker presented at every ARAC meeting. The Committee now invites individual Executive Directors to the meeting to discuss late or non-delivery of recommendations following its approval of a new escalation process. The WAO SA18 report advised that the UHB has a robust process for tracking recommendations by all regulators, not just those identified by External and Internal Audit, and identified it as an area of good practice.
50	How do you ensure you are using taxpayers' resource properly and carefully to deliver high quality efficient services?	Director of Finance	The WAO structured assessment process examines the UHB's arrangements that support good governance and the efficient, effective and economical use of resources and provides an assessment of its findings on the UHB's financial management arrangements in place. WAO reported in SA18 that the Turnaround Programme had strengthened internal processes relating to achievement of the UHB's savings target, with fortnightly directorate HTA meetings, 60-day cycle meetings to identify new areas of efficiencies, and a new escalation process with the

			CEO for directorates that are failing to deliver; however the UHB needs to increase its focus on improving efficiency and embedding value-based healthcare. A full review of savings opportunities based on an analysis of the Efficiency Framework was undertaken in December 2018/January 2019. Initial findings were presented to both the Executive Team and the Finance Committee who have endorsed the proposed direction of travel. Work is now progressing to translate these opportunities into deliverable savings plans both in the short and medium term. 2018/19 saw the UHB achieve its declared deficit position for the first time since its inception and the UHB aim to repeat this success in 2019/20. Part of this work, will involve gaining better understanding of the causes of the UHB's underlying deficit.
51	Do you have sound systems of financial control?	Director of Finance	The UHB has Standing Orders, Standing Financial Instructions and Financial Procedures in place. Internal audits relating to Treasury Management and Charitable Funds received substantial assurance rating with reasonable ratings issued for the Accounts Receivable and Financial Ledger audits within the financial year. In 2017, the WG commissioned an external review of financial governance at Hywel Dda UHB, which provided a number of recommendations which have been implemented by the UHB. The UHB established a Finance Committee as a formal committee of the Board on 1st September 2018. It is chaired by the Associate Member of the Board who has been appointed specifically to provide financial support to the UHB drawing on significant senior NHS finance experience. The purpose of the Finance Committee is to: • Scrutinise and provide oversight of financial and revenue consequences of investment planning (both short term and in relation to longer term sustainability). • Review financial performance, review any areas of financial concern, and report to the Board. • 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.

			• Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving 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. WAO SA18 reported that whilst financial management and accountability had improved, significant challenges remain as the UHB continues to overspend against its allocation. WAO found that the UHB has adequate budgetary financial management and control arrangements. The controls are designed to ensure clear lines of delegated budgetary responsibility, ensure accuracy of operational financial reporting, and drive compliance with required financial standards and legislation. The assessment recommended that to support its longer-term financial position, the UHB should ensure that the Finance Committee continues to develop its role and provide increasing scrutiny and challenge on the plans to achieve efficiency savings in the medium to long term. One of the key operational objectives of the Finance Committee is to undertake detailed scrutiny of the organisation's overall performance against savings delivery and the cost improvement programme. It receives updates at each meeting on delivery and challenges progress. More detailed work regarding savings strategy for 2019/20 and beyond is being presented to the Finance Committee for scrutiny, and will continue to be presented on a regular basis.
52	Do you have clear arrangements for monitoring governance activities?	Board Secretary	The ARAC Terms of Reference (approved by the Board in March 2019) state that its role is to monitor, review and report to the Board on the processes of governance. The ARAC Chair facilitates a reflective summary at the end of each meeting in order for the Committee to agree which items need to be raised to Board level. The ARAC Chair presents a written report at each Board meeting and an annual report of the Committee's business at year end. The WAO undertake an annual structured assessment process and as with previous years, their work has reviewed aspects of the UHB's corporate governance and financial management arrangements. In reviewing the UHB's corporate governance and board assurance arrangements in 2018, WAO's main conclusion was that the UHB has continued to strengthen governance and management arrangements, however there was recognition that there remained some

			weaknesses in quality and safety governance arrangements, more needs to be done to streamline the organisational structure to support implementation of the new strategy, and the efficiency of both resources and assets in the short to medium-term could be further improved. The UHB has developed a management response in response to the recommendations made by WAO and progress on implementing these is monitored by ARAC at each meeting. The CEO produces an Annual Governance Statement (AGS) which reflects the UHB's governance, risk management and internal control arrangements and how they operate in practice. The statement also reflects the UHB's governance procedures and systems and provides a clear understanding of the organisation and its internal control structure, and the stewardship of the organisation. ARAC's role is to review the AGS and provide assurance to the Board that a robust governance process was enacted during the year. The UHB has a clear Risk Management Framework which details the monitoring arrangements in place for risk through the Board and its committee structure and within Directorate management structures. Assurance systems, such as monitoring progress against recommendations made from internal and external audits, inspections and reviews, are clearly detailed in the Management of External Agency Visits, inspections and Accreditations Procedure. Implementation of Welsh Health Circulars (WHC) and Ministerial Directions are also tracked and undertaken through the Board Committee structure and through the Executive Performance Reviews, with assurance provided to ARAC on the process at year end.
53	Are all new services/ business cases underpinned by the Health and Care Standards?	Director of Planning, Performance & Commissioning	All UHB business cases are subject to the scrutiny and approval at the relevant Committee and/or Board in accordance with established governance procedures. Depending on funding source, they will also be subject to WG scrutiny and approval. Business case objectives align to the extant Operational Plan or Annual Plan and are consistent with local and national strategy and therefore align with established Standards. All business cases are required to complete an SBAR prior to submission to the relevant Committee and/or Board. A core requirement of the SBAR is to demonstrate how this underpins the HCS.

54	Are your workforce aligned to delivery targets, with clear responsibilities?	Director of Planning, Performance & Commissioning	The Annual Plan 2018/19 sets the strategic direction and the key objectives for the organisation. This was underpinned by enabling plans including the workforce plan which details at a high level the organisational development plan. The underpinning enabling plans of the Annual Plan have deliverables aligned to individuals. This has been continued through 2018/19 in the development of the 2019/20 Annual Plan. The actions within the Workforce and OD enabling plan are reported to the Workforce and OD Sub-Committee. The Performance Management Assurance Framework 2018/19 sets out the roles and responsibilities of site triumvirates and directorate management in respect to delivering performance targets within their respective service areas, as well as the governance and reporting arrangements for performance management.

Health services foster a culture of learning and self-awareness, and personal and professional integrity			
		Executive Lead	**Position**
55	Does your Board/ service have a formal improvement process?	Board Secretary	There is a programme of Board Seminar Sessions for Executive Directors and Independent Members with targeted sessions to provide ongoing learning and development. In September 2017, the Board approved the proposed approach to, and content of, the Board Development Programme which takes into account the recommendations made in the review of financial governance. The proposal built on work previously undertaken, including the elements delivered by Academi Wales, to provide ongoing support to the Board. A steering group made up of the UHB Chair, BPPAC Chair, Head of OD, Board Secretary and Academi Wales, formed the view that the programme should aim to provide an ongoing learning forum which stimulates discussing and thinking on the way the UHB organises and enacts its business. It proposed that separate sessions were held for Independent Members and Executive Directors to provide a foundation for continued learning and development. These development sessions would take place in 3 stages. Further information is provided in the report which was approved by Board – Board Development Programme – September 2017. The combination of Board OD sessions and Board Seminars provides 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 to adequately assess organisational performance and the quality and safety of services. The Board and Committees undertake an annual review of self-effectiveness with an improvement plan being put in place.
56	How do you gain a clear understanding of how well you are performing, what services are doing well, and what service need improving,	Director of Planning, Performance & Commissioning	Under the guidance of BPPAC, the IPAR continues to develop; the aim being that integrated reporting helps Board members and the public to better grasp what our performance is telling us, i.e. the relative and comparative understanding of the more critical deliverables. The IPAR is scrutinised by both the Board and BPPAC. The Sub-Committees reporting to BPPAC during 2018/19 were as follows: Capital, Estates & IM&T Sub-Committee; Planning Sub-Committee; Health & Safety and Emergency Planning Sub-Committee; and Information Governance Sub-Committee.

	including services that are carried out by others on your behalf?		Throughout 2018/19, BPPAC was provided with quarterly updates on the 2018/19 Annual Plan, focused on actions to improve the UHB's position and complement performance, quality and safety. Following scrutiny and feedback from BPPAC throughout 2018/19, the quarterly monitoring has evolved to ensure that there is greater clarity on actions that are currently not being met and to ensure that clearer mitigation plans are put in place. WAO SA18 recommended that the UHB needed to streamline its performance review meetings and HTA meetings to free up capacity for both executive and operational teams. The quality dashboard continues to be developed throughout 2019/20. WHSSC, EASC and NWSSP, through formal joint committee reporting to the Board and the In-Committee Board have requested the attendance of Lead Officers at Hywel Dda Board and Committee meetings. The UHB is represented on these Joint Committees. The relationship between the UHB and SBUHB has been strengthened through the mechanisms and opportunities provided by ARCH and the JRPDC, securing together our longer-term strategy for regional collaboration between University Health Boards and with our university partner, Swansea University. During 2017/18, the Mid Wales Healthcare Collaborative (MWHC) led on the implementation of the findings and recommendations of the Mid Wales Healthcare Study, which has now been succeeded by the Mid Wales Joint Committee for Health & Social Care from March 2018. The Committee will build upon the strengths and learning from the MWHC arrangements for 2018/19. Following the change of Executive portfolios a Commissioning Framework is to be drafted to strengthen performance and monitoring of services provided on behalf of the UHB.
57	How do you ensure that you respond quickly and	Director of Workforce & OD/Director of	There are processes in place to address immediate concerns raised from regulatory bodies and these are monitored through the Board's Committee structure. This is detailed in the Management of External Agency Visits, inspections and Accreditations Procedure.

	effectively to areas of concern, including those relating to individual performance?	Nursing, Quality and Patient Experience	A process for establishing Control Groups has been established and approved by the Executive Team for incidents and events which meet certain criteria which have either wide ranging impact across the UHB. Control Groups were established in 2017/18 to address areas of concern such as improving fire compliance, approving vacant posts and ensuring the UHB were exploring efficiencies and opportunities. Complaints Scrutiny Panels were established, and will be replaced by the Listening and Learning From Events Group in 2019/20. This is due to the introduction of the all Wales WRP Peer Review process which will undertake scrutiny of the Putting Things (PTR) Process. Reports from this process will be reviewed by the IESC and assurance provided to QSEAC. Performance in relation to the WG target for responding to concerns in line with the PTR regulations has significantly improved and is consistently monitored via the Executive Performance Management arrangements. Systems for responding to concerns including those relating to individual performance are reviewed. The UHB has various procedures in place for reporting incidents and investigations: Lessons Learnt Flyers: http://howis.wales.nhs.uk/sitesplus/862/page/55564 Incident Reporting Guidance: http://howis.wales.nhs.uk/sitesplus/862/page/64011 Additional guidance on concerns and issues: http://howis.wales.nhs.uk/sitesplus/862/page/55563 reported via BPPAC and IE group. The UHB has a range of employment policies in place to manage conduct, capability and in relation to raising individual, collective or anonymous concerns. There is an experienced operational workforce team in place to support managers in addressing concerns. The operational workforce team have a presence on each of the main sites and are well positioned in terms of access and response should issues arise. There are well established links between operational management and their dedicated workforce links which assists in addressing concerns promptly. The PADR process is in place to identify development needs and support personal CPD. Performance against the target is closely monitored through the Executive Directorate

			Performance monitoring reviews. This is supported by professional revalidation requirements. PADR compliance is also registered on ESR and is reported to Board meetings.
58	How do you invite effective feedback and use the lessons learned to develop and improve the board's and senior management team's effectiveness?	Director of Workforce & OD	The UHB publicises through posters, leaflets and the UHB internet page how the public can raise concerns about our services. There are Raising Concerns policies and processes in place to ensure staff are confident to raise any issues which are identified at Staff Induction. The Board and Committees undertake a self-assessment process annually to ensure they remain fit for purpose and continuously improve. The feedback is analysed and an action plan is developed. The findings are incorporated into the annual Board OD Programme. All of our Executive Directors have participated in a 360 degree feedback process and a suite of leadership diagnostics including Myers Briggs Step 2 and Team Climate Surveys. The feedback from these has been extensively worked through on an individual and collective basis. Participants on our System Level Leadership Improvement Programme also undertook 360 degree feedback and leadership diagnostics.
59	Do you know about all accreditation and licensing schemes that apply to your organisation and how do you comply with them?	Board Secretary	A Legislative Assurance Framework is maintained and an Assurance Report is presented annually to ARAC. This has been reviewed and strengthened in 2018/19 and now provides an assurance rating and is linked to the UHB's risk management process.
60	How do you ensure your staff comply with their professional standards?	Director of Workforce & OD	There is an expectation that Executive Directors, e.g. Director of Nursing, Medical Director and Director of Therapies and Health Sciences, and all other professional heads of service, will ensure compliance in accordance with their portfolios and through their lines of accountability. The responsibility for ensuring staff comply with professional standards is articulated in the UHB Scheme of Delegation and will be included in any change of Director portfolio. The UHB has the following systems in place:

			• Arrangements in place to ensure that all registered nurses and consultants revalidate; • Arrangements are in place to ensure all registered health professionals maintain their statutory registration; • Registration checked at point of recruitment and monitored by line managers; • PADR process; • Respective Codes of Practice and Codes of Conduct are referenced in appropriate workforce policies i.e. All Wales Disciplinary Policy; • Revised values and behaviours based PADR documentation; • Through learning & development plans; • Failure to adhere to professional standards can be addressed through the respective disciplinary policies i.e. All Wales Disciplinary policy and All Wales Upholding Professional Standards In Wales; • Monthly Revalidation and Performance Panel chaired by the Deputy Medical Director to ensure compliance with medical revalidation and appraisal and to manage doctor performance; • Nursing Practice Standards are reviewed through regular practice audits as well as senior nurse spot checks, with findings scrutinised at Assurance and Scrutiny meetings held within each service.
61	Is evidence of CPD required for annual performance and development reviews?	Director of Workforce & OD	The UHB, as a learning organisation, supports lifelong learning through CPD. The PADR process is in place to identify development needs and to support personal CPD. All staff are responsible for maintaining a personal development/CPD portfolio. As part of the Nursing and Midwifery Revalidation Process, a nurse or midwife must declare that they have practiced for 450 hours during the last 3 years and have undertaken as least 35 hours of CPD in the preceding 3 years. To support access to CPD opportunities, the Nursing and Midwifery services hold an educational contract with the University through which targeted CPD opportunities are purchased on behalf of the services for both nursing and midwifery registrants and also for some Level 4 development opportunities for Health Care Support Workers (HCSW) who form an increasingly important section of the workforce. As part of the Medical Revalidation process, doctors must evidence approximately 50 CPD points at each annual appraisal, which should incorporate both internal and external activities. This is checked

			prior to a recommendation for revalidation being made. The UHB's compliance with delivery of PADR has improved during the year and is reported bi-monthly to BPPAC. There is a new guidance booklet for managers and staff to aid in operational delivery and ensure all are aware of the expected style and delivery of the PADR Process. The UHB has also reminded doctors of the requirement to undertake mandatory training, particularly with increased Board scrutiny of compliance rates. There will be greater monitoring of this during 2019/20.
62	What is the feedback and process of reflection from complaints, compliments and incidents?	Director of Nursing, Quality and Patient Experience	The UHB has suitable processes in place to learn from events. The IESC provides assurance to QSEAC on all matters relating to complaints, compliments and incidents and patient experience. IESC's key role is to ensure the statutory accountability of the Board in regard to meeting the requirements of the NHS Concerns, Complaints and Redress arrangements (Wales) Regulations 2011. This Sub-Committee is also responsible for ensuring that processes are in place to enable learning from events to be shared across the organisation and primary care contractors to improve quality of services and standards. The sharing of patient stories at Board and Committees is an additional step in the feedback process which can lead to reflection of practices and suggestions for improvement. Patient stories are also shared at departmental and service level for reflection and discussion about lessons learnt and at internal/external training events. At Directorate level, there are governance/lessons learnt arrangements in place, whereby feedback is received and outcomes from closed investigations are reviewed and action plans agreed. Assurance reports are prepared from this process which feed into the Quality, Safety and Experience governance structure. During the year, significant work has been undertaken on improving reporting, including establishing a quality dashboard, escalation processes, and revising Datix to provide better reporting mechanisms. Weekly and monthly reports are provided to services, to ensure earlier identification of emerging themes/trends and any concerns regarding the management of investigations. The UHB continues to report patient safety incidents to the National Reporting and Learning System (NRLS) which enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

			During the 2016/17 year, the UHB developed dashboard reporting to reflect emerging trends. Information on incidents is made available to operational teams who are asked to include actions being taken in their reports to IESC and QSEAC. Where it is identified that education, training and patient information is of concern, focused work has been undertaken to improve our services. In regard to claims the Legal Services Manager attends meetings and training sessions with clinical and managerial staff to ensure that appropriate feedback is provided on the lessons learned from claims. Members of the Concerns Team (claims, complaints, redress and Ombudsman) attend governance meetings regularly to provide feedback on trends and key issues arising from concern/patient experience feedback. During 2017/18, the range of methods that patients and members of the public can utilise to provide feedback to the organisation on the services has increased, with the pilot of the Friends and Family Test in Emergency Departments/Minor Injury Units. During 2019/20 this will be expanded to all services. This will include electronic systems, feedback cards, and real time surveys, as well as continuing with the patient story and appreciative inquiry work. The Patient Advice & Liaison Service (PALS) will also be reviewed and developed to ensure more time is spent in wards and clinical areas providing information and support where required and capacity will be increased with the support of volunteers to extend working hours to ensure access to support during visiting times and over weekends. The establishment of the Listening and Learning From Events Group will strengthen the lessons learnt and assurance arrangements as a result of patient safety and clinical governance across the organisation.
63	Is there a just/open culture which encourages staff to seek help and advice?	Director of Workforce & OD	To achieve the organisational vision, the UHB has been developing a culture of engagement, openness and honesty and in which all elements of the workforce are encouraged to be innovative. Central to this is the need for clear and supportive leadership, including robust and empowering clinical leadership and staff engagement, and clear schemes of delegation. The UHB recognises that high quality leadership is crucial to the achievement of organisational objectives and to ensure sustainability and future development. The UHB has a strong commitment

			to leadership development and acknowledges its role in increasing the capability of current leaders, developing future leaders and ensuring the organisational values underpin the new suite of management and leadership programmes. Implementation of the values encourages an open and honest culture. The UHB recognises that in order to do this there needs to be a certain amount of psychological safety for employees to feel comfortable to do so. Organisational Development is currently reviewing ways in which this can be achieved and will implement various communication methods to encourage constructive feedback. The organisation has also implemented a Colleague Experience group to review how the organisation can build on staff engagement. This group is an amalgamation of both the Anti-Bullying and Health and Well Being groups. The groups are establishing how to build further psychological safety and support needed for both staff that have concerns or concerns raised against them. There has also been a development of Anti-Bullying pages for the staff intranet that should educate and inform individuals on what inappropriate behaviours are and how to deal with them. There is also a webpage titled 'Are you a Bully?' Where colleagues are invited to reflect on their own behaviours and how these could be perceived by others.
64	What learning programmes are available for staff, and are these aligned to delivery targets, and organisational values and behaviours?	Director of Workforce & OD	The UHB has an on-line Learning and Development catalogue, which provides a comprehensive list of learning and development opportunities available to staff. The Core Skills Training Framework (CSTF) and all the mandatory training programmes are monitored and reported monthly to the Board as Tier 1 targets. The UHB values have now been incorporated into induction, management and leadership and PADR. Values workshops outline the values and associated behaviours, discussing how they can be incorporated and measured within the organisation. The workshops are continually reviewed to ensure the messages do not become outdated as we seek to embed them into all that we do in Hywel Dda UHB. It is recognised that it will take time to embed fully across the organisation, however the values were defined by our staff during a detailed engagement exercise and have been very well received to date.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Accountability Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Hywel Dda University Health Board (the UHB) is required to provide an Accountability Report as part of its Annual Report and Accounts for 2018/19. Guidance on how to complete and display these reports has been issued by Welsh Government in Chapter 3 of the Manual for Accounts, in accordance with HM Treasury reporting requirements as stipulated in the HM Treasury Financial Reporting Manual (FReM).

Cefndir / Background

In 2015/16, HM Treasury undertook a project to simplify and streamline the presentation of the Annual Report and Accounts. As a result the FReM has amended the format of the Annual Report and Accounts document and NHS bodies are required to publish, as a single document, a three-part annual report and accounts which includes:

a. The Performance Report, which must include:
- An overview
- A Performance analysis.

b. The **Accountability Report**, which must include:
- A Corporate Governance Report
- A Remuneration and Staff Report
- A National Assembly for Wales Accountability and Audit Report.

c. The Financial Statements

The Accountability Report
The Accountability Report demonstrates how the UHB meets key accountability requirements to the Welsh Government and is required to have three sections:

a. The Corporate Governance Report
This explains the composition and organisation of the UHB's governance structures and how they support the achievement of the entity's objectives.

b. Remuneration and Staff Report
This contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc.

c. National Assembly for Wales Accountability and Audit Report
This contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long-term expenditure trends, and the audit certificate and report.

For 2018-19, the Audited Annual Accounts and Accountability Report are required to be completed and submitted to Welsh Government by Friday, 31st May 2019.

Asesiad / Assessment

The purpose of the accountability section of the annual report is to meet key accountability requirements to Parliament. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of the SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The requirements of the Companies Act 2006 have been adapted for the public sector context.

Auditors will review the accountability report for consistency with other information in the financial statements and will provide an opinion on the following disclosures which should be identified as audited within the accountability report:

- Single total figure of remuneration for each director
- CETV (cash equivalent transfer value) disclosures for each director
- Payments to past directors, if relevant
- Payments for loss of office, if relevant
- Fair pay disclosures
- Exit packages, if relevant, and
- Analysis of staff numbers

The accountability report is required to be signed off by the Accountable Officer/Chief Executive.

As a minimum, the corporate governance report must include:

i) The Directors' Report – the guidance stipulates what information must be included, unless disclosed elsewhere in the annual report and accounts in which case a cross reference may be provided;
ii) The Statement of Accountable Officer's responsibilities – the Accountable Officer is required to confirm and take personal responsibility and the judgements required for determining that the annual report and accounts as a whole is fair, balanced and understandable;
iii) The Annual Governance Statement – the AGS is a key feature of the organisations' annual report and accounts & is intended to bring together in one place all disclosures relating to governance, risk and control. The UHB's AGS has been compiled in accordance with the relevant guidance and includes mandated wording.

The Accountability Report now being presented for approval by the Board is inclusive of any comments, including those received from Wales Audit Office, Welsh Government and Internal Audit, following consideration of the draft report by the Audit & Risk Assurance Committee. The Audit & Risk Assurance Committee has therefore recommended approval of the Accountability Report to the Board.
Argymhelliad / Recommendation The Board is requested to approve the Accountability Report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Evidence obtained from the Health Board's processes, procedures and outcomes during 2018/19 Board & Committee Papers, Reports & Minutes Audit Reports Structured Assessment External Reviews
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Chair, Hywel Dda UHB Chief Executive Audit & Risk Assurance Committee Director of Workforce & OD Head of Internal Audit Board Secretary Wales Audit Office Welsh Government

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Robust governance arrangements underpinning financial management contributes to accountability, safeguards

	public funds and the Health Board's assets and resources and ensures value for money is being achieved.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Where applicable included within the report.
Gweithlu: **Workforce:**	Where applicable included within the report.
Risg: **Risk:**	Robust risk management arrangements are a key component of corporate governance and help to enable the UHB to achieve its objectives
Cyfreithiol: **Legal:**	This report enables the UHB to meet its key accountability requirements to Parliament.
Enw Da: **Reputational:**	Being unable to demonstrate robust corporate governance arrangements would result in reduction in confidence from the UHB stakeholders, e.g. WG and the public it serves.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	• Has EqIA screening been undertaken? No • Has a full EqIA been undertaken? No

Hywel Dda University Health Board

Accountability Report 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Contents Page

Hywel Dda University Health Board

Corporate Governance Report 2018/2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

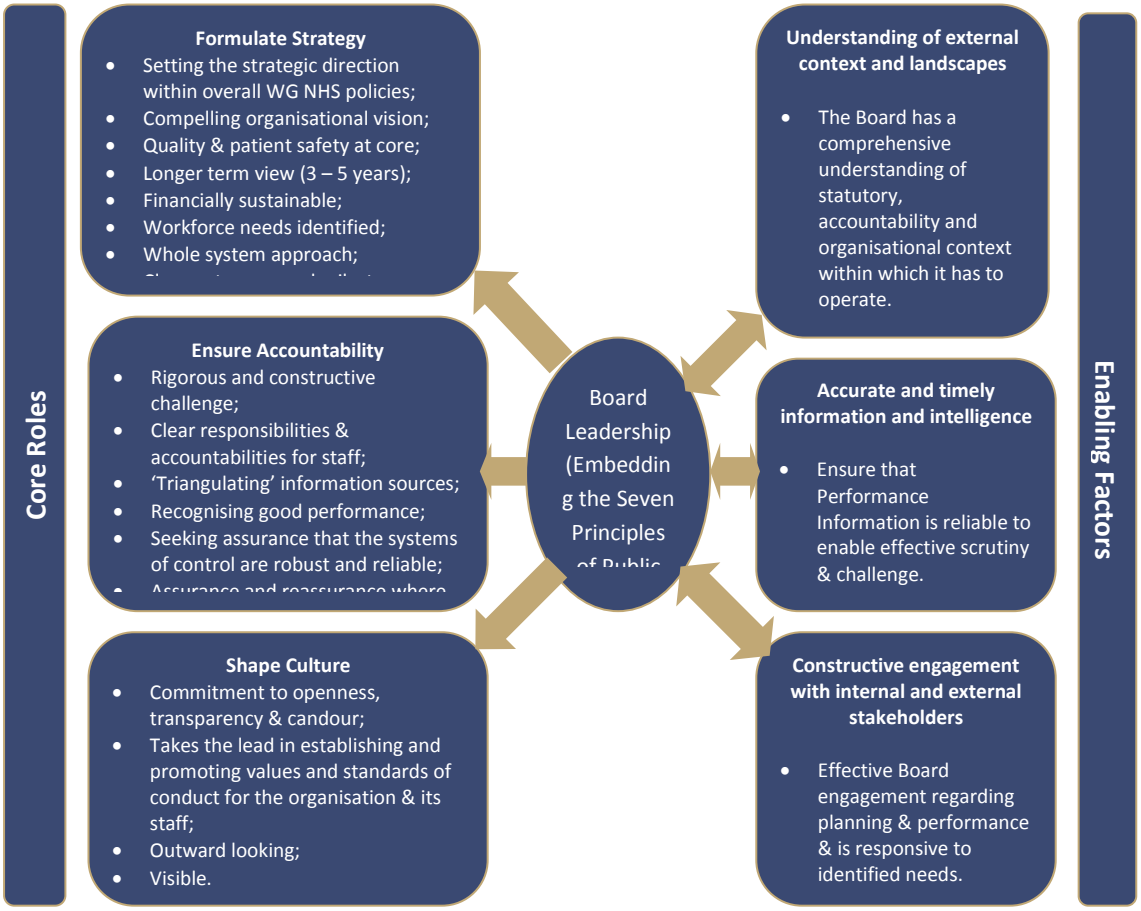
The HB has remained at the “Targeted Intervention” level of the NHS Wales Escalation and Intervention arrangements throughout the year, with no further escalation. The rationale for the HB remaining at Targeted Intervention level is reported regularly to both The Board and the Audit and Risk Assurance 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

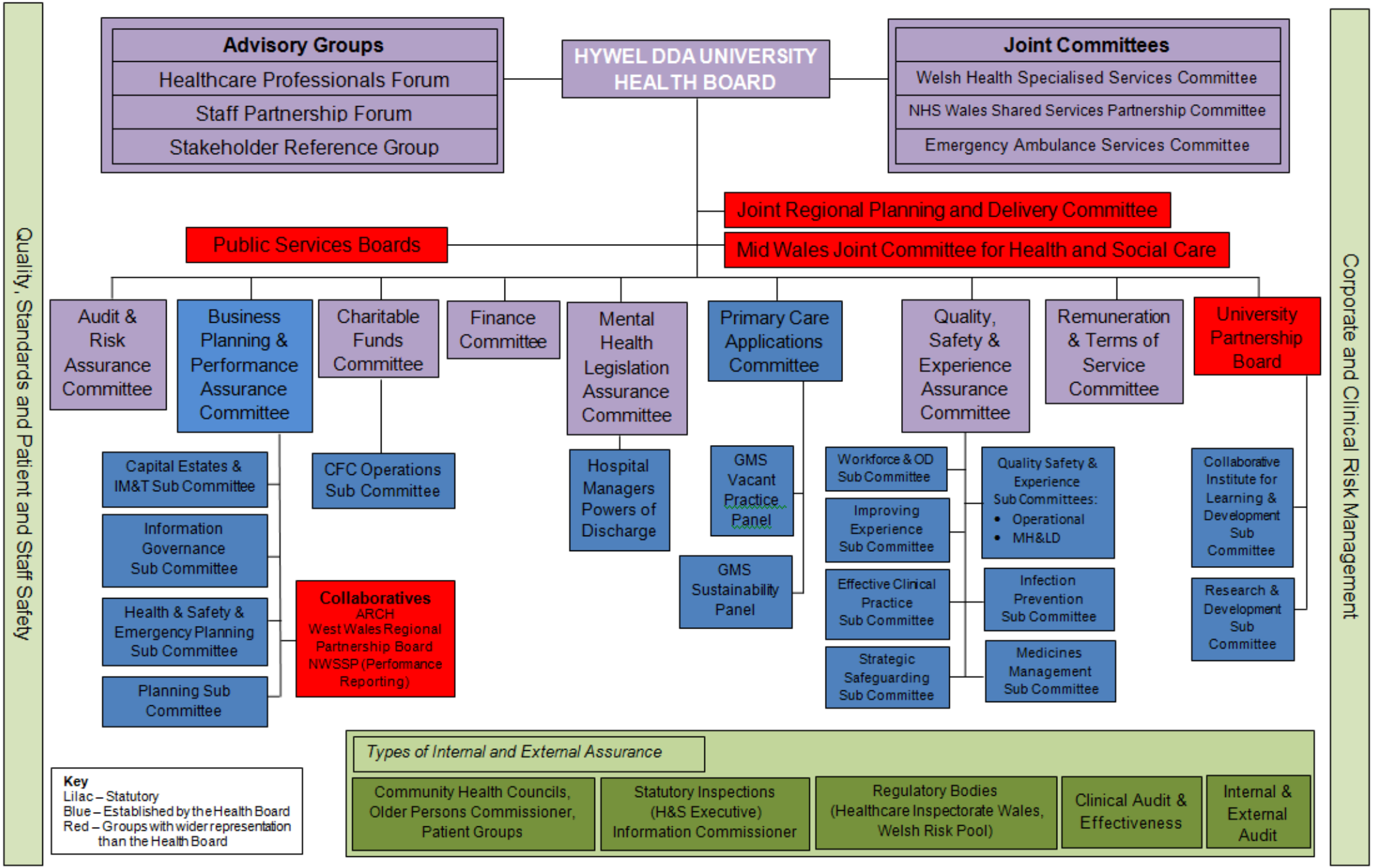
Dates of Meeting												
Meeting	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**Aug 2018**	**Sep 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**March 2019**
Board	19.04.18	30.05.18 31.05.18		26.07.18		26.09.18 27.09.18		29.11.18		31.01.19		28.03.19
Audit & Risk Assurance Committee	17.04.18	02.05.18 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:

HB Wide Issues (Approval)	• Approved the Draft Operational Plan for 2018/2019. • Approved the savings element of the interim Financial Plan 2018/2019 as the basis for delivery in year. • Approved the Committees' Annual Reports and the Governance, Leadership and Accountability Report. • Approved the Annual Quality Statement, Accountability Report, Annual Governance Statement, Annual Accounts, Letter of Representation and WAO ISA 260 for submission to WG. • Approved the Annual Report for 2017/2018. • Approved the revised Performance Management & Assurance Framework. • Approved the establishment of the Transforming Clinical Services Design Steering Group, its supporting governance structure and the Terms of Reference for the Group. • 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. • 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. • Approved the Seasonal Influenza Plan 2018/2019. • Approved the updated Major Incident Plan 2018/2019. • Approved the HB's Risk Appetite Statement. • Approved the contents of the Board Assurance Framework based on the

	HB's strategic objectives and approved updates to existing risks and new principal risks for inclusion. • Approved completion of Stage 2 of the consultation process (public consultation) aligned with Transforming Clinical Services and a number of clinical recommendations as follows – - 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. - 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. - Approved a modification of the remaining proposals for delivering hospital services. - Approved the progression of a proposed new Planned and Urgent Care hospital on a single site through the business case process (Five Case Model). - 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. - 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. - 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. - Approved the development of a workforce redesign and transformation plan – starting now and forward planning – to enable delivery and sustainability of the future model. - 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. - Approved the further development of all recommendations into the draft Health Strategy for consideration at the Public Board meeting on 29 November 2018. • Approved the revised Scheme of Delegation and Reservation of Powers. • Approved the establishment of the Finance Committee as a Committee of the Board. • Approved the HB's Health and Care Strategy and the underpinning updated Integrated Impact Assessment. • Approved the HB's 3 re-framed strategic goals to replace the existing 8

	health-related strategic objectives. • Approved the Strategic Equality Plan Annual Report 2017/2018. • Approved the Organ Donation Annual Plan for submission to NHS Blood & Transplant (NHSBT) and WG. • Approved the HB's Health and Wellbeing Framework. • Approved the Hywel Dda Community Health Council and Hywel Dda University Health Board Framework for Continuous Engagement and Consultation. • Approved the preferred option regarding Laundry Services outlined within the Outline Business Case. • Approved the revised version of the HB's Standing Orders and Standing Financial Instructions. • 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". • 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. • Approved the Terms of Reference of the Health and Care Strategy Delivery Group subject to clarification regarding frequency of reporting to Board. • Approved the development of a Transformation Programme Office team to drive forward delivery of the health and care strategy. • 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. • 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. • Agreed the onward submission to WG of the draft interim 2019/2020 Annual Plan including the draft interim financial plan. • Approved the Policy Statement on the use of the Welsh Language internally.
HB Wide Issues (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. • 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. • Received for information the Annual Report from Healthcare Inspectorate Wales (HIW) 2017/2018. • Received for information the Medical Revalidation and Appraisal Annual Report 2017/2018. • Acknowledged the risk in delivering the HB's financial forecast position. • 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. • 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.

	• 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. • 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. • Endorsed the Register of Sealings as appropriate. • 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. • 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. • 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. • 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. • 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. • 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:

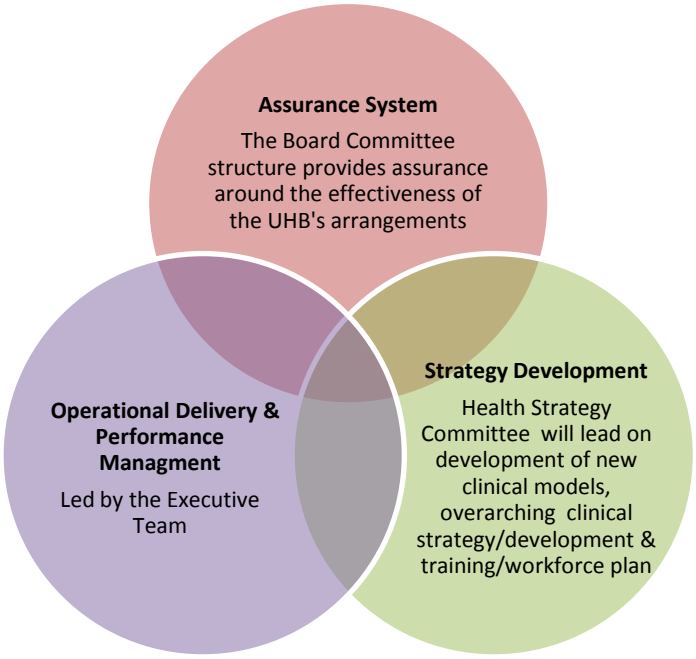
- A concern that caps on visas affect all departments within the HB, with a joint letter from the Nuffield Trust, Kings Fund and Health Foundation sent to the Prime Minister on this issue;
- In respect of the development of the Health and Care Strategy, the following risks were highlighted:
    - The 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.

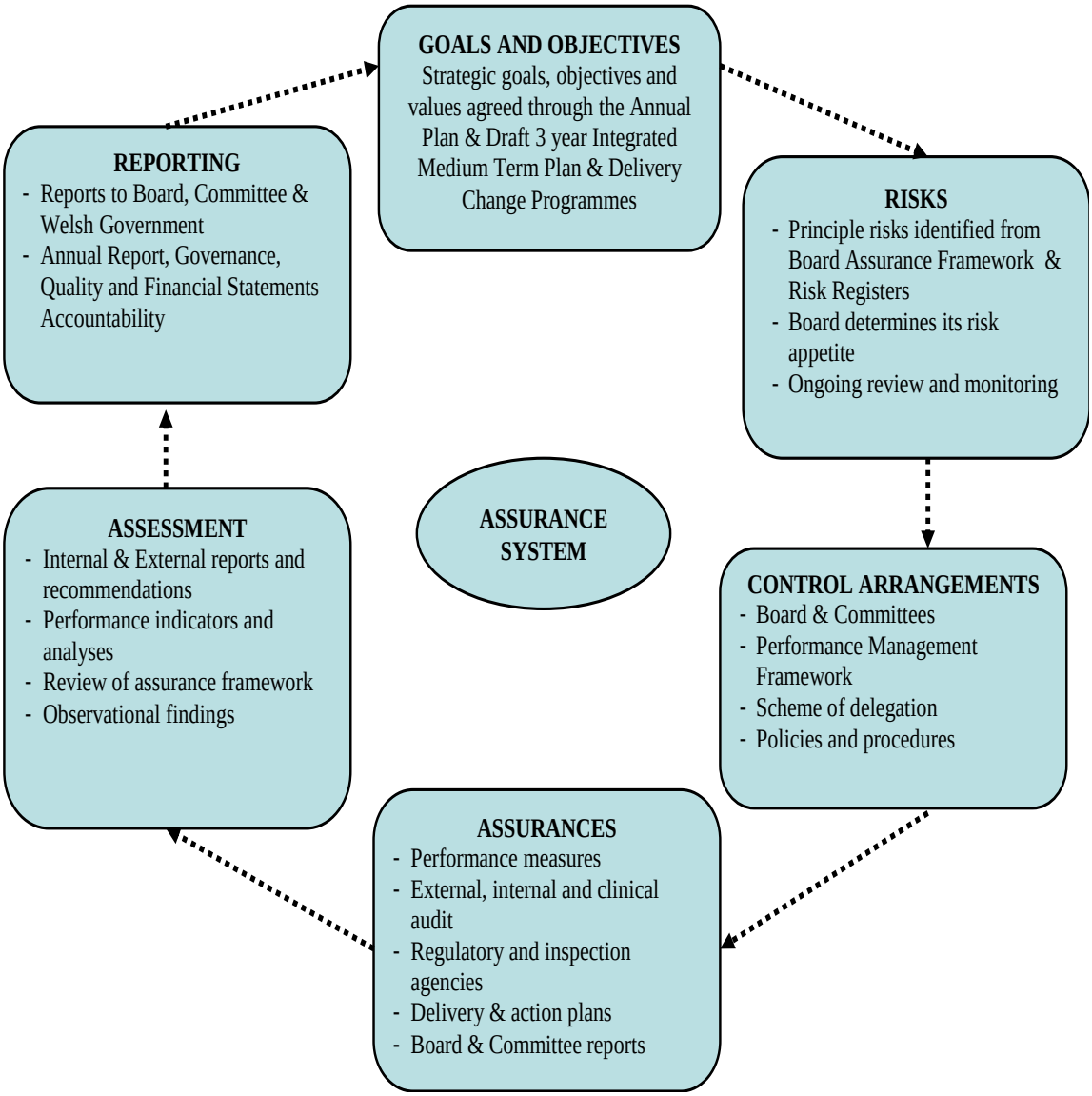
The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively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



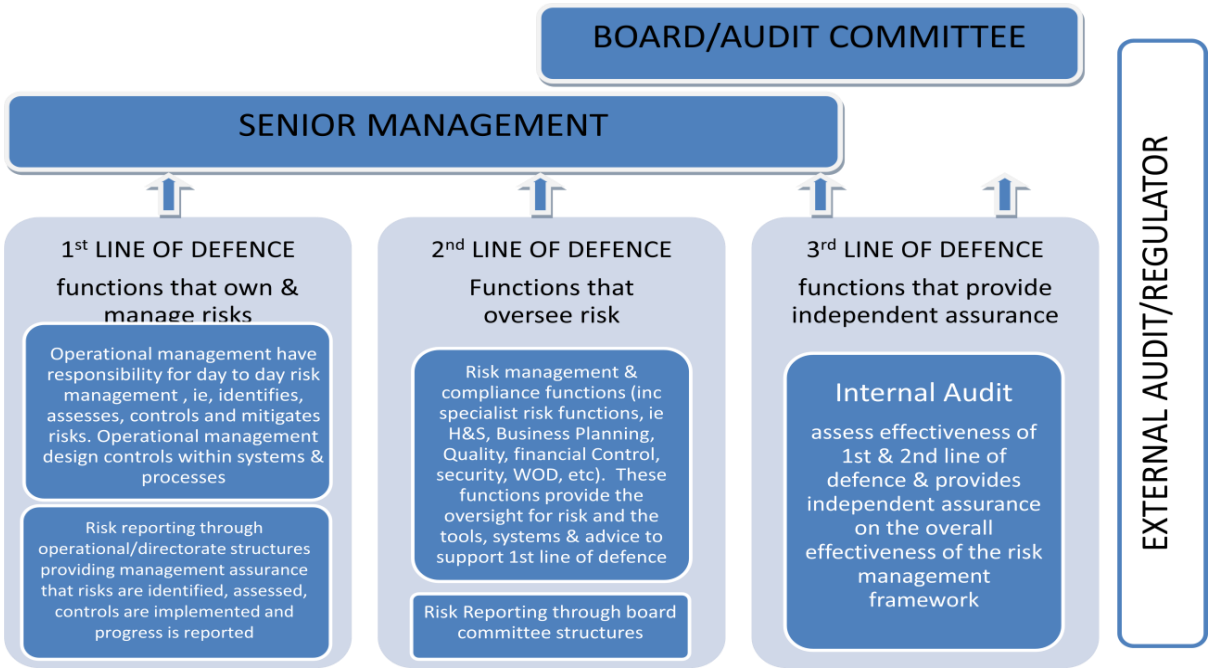
Combined, these provide the body of evidence required to support the continuous assessment of the effectiveness of the management of risk and internal control and that internal control has been in place for the year ended 31 March 2019.

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.

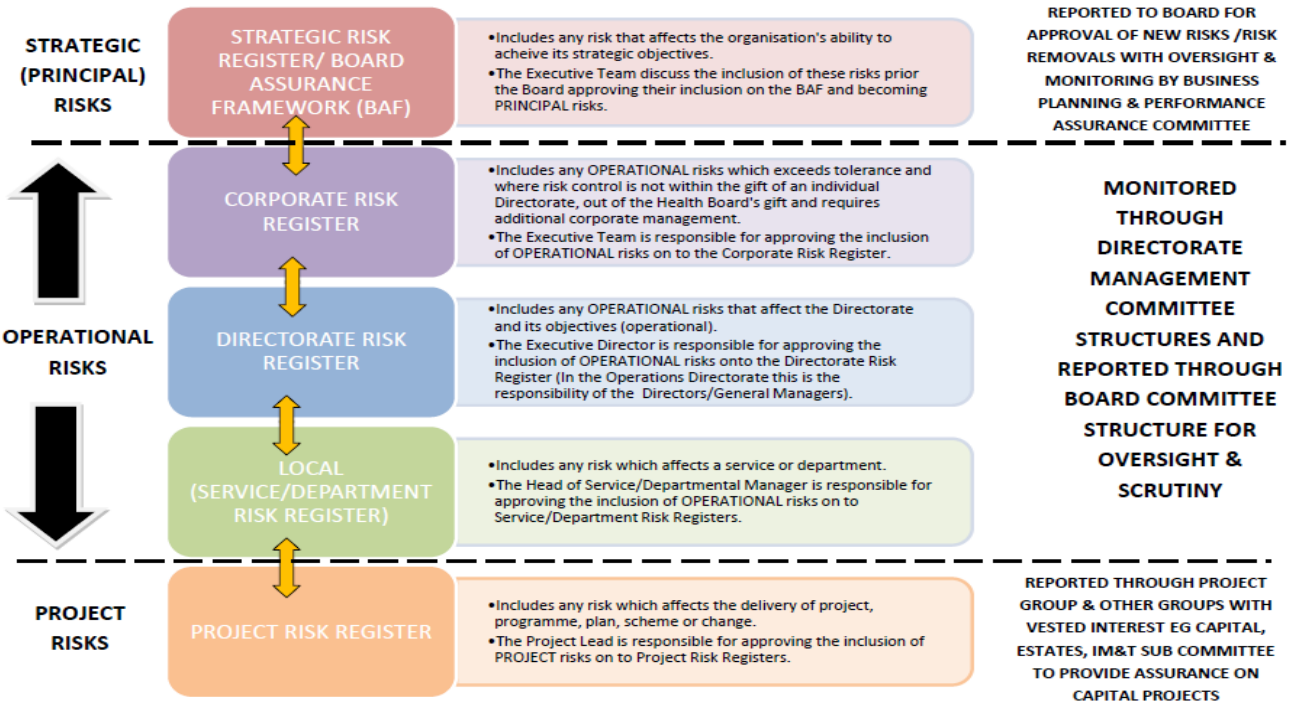
Risk Management Procedure & Protocols

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.

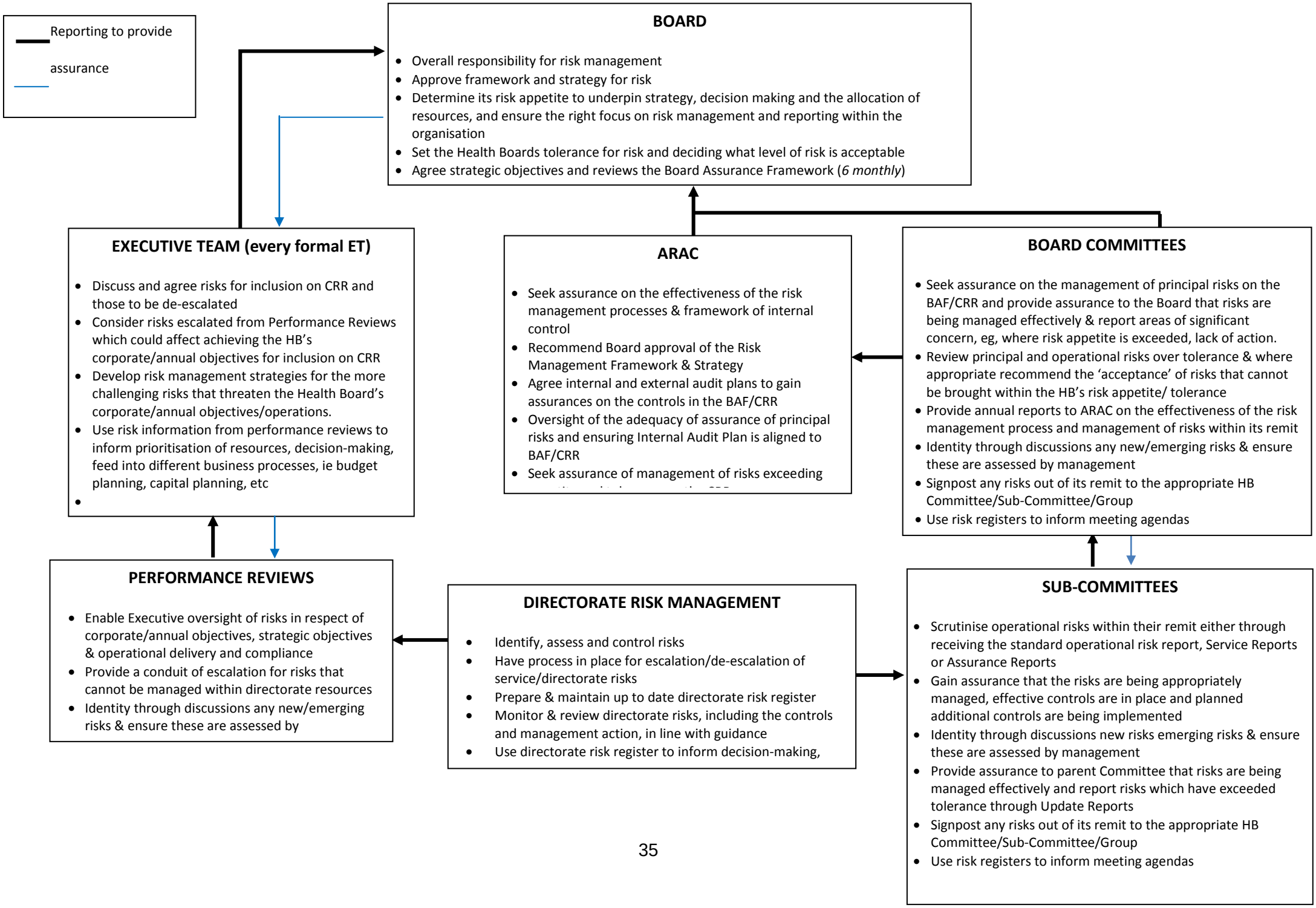
There were 29 principal risks on the CRR which will be presented to the Board in May 2019. The paper details the movement of risk since its last presentation to the Board in January 2019. Both these reports can be viewed via the following links:
January 2019 Corporate Risk Report
May 2019 Corporate Risk 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	508 634	626 627	
MAJOR 4		630 648	295 384 291 43 44 631 636 646 647 652	624 625 628 629 632 686	451 245
MODERATE 3			635 650	633 129	
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	 - + 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) 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: R1 – Should consider a wider security awareness programme. 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. 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 February 2019	• The extant Corporate Records Management Strategy document does not reflect new legislative arrangements. • Lack of health records inventory in place by Service and Departmental Managers; • Current storage arrangements are impacting on the HB capacity-wise and financially. • Patient information continues to be held beyond the required retention period set by the WG, which increases the risk of storage breaching its capacity. • The *Access to Health Records Policy* does not reference the introduction of new legislation.	The following actions are outstanding: • R1 – Update the Corporate Records Management Strategy • R2 - Information Asset Owners questionnaire to be circulated • R5 - Access to Health Records Policy to be reviewed and updated • R7- possibility of introducing joint IG/Health Records training sessions • 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. • Lack of registers or logs noting the records and patient information currently in storage. • Some staffing groups continue not to have received training for the management of health records. • Policies and terms of reference do not reflect the requirements set out by the WG in the revised Health & Care Standards 2015. • The lack of regular Health Records Committee meetings, as per the terms of reference, could lead to a lack of scrutiny.	reference). Whilst some timescales have slipped, recommendations should be delivered by September 2019.
National Standards for Cleaning Follow-Up April 2019	• Cleaning and Estates issues, although being reported upon are not actually being resolved. • 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. • C4C audits are not always uploaded to the PMS website on the same day as the checks are undertaken. • 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. • 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 April 2019	hazards or issues. • The HB's implemented policy and procedures may not sufficiently address legislative compliance requirements. • Plans may not be appropriate to effectively manage an outbreak. • 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). • 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. • The legionella risk may not be effectively prioritised and managed within Estates. • Potential non-compliance with ACOP/WHTM 04-01. • 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. A follow up has been included in the internal audit plan for 2019/2020.
Workforce management		
PADRs 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) • Remuneration & Terms of Service Committee (Chair) • University Partnership Board	8/8 2/3 1/4	• Unscheduled Care
Judith Hardisty	Vice Chair	Mental Health Primary Care & Community Services	• Board (Vice Chair) • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee (Vice Chair) • Finance Committee • Mental Health Legislation Assurance Committee • Quality, Safety & Experience Assurance Committee • Primary Care Applications Committee	8/8 7/8 6/6 4/6 2/3 4/6 6/6	• Carers
Judith Hardisty	Interim Chair		• Board (Chair)	1/1	• Unscheduled Care
Julie James until April 2018	Independent Member	Third Sector	• Board • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • (Vice-Chair) Audit & Risk Assurance Committee • (Vice-Chair) Primary Care Applications Committee	0/1 0/1 0/1 0/1 1/1	• NHS (Concerns; Complaints and Redress Arrangements (Wales)
Anna Lewis	Independent Member	Community	• Board • Charitable Funds Committee • Quality, Safety & Experience Assurance Committee • Primary Care Applications Committee	8/9 2/4 5/5 4/5	• Public and Patient involvement
Professor John Gammon	Independent Member	University	• Board • Business Planning & Performance Assurance Committee • Quality, Safety &	8/9 4/6	

NAME	POSITION	AREA OF EXPERTISE REPRESENTATION ROLE	BOARD COMMITTEE MEMBERSHIP/ATTENDANCE	ATTENDANCE AT MEETINGS	CHAMPION ROLES
			Experience Assurance Committee (Chair) • Remuneration & Terms of Service Committee • University Partnership Board (Chair)	6/6 3/3 4/4	
Owen Burt	Independent Member	Third Sector	• Board • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Primary Care Applications Committee	8/9 6/7 4/5 4/4 5/5	Design
David Powell	Independent Member	Information Technology	• Board • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee (Chair) • Finance Committee • Primary Care Applications Committee (Vice-Chair) • Remuneration & Terms of Service Committee • Quality, Safety & Experience Assurance Committee	9/9 8/8 6/6 7/7 6/6 3/3 6/6	
Simon Hancock	Independent Member	Local Government	• Board • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee • Charitable Funds Committee (Chair) • Mental Health Legislation Assurance Committee • University Partnership Board (Vice-Chair)	8/9 7/8 6/6 4/4 2/4 3/4	• Older People • Equalities & Diversity • Flu • Emergency Planning • Armed Forces & Veterans
Adam Morgan	Independent Member	Trade Union	• Board • Charitable Funds Committee • Quality, Safety & Experience Assurance Committee (Vice-Chair) • Mental Health Legislation Assurance Committee	7/9 2/4 5/6 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 • Charitable Funds (Vice-Chair) • Mental Health Legislation Assurance Committee (Vice-Chair) • Quality, Safety & Experience Assurance Committee • University Partnership Board	8/9 3/4 3/4 6/6 3/4	• Welsh Language • Cleaning, Hygiene and Infection Management • Children, Young People & Maternity Services • Nutrition & Hydration • NHS Concerns complaints and redress arrangements
Mike Lewis	Independent Member	Finance	• Board • Audit & Risk Assurance Committee (Vice-Chair) • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Finance Committee (Vice-Chair) • Mental Health Legislation Assurance Committee	9/9 8/8 6/6 4/4 5/7 2/4	
Paul Newman	Independent Member	Community	• Board • Audit & Risk Assurance Committee (Chair) • Remuneration & Terms of Service Committee • Mental Health Legislation Assurance Committee	7/9 7/8 3/3 3/4	
Steve Moore	Chief Executive Officer		• Board • Finance Committee • Remuneration & Terms of Service Committee	9/9 6/7 3/3	• Time to Change Wales Mental Health
Joe Teape	Deputy Chief Executive Officer/ Director of Operations		• Board • Business Planning & Performance Assurance Committee • Finance Committee • Quality, Safety & Experience Assurance Committee	9/9 6/6 4/7 6/6	• Delayed Transfers of Care • Sustainable Development • Security • 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 • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	9/9 6/6 6/6 2/4	
Stephen Forster (until September 2018)	Executive Director of Finance		• Board • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Quality, Safety & Experience Assurance Committee • Finance Committee	4/4 5/5 3/3 1/1 0/3 1/2	
Huw Thomas	Interim Director of Finance until September 2018 & Executive Director of Finance		• Board • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Finance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	5/5 4/4 3/3 3/3 7/7 2/3 1/2	
Mandy Rayani	Executive Director of Nursing, Quality & Patient Experience		• Board • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	9/9 5/6 6/6 3/4	• Violence & Aggression • Children's Act 2004 • Children Young People and maternity services
Jill Paterson	Director of Primary Care, Community and Long Term Care		• Board • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance	9/9 3/6 5/6	

NAME	POSITION	AREA OF EXPERTISE REPRESENTATION ROLE	BOARD COMMITTEE MEMBERSHIP/ATTENDANCE	ATTENDANCE AT MEETINGS	CHAMPION ROLES
			Committee • Primary Care Applications Committee	5/6	
Alison Shakeshaft	Executive Director of Therapies and Health Science		• Board • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	9/9 5/5 6/6 3/4	
Lisa Gostling	Executive Director of Workforce & Organisational Development		• Board • Business Planning & Performance Assurance Committee • Finance Committee • Quality, Safety & Experience Assurance Committee • Remuneration & Terms of Service Committee • University Partnership Board	9/9 5/6 7/7 6/6 3/3 4/4	
Ros Jervis	Executive Director of Public Health		• Board • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	9/9 3/6 6/6 1/4	• Emergency Planning
Sarah Jennings	Director of Partnerships & Corporate Services		• Board • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	7/9 3/6 4/4 3/6 4/4	• Public Patient Involvement
Joanne Wilson	Board Secretary		• Board • Audit & Risk Assurance Committee • Quality, Safety & Experience Assurance Committee • Remuneration & Terms of Service Committee	9/9 8/8 6/6 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 • Business Planning & Performance Assurance Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	9/9 5/6 5/6 4/4	• Patient Information
Andrew Carruthers	Turnaround Director		• Board • Business Planning & Performance Assurance Committee • Finance Committee	9/9 3/6 6/7	
Libby Ryan-Davies	Transformation Director		• Board • University Partnership Board	5/9 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 01.03.2019	31.03.2020	Vice Chair Interim Chair
Paul Newman	01.04.2017 (Independent Member) 06.03.2019 (Interim Vice Chair)	31.03.2019	Independent Member 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) Senior Consultant with IMROC Hosted by Nottinghamshire Healthcare NHS FT (Freelance) 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

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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 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

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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 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 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 Independent Member Audit Committee Local Democracy Boundary Commission Wales Trustee of the National Botanic Garden of Wales Member of Court Swansea University Member of Pembrokeshire Coast National Park Authority (from 01.06.17) Member of Court University of Luton 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 Trustee of Brecon Beacons Trust External Voting Member of Carmarthenshire County Council Audit Committee (from 08.06.2016) 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 Sister is a Development officer for Centre for Excellence in Rural Health & Social Care Sister in law is an

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								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)

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Michael Hearty	Associate Member (Finance)	No	No	No	No	Finance Advisor – Betsi Cadwaladr University Health Board	HMRC – Non-Executive Director Blackpool Teaching Hospitals Foundation Trust – Non-Executive Director 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 Independent Member, South Wales Police Ethics Committee Independent Member, City & County of Swansea Standards Committee 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 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

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			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 Penman Properties ltd Copper Court Ltd Vivian Court (Swansea) Ltd Llys Felin Newydd Management Company Ltd Rivalsot Ltd Maysouth Ltd Flowlong Ltd Lonpark Ltd Leapgold Ltd Magnetrade Ltd	No	No	No	No	No	No

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Philip Kloer	Medical Director/ Director of Clinical Strategy	No	No	No	No	No	Member of Council of St John, Carmarthen Honorary Professor, Swansea University, Medical School 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) 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

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								Interest Company) 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 Curator/Manager of Haverfordwest Town Museum	Chair of the West Wales Care & Repair Agency Torch Theatre Board Member Member of Pembrokeshire MENCAP Member of Pembrokeshire Blind Society Chair of the Veterans in Community Gallery Board	Vice Chair , Pembrokeshire County Council Magistrate, Pembrokeshire-Ceredigion Bench Member of the Court of Swansea University Member of Neyland Town Council Mayor of Neyland	Brother employed at Argyle Surgery, Pembroke Dock Sister in Law: GP in Newport (Retired) Niece: Nurse, Withybush Hospital

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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 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 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

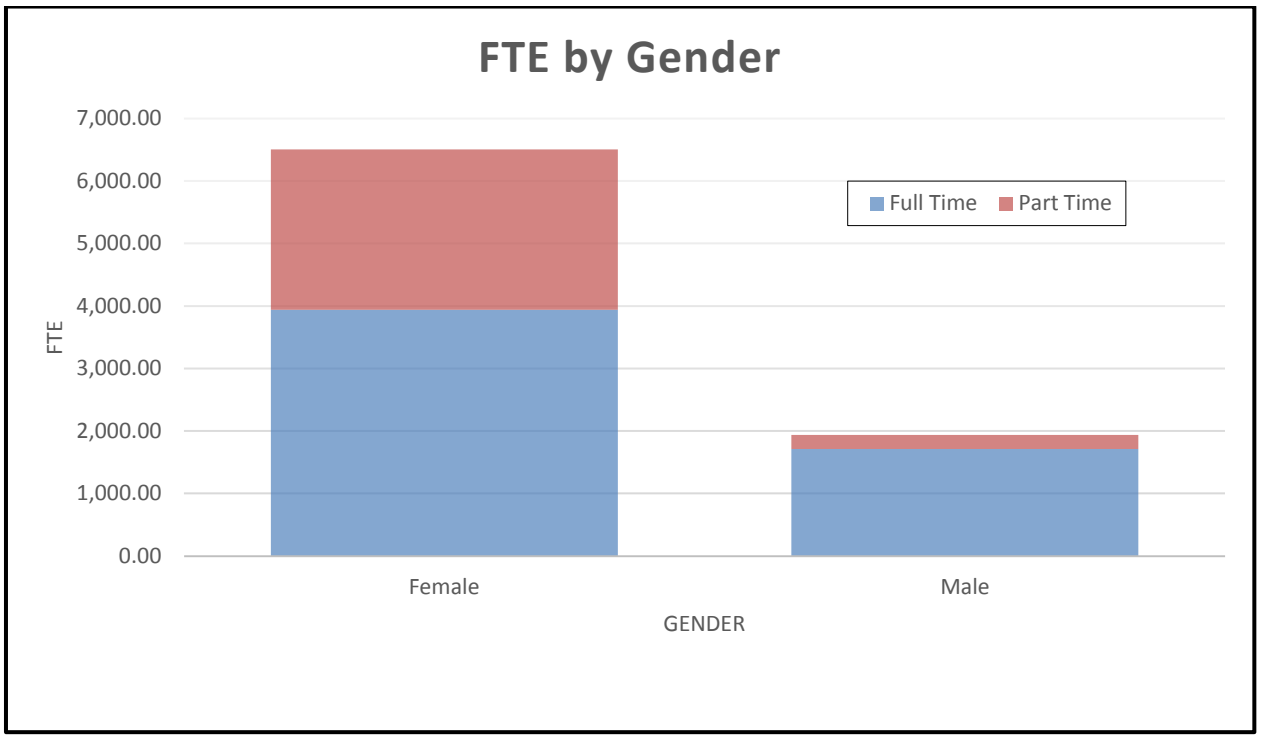
Staff Composition

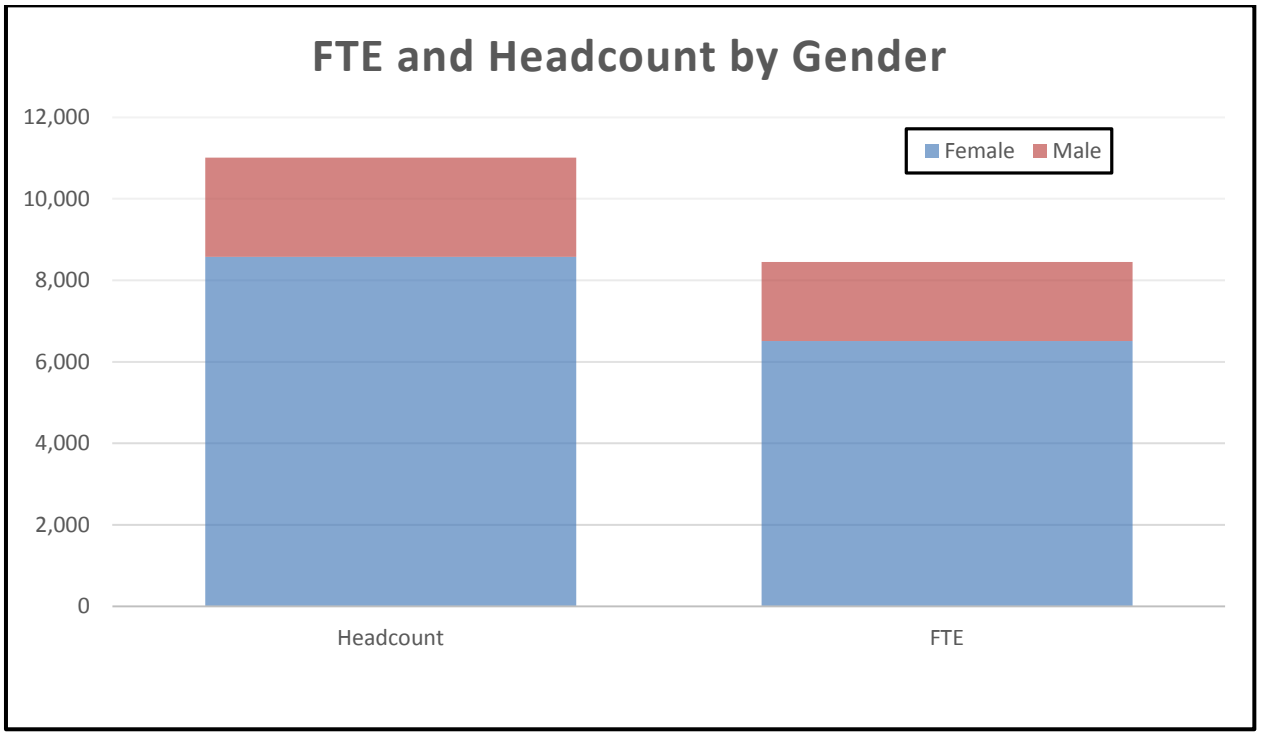
Staff Composition 31.03.2019

	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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Quality Statement 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Louise O'Connor, Assistant Director (Legal and Patient Experience)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The attached Annual Quality Statement (AQS) is required to be published on the University Health Board (UHB) website by 31st May 2019, subject to Board agreement. The Board will note that the timescale for publishing the AQS is earlier than previous years (previously 31st July), in line with the annual accounting and reporting timetable.

Cefndir / Background

The Welsh Health Circular WHC/2019/007 (WHC) was issued on 13th February 2019, providing detailed guidance on the production of the AQS for 2018/19.

An AQS Editorial Board was established in 2018, chaired by the Director of Nursing, Quality & Patient Experience, prior to release of the WHC.

The key priority for this year's report is to ensure that the document is accessible and understandable by service users and the resident population and that it clearly sets out all of the work of the past year to support the UHB's quality improvement goals. Links to the UHB Health & Care Strategy 'A Healthier Mid and West Wales' and the new 'Framework for Health and Well-being' are explicit throughout the document, with links to encourage engagement in the design of the future delivery of services.

The document was reviewed by the Siarad Iechyd Reader Panel which provided helpful comments and suggestions. Following incorporation of these comments, the Quality, Safety & Experience Assurance Committee (QSEAC) received the final draft on 4th April 2019, subject to the inclusion of end of year figures and document design. The version presented to Board was approved by QSEAC Chair's action on 15th May 2019. The Audit & Risk Assurance Committee received the AQS on 7th May 2019, for the purposes of assurance regarding compliance with the WHC.

The document has been submitted for Welsh translation and will also be available in other languages, large print and a range of alternative accessible formats.

Asesiad / Assessment

The AQS is compliant with the guidance and framework as set out in WHC/2019/007 and incorporates all key themes of the Health and Care Standards for Wales and the NHS Wales Outcome and Delivery Framework.

A significant amount of data was collected from across the organisation and scrutinised by the Editorial Board and QSEAC in April 2019. All comments have been incorporated into the final draft of the document.

There are many examples of innovative work being undertaken across our hospitals and communities to improve patient outcomes and experiences by working together and in different ways. Examples include the appointment of healthy lifestyle advisors within South Pembrokeshire; social prescribers in the Tywi/Taf locality; pharmacist medicine management advice in areas such as minor injury units, community and primary care settings; and physiotherapist and occupational therapist sessions within GP cluster areas.

Strong partnership work has resulted in development of new integrated facilities, such as the Cardigan Integrated Resource Centre and Cylch Caron. Our regional collaboration with Swansea University and Swansea Bay University Health Board has seen improvement in services such as cardiology and neurology by adopting a regional joint working approach.

We are using technology to improve patient access to information and support without the need to travel to appointments; this is evidenced by the introduction of the 'patient knows best system' into the Respiratory Service which has been received very positively by patients and staff. There are a number of projects which have been recognised as exemplar projects and are being supported by The Bevan Commission, including community work on antibiotic resistance; a self-management programme developed by the Continence Service; and provision of pulmonary rehabilitation sessions via video-conferencing in community settings in North Ceredigion. In 2018/19, 7 Bevan exemplar projects and 3 Bevan Technology bids were accepted. The Hywel Innovation Hub was launched in July 2018 with both a physical and virtual space to encourage sharing of best practice.

It is rewarding to see so many positive examples of the work being undertaken by our staff that are being recognised as leading examples and receiving national awards. Two projects were finalists in the Patient Experience Network Awards: the Multi-Agency Care Assessment Meeting (MACAM) Project in Withybush Hospital; and also the Digital Reminiscence Therapy work in Prince Philip Hospital to help patients with dementia and elderly inpatients. So many of our staff have been honoured with various awards, including RCM Midwife of the Year, received by Emma Thomas; and RCN Wales Nurse of the Year and Community Nurse of the Year, received by Evie Lightfoot.

The year has not been without challenges, and these have been recognised as priorities for improvement in 2019/20. These priorities include reducing incidents of avoidable pressure damage; reducing the number of incidences of hospital acquired thrombosis; improving access to areas such as ophthalmology and orthodontic services; improving waiting times for follow-up appointments; reducing waiting times for assessment & treatment at emergency departments; reducing smoking rates in pregnancy; and improving the standard of our clinical documentation.

The AQS has utilised a number of methods to convey information, through a mix of case studies and patient stories demonstrating positive patient feedback, with links to more detailed or technical information where required.

Argymhelliad / Recommendation

The Board is asked to endorse the University Health Board's Annual Quality Statement for 2018/19 for publication, noting that a detailed review of the report has been undertaken through the Quality, Safety & Experience Assurance Committee, on behalf of the Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	We have engaged with the Health Board Directorates to develop the AQS 2018/19. The Siarad Iechyd Readers Panel has scrutinised the document.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Quality, Safety and Experience Assurance Committee Audit, Risk and Assurance Committee Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Translation, design and minimum print run costs
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Sets out to describe some of the UHB's achievements and conversely limitations in patient care and services across the UHB's duties.
Gweithlu: **Workforce:**	Engagement of the services to provide the examples of areas for inclusion.

Risg: **Risk:**	Statutory duty to publish the AQS as part of the annual reporting structure of the UHB
Cyfreithiol: **Legal:**	Statutory duty to publish the AQS as part of the annual reporting structure of the UHB.
Enw Da: **Reputational:**	Statutory duty to publish the AQS as part of the annual reporting structure of the UHB.
Gyfrinachedd: **Privacy:**	Not applicable.
Cydraddoldeb: **Equality:**	The UHB has a statutory duty to fulfil this function and as part of its development must consider all issues of its equality duty and consider evidence within the AQS to support equality.

Hywel Dda University Health Board

Annual Quality Statement 2018 / 19

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Contents

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Calon Iechyd Lleol
The Heart of Local Health

Gwasanaethau Eich Dyfodol
Your Future Services

Alternative formats and large print are available on request by calling 01267 239554.

Foreword

Welcome to our Annual Quality Statement for 2018/2019. We are pleased to be able to share with you the work undertaken over the year to improve the quality of our services and to meet the needs of our patients across Carmarthenshire, Ceredigion, Pembrokeshire and borders.

This has been an exciting year and we have been priviliged to work with our staff, local populations and interested organisations to design the way our patients will receive health care and support in the future. This has been one of the largest local NHS consultations in the UK and will result in a challenging 20 year journey. We very much want you to be part of this journey and continue to help us grow and improve our services, provide safe and effective care, and better preventative and community based services. More details can be found here: **www.hywelddahb.wales.nhs.uk/healthiermidandwestwales** (A Healthier Mid and West Wales Strategy) and ways in which you can get involved are also included at the end of this document.

During the past year we have begun to better understand the health needs of our local population, the challenges we face and the reasons why we need to change. Our new Framework for Health & Wellbeing: Our future generations living well document puts 'living well' at the heart of what we do – good health and well-being is also about having a good start in life, good education, safe housing and employment. We know that we are living longer, but not always in good health, so we need to make changes, providing the healthcare services we need, to make for a healthier and joyful future for us all.

Last year we shared with you the work we have been doing to co-design the future of our mental health services with our service users, staff and local organisations, where people are supported to recover from mental health difficulties, and live full and meaningful lives through services that inspire hope, confidence and understanding. We will share with you below the achievements to date of this work and further information may also be accessed here: **http://www.wales.nhs.uk/sitesplus/862/page/92265**

There have been many new services introduced throughout the year, such as the Tenby Walk-In scheme and the Front of House Project at Prince Philip Hospital, which are described below and are good examples of what can be achieved by working together to look at different ways of providing our care.

We are very proud to have achieved so much this year, but we must also acknowledge the challenges we have faced, particularly in relation to staffing levels and recruitment; sometimes there have been occasions when the services we have provided have not been of the standard we would aspire to achieve.

At the same time we know that there have been some significant operational challenges with some of the services which the Health Board contracts from Independent Providers. A number of Domiciliary Care Agencies have left the market which can mean that sourcing sustainable and appropriate Home Care packages for eligible individuals in some parts of our geography is an increasing challenge.

Similarly the continued pressure experienced by the Primary Care workforce has meant that there have been a number of contractual changes. The Health Board has managed 5 General Medical Practices over this period, for a total of approximately 32,000 patients, and continues to work with professionals, patients and public to explore and implement different ways of working in order to secure a more sustainable approach in line with the national Primary Care model for Wales. We are pleased to report the return to Independent Contractor status for one of the 5 Managed Practices in March of this year as a result.

The winter period is without doubt one of the most challenging periods for the NHS. During the year, we have worked very closely with the Wales Ambulance Services Trust, primary care teams (such as GPs and pharmacies); local authorities, agencies that provide care, and transport providers to reduce avoidable demands on the services. This is to ensure everything runs as smoothly as possible to ensure everyone can access the right services when they need them. We have been asking our patients and our communities to 'choose well' and access the right services for their needs. We have worked with pharmacies to develop 'walk in centres' to deal with the most common ailments, to ensure flu vaccinations are received, and to promote the things we can all do to try to remain well during winter, including ensuring friends, family and neighbours are well looked after.

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.

Thank you for taking the time to read this report, we hope it helps to explain a little more about what we do and plan to do in the future. Please get in touch if you have any ideas to share with us or want to become more closely involved in our work. If you would prefer to read a printed version in either Welsh, English or other language, or if you would prefer to receive the document in other accessible formats, please contact us on **01267 239554** or Email: **communications.hdd@wales.nhs.uk**

Bernardine Rees OBE
Chair

Steve Moore
Chief Executive

Professor John Gammon (Independent Member)
Chair – Quality, Safety, Experience Assurance Committee

Mandy Rayani
Director of Nursing, Quality & Patient Experience

Our Health Board

Providing excellent quality, safe and effective services is extremely important to us and this year we launched our Quality Improvement Framework which introduces improvement activities to give staff the knowledge, skills and confidence to recognise when improvements are required and to make the necessary change. Within the framework we have identified 5 quality improvement goals.

- ✓ No avoidable deaths.
- ✓ Protect patients from avoidable harm.
- ✓ Reduce duplication and eliminate waste.
- ✓ Reduce unwarranted variation and increase reliability.
- ✓ Focus on what matters to patients, service users, their families and carers, and our staff.

The information provided in this document will demonstrate how we are achieving these goals or where we still have some work to do to make things better.

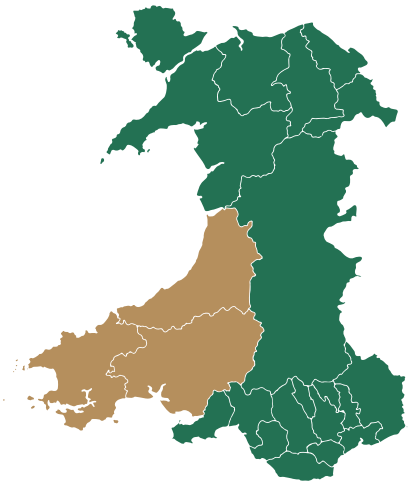
Who We Are

384,000

We serve a population of around **384,000** in Carmarthenshire, Ceredigion, Pembrokeshire and borders.

25%

We cover a **quarter** of the landmass of Wales.



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Nearly a quarter of our population is aged over **65.**

3,142

3,142 babies are born in our area every year.

We have fewer people aged **25-44** and more people aged **55-79.**

There are areas of **deprivation** including parts of **Llanelli, Pembroke Dock** and **Cardigan.** Within less deprived areas there are often pockets of hidden deprivation.

11,180

We employ **11,180** staff.

We have **four** main hospitals:

Bronglais in Aberystwyth;
Glangwili in Carmarthen;
Prince Philip in Llanelli;
Withybush in Haverfordwest.

We have **seven** community hospitals:

Amman Valley and **Llandovery** in Carmarthenshire;
Tregaron, Aberaeron and **Cardigan** in Ceredigion;
Tenby and **South Pembrokeshire Hospital Health and Social Care Resource Centre** in Pembrokeshire.

Last year we:

Helped **164,937** people through our Emergency Departments.

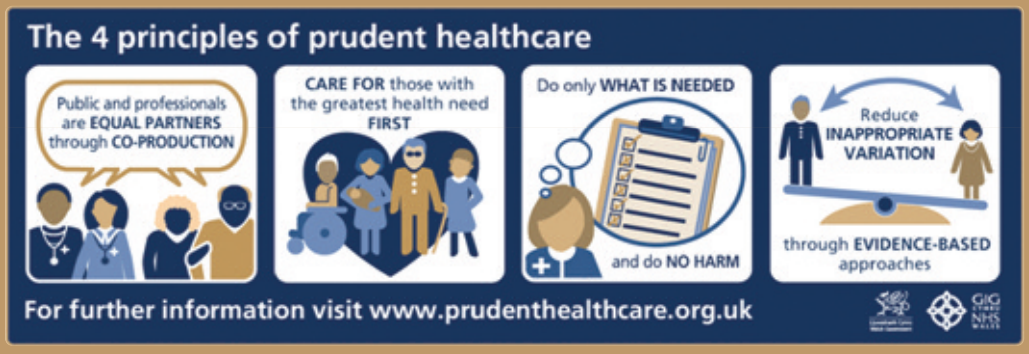
Cared for **64,408** inpatients in our hospitals.

We have:

48 general practices;
47 dental practices plus 3 orthodontic practices;
99 community pharmacies;
61 general ophthalmic practices;
11 health centres; **numerous** locations providing mental health and learning disabilities services.

Specialised services support people with a range of rare and complex conditions. They are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally, specialised services are planned nationally by welsh health specialised services (WHSSC) on behalf of the seven health boards in Wales. WHSSC works closely with the health boards to ensure that any specialised service commissioned is of a high standard and that there are no concerns identified from a quality perspective. They do this on our behalf through a quality assurance frame work which is monitored by their quality and patient safety committee and reported into the health board.

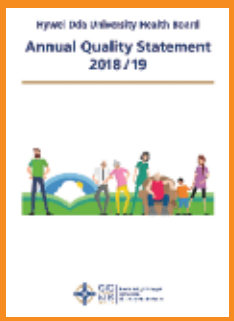
We work according to the four principles of Prudent Healthcare



We also need to meet the 26 national Health and Care Standards across all our services

We also ensure that we follow our own organisational values and behaviours in all that we do

All of these pieces fit together to inform the work we do as described in this report



Looking Back On 2018/19

Despite the challenges that we have faced this year, we have achieved many exciting developments that demonstrate our commitment to putting the patient at the centre of all that we do – this means that we will focus on the needs of the person using our services, rather than the needs of the services themselves and we will take account of individual needs and health choices. The information we wish to share with you has been presented according to our health and care standard priorities. These standards support us and the wider NHS by setting out expectations for services and organisations in providing effective, timely and quality services.

We Said, We Did

In our statement last year we identified **a number of important improvement projects for 2018/19.** Our progress is shared below:

We Said	We Did	Target Status
We would reduce the number of avoidable in-patient falls	A number of improvements have been made including: closer supervision of patients at risk of falls in ward areas; the introduction of patient alarms; staff workshops continue to be held to review incidents of falls and learn from what has gone wrong; and the introduction of a new patient information leaflet and posters identifying the learning. The outcome of this work is that there has been a reduction in the number of falls on our wards by 5%; however there is still further work to do and this area will remain a priority for us.	
We would ensure patients encounter minimal delays as they move through the different stages of care	A new process has been introduced, ensuring each patient staying on a hospital ward is reviewed before mid-day each day by a senior clinician; a clinical team will review patients who have been staying in hospital for 7 days or more; each patient will know what their expected discharge date will be and what will need to be in place to allow this to happen. 33% of patients to be discharged will go home before mid-day. Daily rounds identify and reduce any unnecessary delays to improve the patient experience and reduces the clinical risks associated with a prolonged hospital stay.	

We Said	We Did	Target Status
We would develop the culture of 'Home First'	We know it is best for people's health and well-being to be treated away from hospital, ideally in their own home, when medically safe to do so. The 'Home First' principle encourages people to find the best way to support their healthcare needs and help them to be as independent as possible by providing support: • So they don't need to go to hospital. • To those who attend A&E to be discharged with support at home if necessary. • To people who have been admitted to leave hospital earlier (if they are well enough to do so and the support and care they need can be carried out at home).	
We would improve the way we collect patient experience	We are collecting the views of patients, service users, families and carers on their experiences of using our services. The Patient Advice and Liaison Service (PALS) team regularly visit our wards and clinic areas to engage with people using our services. We are ensuring all staff have access to the patient feedback we collect as care is happening so that it can be acted on and shared with the wider team. We are introducing a new digital (electronic) system that will allow all staff to capture patient experience feedback, both positive and negative and escalate the feedback where necessary.	
We would reduce the amount of avoidable pressure damage experienced by patients in our care	It is our intention to have no incidents of avoidable pressure damage. All such incidents are reviewed to make sure we understand why the pressure damage developed and what we can do to prevent similar incidents happening again. This information forms part of teaching sessions for our staff and helps staff to identify early signs of pressure damage. New air mattresses for patients at risk of developing pressure damage have been purchased. The number of incidents has increased slightly from 133 in 17-18 to 133 in 18/19. This will remain a priority area for the coming year.	

Staying Healthy

Supporting people to manage their own health and well being

We want to make sure that: you know how to look after your own health and wellbeing; that you live a long and active life; that children have a healthy start in life and that you get the information you need, when you need it and in the way you want it.

As stated in our Health and Wellbeing Framework for the Hywel Dda region, 'health is one of the top things people say matter to their wellbeing'. Our services have a very important part to play when we are ill and in need of treatment and care, but this may have as little as 10% influence on our overall health so we have to work together to look at the wider aspects of health if we are to see improvements.

We place people and communities at the heart of what we do, and we commit to work closely with our population and other services to create the most positive impact that our health services can make on the health and wellbeing of our local people. Our attention also has to focus on the wellbeing of our future generations. With this in mind, we are committed to delivering the following goals and outcomes:

- Starting and Developing well – 'Every child will have the best start in life through to working age, supporting positive behaviours, and outcomes across the life-course'.
- Living and Working Well – 'Every adult will live and work in resilient communities that empower personal collective responsibility for health and well-being'.
- Growing older well –'Every older person will be supported to sustain health and wellbeing across older age, living as well and independently as possible with supportive social networks'.

We are pleased to share with you some of the work we have been doing to help us achieve these goals:

Healthy Child Wales Programme (HCWP)

The Healthy Child Wales Programme is for families with children aged 0-7, and it sets out what services every child can expect to receive from health boards for screening, immunisation and supported child development. All babies should receive a visit from the Health Visitor between 10 and 14 days old, this has been achieved in 92% of cases and is an area for improvement for the forthcoming year.

Llanelli's Wellness and Life Science Village

The Llanelli Wellness and Life Science Village aims to deliver health, wellbeing and economic benefits to the people of Llanelli and the region through the regeneration of development land in south Llanelli. The project proposes to deliver a range of new facilities comprising:

- Wellness Hub – a new sports, and wellbeing centre designed to facilitate rehabilitation.
- Community Health Hub – for business start-up and clinical research and product development, health service delivery, education and training.
- Assisted Living – including a nursing home and extra care housing.
- Wellness hotel and housing.

The planning for health services within the Village meets our priorities as set out in our Transforming Clinical Services Strategy and the Transforming Mental Health Strategy.

Our Public Health Team provided a Health Impact Assessment (HIA) for the Wellness Village which has helped develop the programme at the new facility. The team engaged with the community and other organisations to ensure that everyone's voice was genuinely heard.

Smoking Cessation

Within our Health Board area, 19 % of adults smoke. We now have 47 community pharmacies providing smoking cessation services and we are pleased to say that we have helped 1019 people to stop smoking between April 2018 and Sept 2018 and we are seeing a reduction in the number of people who smoke.

Foodwise Programme

An adult 8 week Weight Management Service is helping people to manage their weight and gain improvements in their overall health. The service is provided by a compassionate, caring team including dieticians and clinicical psychologists. Addressing the underlying reasons behind weight gain, eating and lifestyle behaviours, people are being supported to make lasting changes. We are delighted to have helped almost 1,400 people in the last year, with 76% achieving weight loss and seeing improvements in their existing medical conditions, requiring less medication and hospital appointments.

This is some of the feedback received:

"My diabetes doctor has told me that my fatty liver has returned to normal and they have cut my medication dose by a third; they are very pleased with my weight loss"

"I dropped two sizes in trousers as my waist is smaller and my blood sugar levels have never been so good...diabetes nurse took some of my medications off and reduced the others"

Diabetes Prevention

Programmes in North Ceredigion and North Pembrokeshire are being provided to patients at risk of developing Type 2 diabetes. This involves providing information on the condition and being supported with lifestyle changes, such as diet and exercise, so that early action taken will prevent development of the disease. In Ceredigion, Aberystywth University is helping to evaluate the project. The success of this project has led to the programme being developed for the rest of Wales.

Vaccinating our staff is very important to protecting patients, **5537 flu vaccines** were administered to staff this season, more than ever before. Withybush Hospital Preoperative Assessment Clinic (PAC) Team were recently awarded Team of the Month for increasing the uptake of flu vaccinations by providing the vaccine at same time as assessment clinic appointments. A flu vaccination social media message for Hywel Dda Staff was provided to encourage uptake **https://www.youtube.com/watch?v=_1er7yCq5as**

In the community, our flu vaccine uptake among patients over 65 this season was 63%, with 38% of patients aged 6 months-64 years in an 'at risk' group receiving a flu vaccine. This has been year 1 of the 'Superprotectors' campaign, promoting the message that vaccinating children is important to protect them and older vulnerable adults in the house too. Forty-five percent of 2-3 year olds in our Health Board area received a flu vaccine this year, and over 70% of school aged children in eligible year groups have been vaccinated. There remain many challenges as the numbers of older and at risk people in the population rises.

Antibiotic (Antimicrobial) Resistance

A new community based project, working with the Bevan Commission, has been developed to tackle antibiotic resistance (The Bevan Commission is a group of international experts providing advice to the Minister for Health and Social Services on best healthcare practices from around the world). We know that resistance can develop when antibiotics are prescribed too often or for illnesses which do not require them. Much of our prescribing is carried out by our general practitioners (GPs), so the project focuses on education sessions and discussions with prescribers out in our community to ensure patients are receiving the right antibiotics and only when needed. So far GPs who have been involved have welcomed this, and sessions have been shown to increase appropriateness of prescribing. The project is one of a number of pieces of work going on in Hywel Dda, including changes to prescribing guidelines and feedback to prescribers on microbiology results, aimed at ensuring we tackle antimicrobial resistance head on.

Bowel Screening Update

Bowel screening uptake across Hywel Dda is at 56.5%, compared to a Wales average of 55.7%. Men and women aged 60-74 receive a test kit and invited to take part every two years. A project has been introduced to increase the response rate for bowel screening in North Pembrokeshire, where uptake is 56.3%. Work is undertaken with people who do not respond to the screening to look at reasons for this and make sure there is opportunity for them to explore any concerns they have about screening.

Healthy Lifestyle Advisors

Two Healthy Lifestyle Advisors were appointed to work within South Pembrokeshire to support patients to make changes to their lifestyle that will improve their health. Working within the community, local businesses and schools, the service has received positive feedback. Part of the role of the advisor is to signpost patients to other support organisations. One of the major benefits of the scheme is the increased uptake of screening services through the advice and support provided.

Social Prescribing

Social prescribing supports patients with their non-medical issues and help them to access appropriate support within the local community, for example around volunteering opportunities, gaining employment, benefits advice, housing support, debt management, parenting skills and increasing physical activity. Two social prescribers in the Tywi/Taf locality work across the 8 GP practices and with the Community Resource Team. Referrals were received for 225 patients during the first 6 months, 100% of patients surveyed rated the quality of service as excellent and helped them deal with their non medical problems more effectively.

Stress Control Course

The Stress Control course is a self-management course to help patients manage the symptoms of stress using a number of different techniques. During the course, a pharmacist provides advice on the safe use and risks of related medications, and patients have the opportunity to discuss different drug treatment options available. Approximately 6 courses are run each year and we were pleased to see 20-30 participants attend each course.

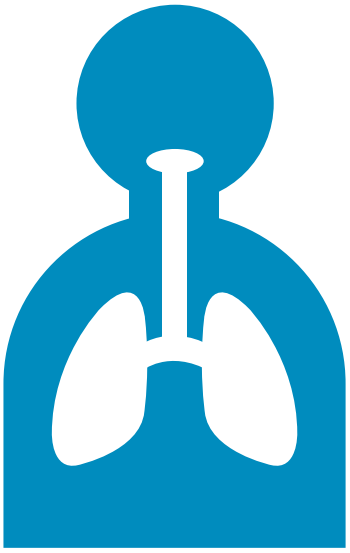
Sexual Health Home Testing Pilot Service

We have launched a new trial sexual health home testing service, the test is for sexually transmitted diseases such as chlamydia and gonorrhoea. The kits are for home use which are then posted (freepost) to the laboratory. One thousand kits are available and when all of these have been allocated the service will then be evaluated to ensure that it is the right thing for Wales. You can find out more information here: **www.friskywales.org**

As of early April 386 kits had been issued, 325 to young people between 16 and 34 years old. The service will be evaluated later this year, with plans to roll it out to other parts of Wales.

Education Programme for Patients (EPP)

A 9 week self-management course is provided by the Medicines Management Team for patients with chronic obstructive pulmonary disease (COPD). The course focuses on how patients can self-manage their symptoms. The course is attended by 10-15 participants, with around 3 courses being delivered per year in various locations across the Health Board area. We are developing similar courses on the management of reflux/dyspepsia and on managing medication.



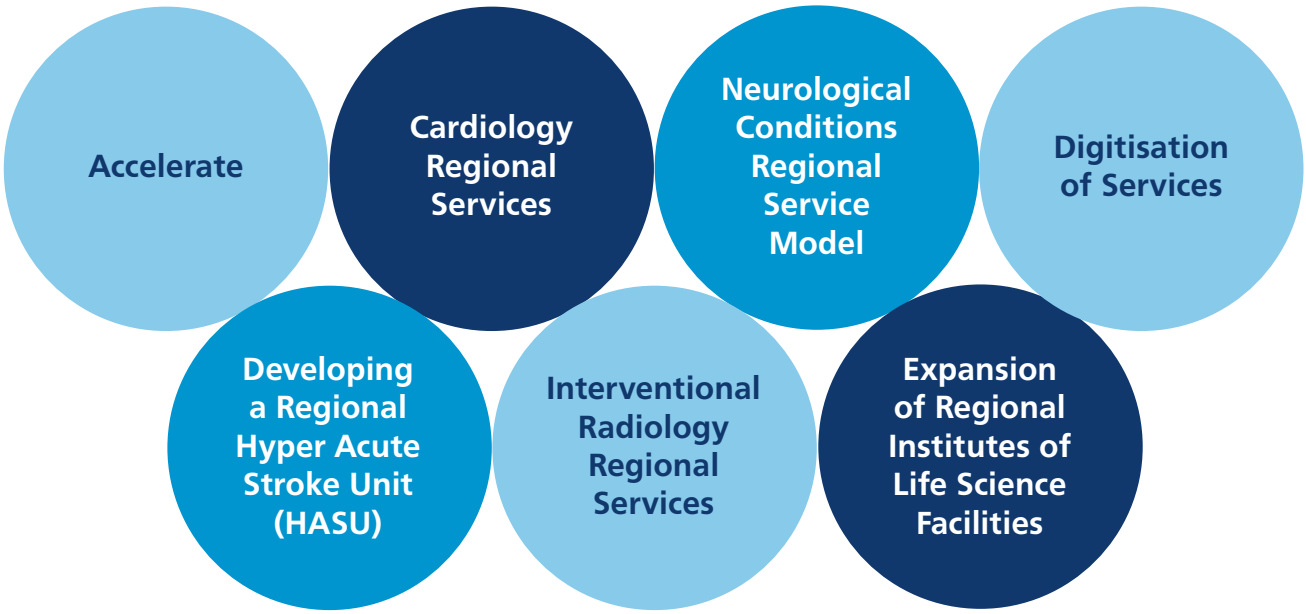
A Regional Collaboration for Health (ARCH)

Swansea University, Hywel Dda and Swansea Bay University Health Boards have continued to build upon their unified aim to improve the health, wealth and wellbeing of South West Wales and its citizens.

In 2018, the ARCH Delivery and Leadership Group reviewed the current progress against the original ARCH Portfolio Development Plan.

In November 2018, ARCH published a 'Regional Working and Collaboration Report' which outlined the progress of individual projects and the successes delivered to date. This document can be viewed under 'Useful Links' at: **www.arch.wales**

During 2018/19 the focus for the ARCH Portfolio has been on the projects below:



@archprogwales @ARCHProg www.arch.wales

Safe Care

Protecting people from harm and supporting people to protect themselves from harm

We want to make sure that: you are supported to protect your health and your family's health; that you are kept safe and protected from harm through the right care and support; and you get good, safe care from all health services.

Examples of the work we have undertaken to ensure that we are providing safe services:

Sepsis

Evidence suggests that compliance with the Sepsis 6 bundle (a bundle refers to an agreed set of interventions that when used together significantly improves patient outcomes within 1 hour) ensures that people are safe from harm through high quality care, treatment and support. This promotes recognition and management of sepsis throughout a patient's hospital stay. An educational programme is provided to all clinical staff, which includes the use of patient stories and regular team meetings to identify themes. The results are positive, from March 2018 to February 2019 – there has has been an improvement from 72% to 93% in all ward areas and from 93 to 94% in admissions units, work is continuing to address any areas for improvement.

Reduction in Healthcare Associated Infections

Every hospital acquired infection is estimated to increase the patient's length of stay by, on average, 11 days, as well as causing further suffering for the patient. We are working across the Health Board to prevent and reduce the number of infections related to healthcare.

Clostridium Difficile Infection (CDI), is caused by Clostridium difficile bacteria in the bowel multiplying and causing diarrhoea. The development of CDI is usually related to the use of antibiotics. We are working with doctors and pharmacists in hospital and the community to make sure that all antibiotics are prescribed correctly and the risk of developing CDI is reduced by 6% in 2018/19 compared with 2017/18.

Escherichia coli Blood Stream Infection also known as *E. Coli*, BSI is caused by bacteria that are frequently found in the bowel of humans migrating into the blood stream. E. coli BSI can often be linked to people who have frequent urine infections. The Infection Prevention Team provide education in hospitals, community services and GP practices to ensure that only true urine infections are treated with antibiotics and to encourage people to drink more fluids especially if they have symptoms of urine infection. Better hydration and better management of urine infections has reduced the number of E. coli BSI in the Health Board by 22% in 2018/19 compared with 2017/18.

Staphylococcus aureus Blood Stream Infection also known as *S. aureus* BSI. *S.aureus* is a common bacteria carried on the skin that causes problems when it gets in to the blood stream. We are working across hospital sites to ensure that lines and catheters are cared for correctly so they are not a source of infection. In the community we are working with District Nurses to ensure that the care of leg ulcers is done in the best environment for the patient.

Asceptic Non Touch Technique (ANTT)

Asceptic Non Touch Technique (ANTT) is the terminology used to describe a process that prevents the contamination of wounds or introducing infection in to the body during a procedure. ANTT is being introduced across the Health Board and is a way for us to be reassured that wound care and

procedures are completed to a certain standard. When all staff are trained in ANTT it will reduce the risk of infections associated with wounds and all procedures.

Infection Prevention and Oral Care

The risk of pneumonia (an infection in the lung) increases in older people with poor mouth care and build-up of dental plaque (a film that builds up on your teeth). Pneumonia is one of the leading causes of infection in care homes. We have been working with our colleagues providing teaching to dental nurses, infection prevention link nurses and delivered a presentation to a Care Home Conference focusing on good oral health.

Acute kidney Injury (AKI)

Acute kidney Injury (AKI) is an abrupt reduction in kidney function which can be very harmful if not recognised and managed effectively. To improve the recognition and management of patients in Withybush, we have provided training to staff and introduced new care bundles to be inserted into the patients notes to improve the treatment of patients. The outcome will be evaluated and discussed with the clinical teams across the Health Board.

Hospital Acquired Thromobosis

Many of these cases are avoidable if the correct processes are followed. Learning is being shared with all clinical staff across the Health Board, to ensure that the risk assessment process is being completed correctly. One of our priorities for next year is to see a reduction in the number of hospital acquired thrombosis cases.

JAG Accredited

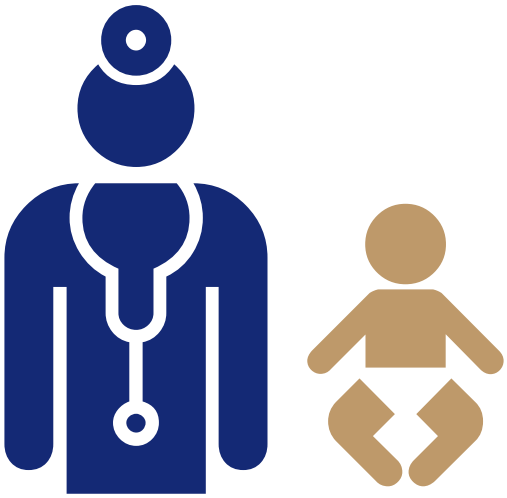
Endocscopy Accreditation

All endoscopy units within the Health Board have been awarded accreditation from the Joint Advisory Group for high quality gastrointestinal endoscopy services. This accreditation provides reassurance to patients that the units are working to the highest standards.

Safe Management of Medications

All incidents relating to medication are reviewed by our Medicine Event Review Group and improvements are made where any lessons learned are identified. The all Wales e-learning package for medication administration, recording and storage is promoted to all relevant staff and training packages are being developed for medical teams to address any prescribing errors. There is also an improved monitoring arrangement for the daily checking of controlled drugs in all ward areas.

Surgical Site Surveillance for Caesarean Section Procedures



Since January 2006, all health bodies in Wales have been required to undertake reviews of surgical site infections following caesarean section procedures. This ensures that any infections following surgery are reviewed and discussed with surgical, midwifery and infection control teams and where necessary changes in practice are made.

The rate of infections has decreased since the start of the surveillance in 2007, with a reduction of 83%. This represents an estimated 379 mothers who have been saved from an infection during this period. This improvement has been achieved by introducing new practices and cleaning techniques.

Management of Stroke

We are pleased to have been consistently rated as one of the top performing health boards for stroke management. Information from December 2018 shows:

We are the highest performing health board in Wales for the:

- Percentage of patients admitted to an Acute Stroke Unit within 4 hours.
- Percentage of patients having a CT scan within 1 hour of arrival at hospital.

We are the second highest of health boards in Wales for the:

- Percentage of patients seen by a Stroke Consultant within 24 hours of admission.
- Percentage of patients receiving treatment to reduce clotting in the blood) within 45 minutes of arrival at hospital.

Over the last year, 100% of eligible patients presenting at Glangwili, Withybush and Prince Phillip Hospitals with stroke and who were eligible for thrombolysis (clot reducing treatment) received this.

In Bronglais Hospital 95.5% of eligible patients received this treatment, which has increased to 100% over recent months.

Partnership with the Lucy Faithfull Foundation

We are delighted to be working with the Lucy Faithfull Foundation to raise awareness among our staff about Child Sexual Abuse and Exploitation.

A multi-agency partnership was launched in November 2018 aimed at preventing and reducing harm from substance misuse among children and young people in Ceredigion. The work of the partnership builds upon the School Beat Cymru programme. It includes promoting awareness of existing harm reduction and prevention within schools, colleges and clubs, developing guidance for staff to respond to substance misuse incidents, and sharing the most recent information on existing and emerging trends and dangers.

Outreach Nurse for the Elderly Project in South Pembrokeshire

Outreach Nurse for the Elderly Project in South Pembrokeshire is a project addressing health checks and flu vaccinations for those most at risk in care homes and the community. The project seeks to identify those patients in care homes and the community at the greatest risk of inappropriate or avoidable admission to hospital. In the future we would like to see all elderly patients receive a health check who have not received a check in the previous 12 months, as they may have undiagnosed needs that need to be addressed.

Never Events

We want to learn from any mistakes that are made and although we would like to have no mistakes, there are times when things do not go as well as we would like. These types of incidents are reported as serious incidents to Welsh Government. Over the past year, two such events were reported, one incident related to the standard of surgery and another the safe administration of medication. We have worked with the services to ensure that lessons have been learned and provided evidence of the actions taken to prevent a similar incident occurring again.

All serious incidents are investigated fully and we work closely with families to keep them involved in our investigations. This year a total of 166 investigations were reported and we have worked hard to ensure that the quality of investigations and the timeliness of these investigations are good, this has been recognised by our Welsh Government colleagues. However, we do recognise that we need to continue to improve on this and investigating incidents in a timely way and to a high standard will continue to be a priority for us next year.

Sharing Learning

We have shared improvements made to the Serious Incident Process via a poster presentation at the National Patient Safety Conference held in the Royal College of Physicians in London. At this conference we also presented a poster which showed how we are using different ways to share learning, this was given first prize by the conference organisers.

Health Inspectorate Wales

Health Inspectorate Wales conducted 8 visits or inspections across our Health Board in 2018/2019 at:

- 2 Mental Health Services.
- 1 Acute Hospital.
- 1 Acute Hospital follow up inspection.
- 1 Community Hospital.
- 1 Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018 (published August 2018).
- 2 GP Practices managed by the Health Board.

Inspections highlight good practice and any areas for improvement. Where improvement is required, improvement plans are completed by us, and our Executive Team Performance Review monitors progress with the required actions on a quarterly basis. Generally feedback received highlights that we have dedicated and passionate staff who are delivering compassionate patient care. All HIW reports can be found on the HIW website: **http://hiw.org.uk**

Community Health Council (CHC)

The CHC works to enhance and improve the quality of your local health service. They are a statutory and independent voice in health services provided throughout Wales. The CHC undertook 7 visits during 2018/19. Where required, improvement plans have been developed and the Health Board is currently working towards completing its implementation. CHC reports can be located here: **http://www.wales.nhs.uk/sitesplus/904/page/46270**

Public Services Ombudsman for Wales (PSOW)

During the year the Ombudsman issued a public interest report relating to the care and treatment provided to a mother and her late son, during her pregnancy and labour. The Health Board took immediate actions to address the recommendations made in the report.

The Ombudsman also issued a public interest report in relation to delays in care and treatment involving Cardiff and Vale University Health Board and Hywel Dda University Health Board. The recommendations in relation to our services were to ensure that all patients referred for a service outside of its area, received a point of contact to discuss any concerns about delays in receiving treatment and appropriate action taken.

HM Coroner

The HM Coroner issued a prevention of future deaths report following an inquest into the death of a patient following a domestic fall. It was found that a referral to the acute diatetic service was not responded to in a timely manner and that there was a training requirement in relation to the diagnostic process to assess a patient's nutritional need.

Safeguarding

The Health Board has participated in multi-agency reviews during 2018/19. Child Practice Reviews (CPR) and Adult Practice Reviews (APR) are commissioned under the Social Services and Wellbeing (Wales) Act 2014. These are formal multi-agency reviews which are the foundation for producing organisational learning, improving the quality of work with children, young people, their families and adults and strengthening the abilities of services to keep people safe.

Learning from these reviews has highlighted that practitioners need to ensure their record keeping meets the required standards. Record keeping practice is subject to audit to ensure that standards are maintained.

An area of good practice is the Midwifery Information Sharing Pathway. It is intended to assist in the transfer of safeguarding information following the antenatal initial assessment from Midwife to Health Visitor and GP and vice versa. In adhering to this procedure, staff will become increasingly effective in the lawful, secure sharing of information, for the benefit of vulnerable babies who may be in need of protection, during the ante and post-natal period.

A Domestic Homicide Review is commissioned under the Domestic Violence, Crimes and Victims Act 2004. This is also a multi-agency process to identify where lessons can be learned to improve outcomes for a person who has died as a result of violence, abuse or neglect by a person they are related to or been in an intimate personal relationship, or a member of the same household.

These reports generally produce recommendations for agencies to improve working together to share information which could help to protect people who may be at risk. The themes for the Health Board include the need to improve practitioner's awareness that domestic abuse affects older people. We have commissioned training from the Safeguarding and Access to Justice Lead at the Older Person's Commissioner's Office to help raise awareness of our staff and have publicised the Information and Guidance for Older People and Domestic Abuse. We are also rolling new training called Ask and Act to promote awareness of violence against women, domestic abuse and sexual violence, which means staff will have the knowledge and skills to identify when people have potentially been affected by domestic abuse and improve the response by working in partnership with others.

Effective Care

Providing the right care and support for people, as locally as possible and empowering each person to contribute to their own care

We want to make sure that you get: the right care and support, as close to where you live as possible; the right care and support to look after your own health and wellbeing; and you receive care and support to stay healthy, that is based on good research.

Development of Hip Fracture Pathway

Following review of the management of hip fractures across the Health Board, there were unnecessary differences in practice for the management of these. A new pathway for hip fractures is being trialled so that the same practice is applied for any patient admitted to hospital with a hip fracture. This work will be expanded if the trial is successful, to capture as many orthopaedic patients as possible ensuring the same standards apply for the period after surgery.

Withybush Hospital has developed a Hip Fracture pain protocol. Following surgery to repair hip fractures, patients will receive safe, effective pain medication with minimal side effects which will also help to reduce the time they need to spend in hospital. An evalutation of this work is currently being undertaken.

Medicines Management Support

The South Carmarthenshire Rapid Access Multidisciplinary Service (SCRAMS) in Prince Philip Hospital with new investment is now providing a clinic 5 mornings a week. The pharmacist working within the team completes a full medication review during the clinic, stopping any medicines which could be potentially causing harm, are no longer required or increase the risk of falls. Between September 2018 and April 2019, 266 patients were seen, with 293 medicines stopped and all patients GP records updated the same day.

Minor Injury Unit at Prince Philip Hospital has a pharmacist that is reviewing patients admitted with a fall or an injury sustained from a fall. The pharmacist can identify any problems the patient is experiencing with their medicines and identify any side-effects or adverse drug events caused by medicines. Between September and November 2018, 53 patients were reviewed with appropriate referrals being made to the Carmarthenshire Rapid Access services, Transfer of Care and Liaison Services, and other specialist clinics and services.

Within Rheumatology an advanced pharmacist will be joining the team to provide medicines management clinics to give medical advice to patients on certain medications and undertake reviews to ensure safe management.

Community Pharmacy Palliative Care Medication Service support community health staff in accessing palliative care medication. Community pharmacies (3 in each county) participate in this service. Since the service was introduced in April 2017, there has been increased access to the specified medication enabling patients that require specific medication in urgent situations to receive this without delay.

North Pembrokeshire Cluster Pharmacists continue to support GP practices across North Pembrokeshire in a wide range of services, including Anti-Coagulant clinics (for patients who require medications to reduce blood clots), dressing prescription reviews, support with prescribing for continence and stoma patients and provision of flu clinics.

Following a successful trial using an alternative healthcare professional to work with a GP practice to undertake an Acute Home Visiting Service, the service will recruit a nurse or paramedic into an advanced practitioner role to support this. The service will operate 3 days a week across the 9 GP practices in North Pembrokeshire. This means that patients will be able to receive more care and treatment in their own home.

South Pembrokeshire GP Cluster – occupational therapists are supporting individuals living with a chronic long-term condition to help plan for an expected change at some time in the future. Patients are receiving timely 'one stop assessments' and with signposting, receiving early intervention allowing self-management; referrals for ongoing rehabilitation with the community team where appropriate. Between April 2018 to March 2019, 544 occupational therapy assessments have been undertaken, with 1070 occupational therapy follow ups generated from these assessments. Eight hospital admissions have been prevented.

For patients who have been admitted to hospital, increasingly, it is becoming evident that they are able to return to their homes earlier, as a result of occupational therapy services working within the GP practice.

Vocational clinics are provided by the occupational therapists, supported by Swansea University, to support people with musculoskeletal (muscular or bone) problems or mental health problems to stay in or return to work earlier by providing individual occupational advice. We will soon introduce an automatic referral process for an occupational therapy assessment for patients with musculoskeletal or mental health issues in employment.

A pharmacist has been working with the cluster for 2 years and 4 out of 5 practices now employ a pharmacist as part of their clinical team. A musculoskeletal physiotherapist will soon be employed to work alongside the GP as a first point contact for patients with musculoskeletal problems. The benefit to patients of receiving physiotherapy soon after attending their GP with a problem will be significant and will enable them to self-manage their condition. The physiotherapy input into the education and training for the clinical teams will also be invaluable. This work will have a positive impact on the number of referrals required to hospital orthopaedic teams, reducing the need for unnecessary investigations.

Patient Knows Best

The Health Board is currently participating in a project with the Patient Knows Best system which improves patient access to their on line (electronic) information and records, and provides access to advice and communication with health care staff. The first service to trial this is the Respiratory Service, within the following 4 patient groups:

- **Interstitial Lung Disease (ILD)**
  For patients with a diagnosis of pulmonary fibrosis, the service will allow the clinical nurse specialists to communicate with patients in a secure way, improving the access to advice and support.
- **Smoking Cessation**
  Patients who are referred to the service from Rapid access lung/lung cancer clinics in Glangwili General Hospital and Prince Phillip Hospital are supported by the Smoking Cessation Practitioner who has access to use their records and can provide educational materials.

- **Rare Lung Disease**
  The system will connect multiple users in the management of their health and will be linked to the charity WORLD (Wales Orphan and Rare Lung Disease), which supports people with rare lung disease and promotes the understanding and awareness of rare lung disease.
- **Pulmonary Nodule** (small masses of tissue in the lung)
  When patients have received scans, they will be able to access their results without any delay, without the need to attend appointments and this will allow the patient to work with the team to monitor and manage the condition.

This exciting trial project will be evaluated and if successful will be considered for other services, improving patient access to information and support without the need to travel to appointments.

Pacesetter Programme

The Pacesetter Programme involves a team of GPs working alongside community services, pharmacists, voluntary organisations, social care agencies and others, often on the same site to populations of 10,000 or more. There are currently a number of programmes in place and we see this as one of the ways in which all health and care agencies will work together in future to ensure better access and preventative care in the community:

- Asthma management and diagnosis/Lifestyle Pods – collaboration between Meddygfa Taf and Coach and Horses Surgery to develop services.
- Physiotherapy Services – to recruit a physiotherapist to be utilised across Furnace House, Morfa Lane and Meddygfa Tywi; and another physiotherapist to work as part of Meddygfa Sarn, Coalbrook and Tumble and Cross Hands surgeries.

Autumn Arrival for Maternity Multi-million Scheme

Following the Welsh Government announcement of £25.2 million investment for the second phase of improvements to Glangwili Hospital's obstetric and neonatal facilities, work began in October 2018.

The plans will provide a modern environment for the delivery of obstetric and neonatal services at Glangwili, and address the urgent areas of concern highlighted in the Royal Colleges' report into the maternity, neonatal and paediatric services provided by the Health Board. The Cabinet Secretary for Health and Social Services, Vaughan Gethin, announced the funding during a visit to Glangwili's obstetric and neonatal facilities in April. The development will significantly improve the patient experience and accommodation for families.

Improvement in the Quality of Care and Treatment Plans within Mental Health Services

A new process has been designed by the Mental Health Team with the invaluable support of service users, to review the quality of care and treatment plans. Staff feel very positively about the process as it provides immediate feedback and learning and identifies any training needs.

Breaking the Cycle

Breaking the Cycle has been embraced by staff in Withybush General Hospital. It is a project which finds new way of working to improve the effectiveness of services and experiences for our patients. Fifteen individual improvement projects were implemented from September 2018 on a number of wards / departments across Withybush and South Pembrokeshire hospitals. Positive changes identified include the opening of a surgical assessment unit, faster blood testing and improved review arrangements on ward areas.

Holistic Needs Assessment (HNA) Clinics in Urology

Holistic Needs Assessment (HNA) Clinics in Urology will assess the needs of newly diagnosed patients to offer appropriate support and advice on services and support. A Macmillan Urology Support Worker will act as the single point of access, provide telephone and face to face advice, provide information, and monitor all aspects of care co-ordination to improve the patient journey and experience.

Pain Study Day

Over 60 health workers attended a study day to raise awareness about the current management and support for acute and chronic pain sufferers. Further days are planned across the Health Board area.

Joint Working in Ceredigion

All agencies involved in health and social care work closely to ensure patients and clients are able to access the most appropriate help they need at the right time and place, without unnecessary admissions to hospital.

Porth Gofal is one aspect of this work which provides a single point of access to receive, track and distribute referrals across health and social care. Weekly discharge planning meetings occur with staff from the hospital, community nursing and social services which ensures a safe transfer for the patient making sure all services are in place as needed.

The continued use of integrated (health and social care) beds provides a safe environment for patients who need a slightly longer assessment and rehabilitation period. On a larger scale of joint working, which includes the ambulance staff, police, mental health, community health teams, physiotherapy, occupational therapies, hospital nursing and medical staff, the team comes together to review cases for them to put in place appropriate support to prevent unnecessary hospital admissions and prevent falls at home.

Aberaeron Health and Wellbeing Centre

The residents of Aberaeron and surrounding district are looking forward to seeing the opening of their new Health and Wellbeing Centre in August 2019.

Cylch Caron

Cylch Caron is an exciting partnership project being developed in Tregaron between the Health Board, Ceredigion County Council, Mid-Wales Housing and the Welsh Government. The scheme will consist of a GP surgery, community pharmacy, outpatient clinics and community nursing and social care facilities, as well as extra care flats and integrated health and social care units.

Cardigan Integrated Resource Centre

Cardigan Integrated Resource Centre is part of the £50million Bath House development scheme in Cardigan. The aim of the project is to improve access to rural services to achieve and sustain the greatest degree of independence for people living in and around Cardigan by providing services which are flexible and responsive to the individual's needs.

The purpose-built facility will provide patients and clients with easy access to modern services, offering a one stop approach. The centre will incorporate a full range of community and social care services together with voluntary services. Staff being located on one site will provide the opportunity to share knowledge resulting in improved standards of care for patients, clients and carers. By enhancing working conditions it is expected to assist in the recruitment and retention of staff. The completion is planned for December 2019.

North Ceredigion Community Mental Health Team

Lower levels of admission into hospital are being seen following the introduction of a daily meeting of staff from the Community Mental Health Team and the Crisis Resolution Home Team to review patients and allocate the most appropriate team to support the needs of the patient.

The team has started a project with Coleg Ceredigion staff and students to tackle the stigma of mental health in young people. Weekly meetings with Aberystwyth University are held and the direct referral pathway for students has helped many who are in need of support and access to the service.

Waiting room facilities at Gorwelion have been transformed in to a large café style waiting area with tables, chairs and sofas. This is having a positive impact on patient experience, and better engagement among staff and service users.

Lindsay Leg Club

Lindsay Leg Club is a Ceredigion community based treatment, health promotion, education and ongoing care service for people of all age groups who are experiencing leg-related problems. The Leg Club staff work in a unique partnership with their members and the local community in a social and friendly setting that promotes understanding, support and informed choice. This is a drop-in service where a cup of tea or coffee and a chat is available while awaiting treatment.

The types of problems that can be treated range from skin tears on the legs, leg ulcers to difficulties in walking. For many people who suffer with leg conditions their main problems are associated with pain, infection, wound leakage, immobility, loneliness and isolation. By accessing the club, support, help and companionship can be found.

Changes in the Care Approach for Patient Falls in Ceredigion

It is estimated that 1 in every 15 people in Ceredigion are at risk of falling each year. Falls in older adults can have a significant impact on the health and life expectancy of a person but are, in many cases, preventable. Staff working together across health (including hospital, primary and community care), leisure, social care, housing and voluntary services are trying to reduce the number of falls by supporting people with prevention techniques to reduce their risk of falls. Research support is provided by Aberystwyth University.

Case studies:

- Early intervention to maintain independence – fear from falling whilst getting in and out of the bath resulted in the installation of a hand rail which the patient found very useful and provided assurance. Risk assessment around the house resulted in the increased awareness of hazards which were rectified.
- Response to a presenting condition – a patient was referred to the Safe and Steady Clinic and from assessing the patient, a vitamin deficiency was diagnosed and corrected. Following a course of movement rehabilitation, the patient's balance and way of walking had improved so much, the fear of falling had decreased, which allowed the patient to walk to town and spend time in the garden.

The service now has 5 Postural Stability Falls Instructors running programmes across the county.

The Digital Plan

The Digital Plan will see all nursing records across all areas of practice becoming digital (electronic). This will provide one standard set of national assessments and documents to support the provision of safe and effective care.

Mortality Reviews

Learning from any deaths in our care help us to improve the quality of care we provide to our patients, and where we need to do more to improve. We have been reviewing this process and ensuring that any deaths are reviewed within 28 days. There has been a significant improvement with 89% of cases being reviewed within this time frame, and lessons learned being shared across the Health Board.

Dignified Care

Ensuring people are treated with dignity and respect and they treat others the same

We want you to: get good quality care from all health services; to ensure you are listened to and always treated with kindess, dignity and respect in all health care services.

Working to become Dementia Friendly

Hospitals are an unfamiliar place to most patients who are admitted, but for patients with dementia this unfamiliarity can be even more distressing. We are providing a 'dementia friendly' environment for patients in our day surgery units. This includes dementia friendly coloured flooring, notices in toilets to minimise the risk of disorientation, and the engagement of all staff. A dementia nurse will provide support to patients who are admitted for surgical procedures, who also have dementia, can be cared for in an environment that minimises the potential for increased confusion and anxiety. This is also reassuring to carers and relatives.

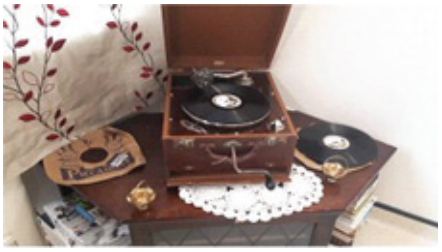
We have introduced Digital Reminiscence Therapy in two elderly care areas, which helps patients with dementia and elderly inpatients to have a more comfortable stay by providing access to archives of historic photos, music, games and by allowing patients to take their own photos. There are a number of benefits of this therapy including reducing social isolation, offering an enjoyable and stimulating activity, promoting self-worth, and providing a way to sustain relationships with loved ones. We have also seen staff benefits as this initiative provides an opportunity for our staff to better understand the patient's history, behaviours, personality, likes and dislikes.

We have seen a reduction in the number of incidents involving inappropriate patient behaviour, including episodes of aggression to both staff and other patients since the introduction of the system. There has also been a reduction in the number of inpatient falls by 87.5% in these areas, supported by the introduction of a range of preventions such as patient alarms, low level beds and training. We believe this system has significantly contributed to this overall improvement by giving patients additional opportunities for social interaction, stimulation, music therapy and other reminiscence activities. It is the intention to expand this initiative across a number of medical wards within our hospitals. This project was successful in being shortlisted as a finalist in the 2019 Patient Experience Network Awards.

The following patient story highlights the value of this project. Mrs James Story:
http://www.wales.nhs.uk/sitesplus/documents/862/AQS%20Patient%20Story.mp3

Cadog Ward steps Back in Time

The medical frailty ward at Glangwili, has been transformed in to a Welsh parlour, recreating a homely environment for frailty and dementia patients. The ward staff understand that being in hospital can be stressful therefore they wanted to create an area whereby patients can relax, socialise during the day and participate in activities. Having recreated the day room, patients are keen to spend time in there, especially at meal times, which has improved the nutrition and hydration. They are supported by our frailty support workers and ward staff to get up, get dressed and leave the bedside areas and participate in social activities and an exercise class conducted by the ward physiotherapy technician.



Multi Agency Care Assessment Meeting (MACAM) Project – Supporting Patients with a Learning Disability in Hospital Environments

The Ward Environment

We are pleased to share with you the work we have been doing to support our patients with a learning disability that have to be admitted to hospital. We are delighted that this work has also been recognised nationally and was a finalist at the Patient Experience Network Awards.

The following patient experience occurred within one of our wards at Withybush Hospital, which prompted changes in practice:

Patient A was admitted with a medical condition due to self-neglect and mis-management of daily medications. Patient A had no verbal communication skills and staff had to observe for non-verbal communication signs. Patient A lived alone and no history was available on admission from community teams or knowledge of next of kin. No learning disability passport was available, it was not clear who the key worker was to discuss the care package and there were problems on the ward which led to a patient safety incident being reported and staff feeling that they were failing the patient by not providing a good patient experience. The main cause related to a breakdown in communication. The end result was a poor outcome for the patient who stayed for 5 months in hospital until a care plan could be safely agreed.

Following this case, a full review was undertaken as staff morale was very low, and the team introduced a system which actively involved people with a learning disability and their carers in the learning process. Following this work, which was greatly valued and appreciated by all involved, the following case study shows how the process has changed and has led to better outcomes and experiences for patients and our staff:

Patient B was admitted onto the ward with numerous medical conditions in addition to learning disabilities. Prior to admission, Patient B had lived with family until diagnosed with dementia and was subsequently transferred into a specialist home. Patient B was described as liking to joke and laugh, and had been sociable up until 6 months prior. On admission staff immediately instigated the Multi Agency Care Assessment Meeting (MACAM) process upon admission as follows:

- The Discharge Liaison Nurse (DLN) set up twice weekly meetings on the ward within 24 hours of admission, this meeting included all relevant staff involved with the patient, including social worker and manager of the care home.
- Discharge Liaison Nurse was the key worker who was involved on a daily basis with the Ward Sister and kept communication open between all.
- An Advocate was nominated and invited to each meeting.
- There was a twice weekly review of progress and treatment plan, with full family involvement ensuring the team were aware of the patient's personal care needs which would enhance Patient B's stay on the ward, for example the ward attempted to mimic the previous sleeping pattern from home and the patiet's favourite music was played regularly.
- Sadly Patient B deteriorated in terms of his physical health whilst on the ward and the decision was made through the Multi Agency Care Assessment Meeting (MACAM) to provide palliative 'end of life' support in his care home. His family were supported through this difficult and emotional process to understand and agree with this approach, they were active participants in the planning of his discharge back home to die in familiar surroundings.
- The excellent communication in this case led to seamless discharge planning and Patient B died where he would have wanted to be, surrounded by his friends and loved ones.

Consultant said:

" the patient was centre of all care, open discussions were available at each meeting allowing all personnel to input on best outcome, an excellent example of MDT working "

Family said:

"fantastic communication throughout I felt reassured that my relative was getting the best management "

Ty Bryngwyn Hospice Refurbishment

A £683,000 refurbishment project for Ty Bryngwyn Hospice in Llanelli has commenced. The first phase of the project will be funded by Hywel Dda Health Charities and will see major improvements to the main entrance, reception and day services area, along with the addition of a designated group/therapy room and clinics. Phase 2 is funded by the Ty Bryngwyn Hospice Committee and will include improvements to the six bedded

inpatient unit along with the development of a new seventh bedroom with en-suite facilities and the ability to support families during the stay.

Working Together to Improve Long-term Care

The Long-Term Care Service has been working with staff, patients and relatives to transform the way long-term care is delivered. Identification of patients that need long-term care is done at the earliest stage following admission so that this can be planned appropriately and there is ongoing communication. Support and advice is given about the process of supporting patients back to their own home or into their chosen nursing home, with information about the package of care or care home chosen and what to expect when they are discharged from hospital.

Dignified Care for Transgender Patients

We have accepted that within the Day Surgery Unit there is less than appropriate provision of dignified care for Transgender patients listed for planned surgical procedures. With advice from the Equality and Diversity Team further training is being provided to ensure we enhance the care provision for our transgender patients and provide a higher standard of nursing care, through a better understanding of the individual needs of patients who identify as Trans met/Trans women/non-binary.

Bladder and Bowel Continence

The Continence Service has identified long delays for patients who require routine referrals to be seen by a Specialist Continence Advisor. A self-management programme is being developed, which will involve an education session for the patient, in partnership with the Expert Patient Programme and Continence Clinical Nurse Specialist (CNS) with support from the specialist nurse on completion of the programme. We are delighted to say that this programme has been awarded the Bevan Commission Exemplar status.

A New Prescription Service

A new prescription service was introduced in Ceredigion, by the Clinical Nurse Specialist for both bladder and bowel care. This service allows the patients who need the specialised products for their health and wellbeing to access the products and also receive the specialised review by the Nurse Practitioner. At this time the nurse would be able to advise and help resolve any issues the patient may be having and consider the use of any new products to meet their needs. Access to this service is by a Freephone number. Early feedback from patients indicates that they find this new service to be positive but a full evaluation will be undertaken.

North Ceredigion Advanced Nurse Practitioner

North Ceredigion Advanced Nurse Practitioner will ensure all frail individuals have specialist assessments to maximise their independence. We are looking at developing a Frailty Service across the Health Board which provides support to district nursing, specialist nurses, GPs, palliative care and mental health teams. They will also be working with voluntary agencies such as Care and Repair and social care agencies.

Timely Care

Giving people timely access to services, based on clinical need and ensuring they are actively involved in decisions about their care

We want to ensure: you can get to see a doctor when you need to; your health needs are understood and treated as soon as possible.

To achieve this, the following is some of the new development we have undertaken this year:

111 Service

From 31st October 2018 patients living across our region will be able to dial 111 to access their GP Out of Hours service and NHS Direct Wales – making it easy to get the advice, support or treatment that is right for them all in one place.

The free-to-call phone number will make it easy for patients to get urgent healthcare support if they are feeling unwell or if their own surgery is closed. The scheme is a partnership between the Health Board, Welsh Ambulance Service Trust and Welsh Government.

Pharmacy 'Walk In'

A number of community pharmacies across Carmarthenshire, Ceredigion and Pembrokeshire are Pharmacy Walk-in Centres. The pharmacist will provide treatments to patients for a range of conditions from hay fever to head lice and eye infections to back pain. This service is provided by **93** community pharmacies in our area. Centres will also offer emergency hormonal contraception, emergency supply of medication, smoking cessation services, sharps return service, flu vaccinations and medicine reviews.

To see where your nearest Pharmacy Walk-in Centre is and to find out more about the services your local pharmacy offers, please visit: **www.hywelddahb.wales.nhs.uk/communitypharmacy**

New Ambulatory (Walk-In) Emergency Care Units

We are developing new ambulatory (walk-in) emergency care units at Bronglais, Glangwili and Withybush hospitals. This is a service that provides same day emergency care to patients in hospital. Patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted overnight. We treat many common conditions including headaches, deep vein thrombosis and diabetes.

Improvement in Waiting Times

Improvement in the waiting times from referral to treatment has occurred in all of our services during the year, as at end of March 2019, there were no patients waiting longer than 36 weeks from the time of their referral to treatment within our hospitals, which is a significant improvement in service quality and patient experience.

'Home First'

We know that it is best for a patient's health and well-being to be treated away from hospital, ideally in their own home, when it is medically safe to do so. The 'Home First' process encourages people to find the best way to support their healthcare needs and help them to be as independent as possible. There are a number of new developments that we have introduced to help us achieve this, Joan's story is an example:

Joan fell at home and was taken to A&E at Withybush, she was assessed by the Multi Agency Support Team (MAST team) that consists of physiotherapy, occupational therapy and district nursing, along with a dedicated Social Worker part of the discharge team. The support provided enables people that do not need to be admitted to hospital to return home, with appropriate equipment and relevant support.

Joan advises that she received a good service from the hospital and the "staff were cheerful and nice to talk to". She feels that this helped her in regaining confidence in putting weight on her leg. She spent one night in A&E and was pleased to be able to go home as she felt "confident in standing as the staff were kind and helpful".

Joan was discharged with a toilet frame which helped her be independent. She was delighted with the equipment and "didn't know you could have all these things, its wonderful".

Ambulance Response Times

We know that achieving the 8 minute Welsh Government target response time for ambulances is a challenge within the area, the demand on emergency care and ambulance services is ever increasing. Advanced practitioner roles in out of hours care were introduced during the year. Lifting aids will be placed in care homes along with re-training of the 'IStumble' programme, which is an NHS falls risk process, which assists staff in nursing and residential homes to properly assess patients to determine whether an emergency ambulance needs to be called.

When A&E departments are busy, and all of the assessment areas are full, this can cause delays in ambulance staff being able to transfer patients from the ambulance into the hospital. We are taking action to ensure that patients are not delayed in the ambulance and crews are released quickly to attend the next call. This work includes the recruitment of physicians at Bronglais and Glangwili hospitals and nurse led services being developed at the minor injury unit at Bronglais.

Treat and Repatriation Project – Cardiac Care

We are extremely pleased with the results of the work we have undertaken with our colleagues in Morriston Hospital, Swansea to provide more timely care for our patients requiring cardiac assessments and treatment. The improvements both in relation to the timeliness of assessment and treatment and clinical outcomes have been significant. For example, the average waiting time for our patients who require an angiography procedure at Swansea has reduced from 10 to 4 days.

Day Surgery Improvements

A new pathway for trauma patients has been introduced, working closely with the pre-assessment clinics, the screening process identifies trauma patients who would be suitable to receive day surgery rather than an inpatient hospital stay. Patients are given a date for surgery before leaving clinic. They are also provided with patient information to prepare them for their visit to the surgical unit and given 'do's and dont's' prior to receiving physiotherapy following their procedure.

Same Day Surgery Admissions for Warfarin Patients

Patients who are required to take Warfarin (medication to thin their blood) are now admitted to hospital on the day of surgery, rather than to a ward the day before, due to the need for tests to be undertaken before surgery. Tests are now available within 30 minutes and patients are given priority on the operating list, reducing their risk from harm.

Ophthalmology Care

During the year, you have told us of your concerns about access to timely ophthalmology treatment and appointments. We have introduced a number of new services to improve access to treatments and release the consultant ophthalmologists to provide specialist eye care to reduce the waiting times in this area. The following are some examples of the work we have been doing to make improvements:

- **Introducing Intra vitrial nurse injectors** into the retinal care of ophthalmology has reduced delays in patients receiving treatment for Wet Age-related Macular Degeneration. All intra vitrial injections are administered by a nurse injector also creating continuity of care to patients. In future, we plan for the nurses to review ophthalmic test results and prescribe treatments.
- **Glaucoma nurse specialists** work closely with the ophthalmologist to provide treatment for patients. These new posts have reduced the waiting times for consultation.

Chronic Pulmonary Disease

Patients with chronic respiratory disease are experiencing long waiting times in receiving rehabilitation, care and advice in order to live their lives as fully as possible. The Pulmonary Rehabilitation Service now has a central referral service, with different routes for the patient to receive the most appropriate care and treatment to meet their individual needs. We plan to expand and improve on this service across the area. The patients will benefit by being discharged home earlier and reduce the need to be admitted to hospital.

The Pulmonary Rehabilitation Programme

The North Ceredigion locality has been working with the Pulmonary Rehabilitation team to deliver pulmonary rehabilitation sessions via video-conferencing in community settings. The rehabilitation programme will be delivered with a class of 10 patients and transmitted in real time via video-conference to another site more local to patients' homes, to a class of 8 patients.

The feedback suggests that using video-conferencing to deliver this service is an effective alternative to the face-to-face programme. In a patient focus group they described how the programme had transformed their lives, by building their confidence and meeting new friends. This will allow patients living in rural areas to access the rehabilitation closer to where they live. This project is recognised by the Bevan Health Technology Exemplar and has won 2 national awards during 2018. Future plans are to expand this service across our area and potentially all of Wales (through the Bevan Commission).

Dental Services

The assessment service for minor oral surgery and adult oral surgery (general anaesthetic) is in place to ensure patients are seen by the service appropriate for their needs and identifies any immediate queries about the general dental practice referral, subsequently reducing unnecessary delays and waiting times for patients.

The Routine Access Service supports those patients who require dental treatment prior to commencing hospital care treatment such as chemotherapy and cardiology in a timely way.

Access to General Dental Services remains challenging and will be one of our priorities for improvement in the coming year. Patients can access dental treatment whilst waiting for access to long-term dental care. We will be reviewing all of the services, including the routine access service, and the urgent access service to ensure these are effective.

We know that waiting times for orthodontic assessment and treatment is a concern and we are looking at ways that we can improve this for our patients. The Orthodontic assessment contract ended on the 31st March 2018 and the funding from this contract was invested in providing additional orthodontic treatment to reduce the waiting time, but we recognise that there is still a lot of work to do to improve this position.

Community Dental Services

Community Dental Services are working closely with Powys Teaching Health Board to provide a wider range of community dental services across Mid Wales, in particular North Ceredigion and North Powys.

Patients in this area are seeing a reduction in travel time and waiting times. A further development will see the expansion of the Newtown service to accept referrals for the specialty of Oral and Maxillofacial surgery. Eventually we hope to see a community led sedation/general anaesthetic service based at Bronglais Hospital.

Individual Care

Treating everyone as an individual, ensuring their care meets their own needs and responsibilities

We want you to be treated fairly to make sure that you have a healthy life; that you are treated as a person with your own needs; and that you get care and support in Welsh if you need to.

Your views are very important to us, we are listening to you and your feedback about your experiences of care.

Putting Things Right

We received 381 formal complaints between 1st April and 31st December 2018. In addition, 917 cases were received and managed by the Patient Advice and Liaison Service and a further 1155 queries and 'on the spot' cases were addressed by the Patient Support Contact Centre.

Access to General Practice and Ophthalmology services were the issues of most concern to you, as well as waiting times for appointments and cancellations of appointments.

Improving Communication – Text Messaging

We appreciate that one of the biggest areas of concern is around the outpatient appointment process. We have introduced a new text messaging service and an appointment reminder service to improve patient experiences in this area and to cut down on the number of missed appointments, which cost us around £4 million a year.

Cancellations of Appointments

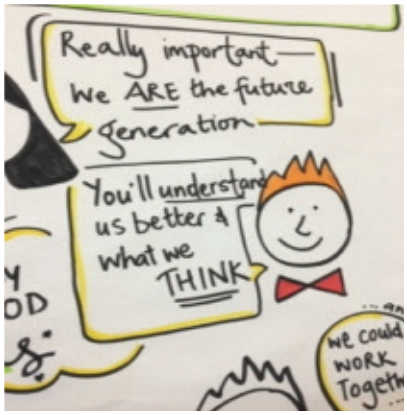
One patient told us "I am suffering from anxiety and stress as a result of you sending me a letter cancelling my surgery at short notice." A recording of the patient's call was played to members of the Health Board to emphasise the impact of short notice cancellations. The Board is now reviewing the process of notifying patients of surgery cancellations, so that the patient receives a call rather than letter, so that any concerns or questions can be addressed during the conversation.

Some of the other concerns you fed back to us were:

You Said	We Did
Phlebotomy service waiting times were unacceptable **"I was told I would not be able to have my blood test, despite having waited for almost an hour"**	The PALS team conducted patient feedback surveys with people attending the Prince Philip phlebotomy service. This feedback allowed us to make a number of changes to the service including improving the information displayed in the area and by providing additional staff at the busiest times.
Nutrition and Hydration needed improvement, particularly the availability of toast provision and beverages	We have developed a pictorial beverage menu for each patient's locker allowing for an extended choice of beverages. Toast preparation has been reviewed and it is now freshly prepared at ward level. Good hydration reduces confusion, dizziness, constipation and risk of urine infections. As part of our infection control work plan, we have introduced a hydration campaign to improve knowledge of hydration, foods used to hydrate and quantity of fluid required for daily health.
"It is difficult to know who does what with all the different colours that staff wear"	The PALS team has visited all wards and clinic areas and displayed posters explaining the different colour uniforms that are in use across NHS Wales.
'Communication needs to be improved and often staff do not introduce themselves or say hello, which does not put me at ease'	Our outpatients departments raised awareness for the #hellomynameis campaign. Reminding staff to introduce themselves and promote compassionate care. This will be promoted across all areas in the health board.
"You are displaying a number of notices that all refer to consultants in the masculine, I am offended as I feel this is misogynistic"	The PALS team removed the notices in the outpatient areas and these will be replaced with gender neutral versions.

Veterans

The Health Board is a partner in the armed forces forum / regional covenant group. Our priority is to implement the priority treatment policy for veterans to ensure that, if a health need identified is attributable to their former military service, that the NHS referral is prioritised. Work is on-going with Welsh Government to develop posters that would encourage veterans to identify themselves with their GP surgery.



The Right Way – A Children's Rights Approach

A successful conference was held in November to focus on the rights of the child and the child's voice within our Health Board. We were pleased that our colleagues in Abertawe Bro Morganwg University Health Board spent time with us to share the excellent work they have undertaken with children and young people in their area, to develop a children's rights charter and children and young people's partnership board. We were also pleased to welcome colleagues from PLANED, University of Wales, Trinity (St Davids) to hear the excellent work that is ongoing to promote the voice of children and young people. Next year we will be developing our own children's rights charter and developing ways to improve our meaningful engagement with children and young people. Work undertaken by the children and young people of Hook CP School as part of PLANED's work on meaningful engagement with children and young people.

Take a Bow, King Hywel

Have you met the latest member of our team? We were pleased to launch our brand new mascot, King Hywel, in December at a special event in Withybush Hospital with children from Wolfscastle School and S4C's Heno. King Hywel has been joining us at fundraising events and presentations across Carmarthenshire, Ceredigion and Pembrokeshire over the last few months.

Celebrating the Welsh Language at Ammanford

A great day of filming was had with the Coleg Cymraeg Cenedlaethol at Amman Valley Hospital, speaking to staff and patients about the importance of using the Welsh language in delivering care to patients. Great to see that a fantastic 82% of staff are Welsh speaking at Amman Valley Hospital!

A Birth Choices Clinic

A Birth Choices Clinic has been established to provide women access to a service that discusses their choices for where and how they wish to give birth. This service specifically supports women who have had a caesarean section in the past, are requesting a caesarean section or planning a birth at home or in a midwife led unit where there are factors that may make birth complicated. We now run 13 clinics per month (increased from 4 clinics) and we are pleased that over 300 women have attended a clinic over an 11 month period. We have seen a decrease in the number of women having a caesarean section by almost 10%.

Critical Care Patient Support Group

We have introduced a Critical Care Patient Support Group, which is open to ex-patients, relatives and NHS colleagues to provide an opportunity to have open discussions about experiences in the critical care units, and following their discharge. This is also supported by the Patient Advice and Liaison Service (PALS) team, to give patients/relatives the opportunity to discuss any issues (positive or negative) they want addressed inside ITU and on ward areas. Volunteer roles will also support patients and families in the critical care units and patient diaries will also be introduced.

Head and Neck Cancer Support Group

We have introduced a Head and Neck cancer support group for patients who have been diagnosed with head and neck cancer. For the patients, this means the ability to communicate and support fellow patients who have suffered with head and neck cancer.

Sensory Loss

Our sensory loss awareness month in November 2018 was very successful, working closely with Wales Council for Blind and Wales Council for D/Deaf people, activities were delivered at all of our hospitals. We are also delighted that the Macular Society are working with us and attending eye clinics on a regular basis to offer assistance to patients.

We have worked with the D/deaf community seeking their involvement in public engagement and consultation activities, and maintaining regular communication to address any issues raised. Within Carmarthenshire work has been on-going within GP services to improve accessibility of services.

The Senior Sister at Outpatients, Glangwili Hospital has been raising awareness of sensory loss with staff members and the public to support Sensory Loss Awareness Month which included the display of a poster highlighting BSL greetings. This means that staff are supported to communicate effectively with patients who are deaf. This will be promoted across all areas.

Understanding Visual Impairment

Patients attending the Day Surgery Unit at Amman Valley Hospital as a result of visual impairments, learn to understand their condition more, what support is available to them and important information about health promotion, such as nutritional requirements, safety and securing advice using special software and an educational TV.

Homelessness

We continue to work with our local authorities and housing providers, contribute to the work of the Regional Commissioning Collaborative for Supporting People and have supported the development of a regional homelessness strategy. Our priority will now be the development of a homeless discharge protocol to ensure patients discharged from our care have appropriate accommodation.

Syrian Vulnerable Persons Resettlement Project

Over the last 3 years, we have received about 150 patients into our area in partnership with local authorities and third sector groups. As a priority we are ensuring there is access to services, including mental health services and interpretation services, to ensure everyone can access our services equally.

Equality and Diversity

During our future of health services consultations on our strategy 'A Healthier Mid and West Wales', we specifically conducted meetings with individuals from protected characteristic groups so that we could learn more and use their input to inform our decision making.

Rhwydwaith LGBTQ+ Hywel Dda
Hywel Dda LGBTQ+ Network

We have taken on board feedback from the Equality and Human Rights Commission on initiatives we can adopt to create, support, and maintain a more diverse and inclusive working environment. One example is the re-launch of ENFYS our LGBTQ+ staff network which supports Lesbian, Gay, Bisexual and Transgender staff. The network aims to create a culture of understanding and collaboration to support both the wellbeing of our LGBTQ+ staff and the Health Board's equality and diversity objectives to enhance the lives of both LGBTQ+ staff and patients. We are actively seeking new members, and meetings have been made more accessible across Health Board sites through offering video conferencing facilities.

We have continued to refresh our equality and diversity training provided to staff to ensure that it is up to date and relevant and reinforces the values of the Health Board. In addition, we have provided diversity and inclusion training on the Destination NHS programme – an exciting programme that we have developed in partnership with Pembrokeshire College which enables students studying a health related qualification to gain experience of working within a health care setting in addition to academic study. For the coming year, we have stated our intention to continuously engage to personalise and tailor our health and care services to the needs and preferences of both individuals and localities, with a focus on supporting people to manage their own care and outcomes. Alongside this, we also seek to offer all staff opportunities to flourish within the Health Board environment.

For more details on progress towards the Health Board's equality objectives, please see our Strategic Equality Plan Annual Reports: **http://www.wales.nhs.uk/sitesplus/862/page/61233**

Investors in Carers (IiC)

The PALS team is able to identify and support families and friends who have become unpaid carers. The PALS team has attended Carer Conferences across the Health Board area and Cardiff. The unpaid carer of the patient will receive information and contact details to seek advice and support which will help them better cope with being a carer. One relative who lives abroad was able to gain support for her parents by contacting the service.

A questionnaire was devised to ensure that carers are also looked after whilst adjusting to coming to terms with what it means when a relative is suffering from illness requiring help and support from the Crisis Resolution Team. On completion of the assessment which covers the carer's physical and psychological needs and ensures they have been given adequate information and learning regarding their relative's condition and treatment plan. The assessment for the carer covers:

- Their caring role and how it affects their life and wellbeing.
- Their health – physical, mental and emotional issues.
- Their feelings and choices about caring.
- Work, study, training, leisure.
- Relationships, social activities and your goals.
- Housing.
- Planning for emergencies.

The assessment concludes with a section on consent and confidentiality of the information the Health Board holds. Staff will be extending the assessment across the service in the coming year.

Care to Share Sessions

Care to Share sessions have been running in Prince Phillip Hospital, and involve organised attendance sessions to wards in the morning or afternoons providing an opportunity for the patient and/or families to provide feedback in a confidential environment at a time to suit them. Care to Share sessions will continue at Prince Phillip and across all hospital and community sites in the future.

NEW Way of Recording Patient Experience Feedback

A new way of recording patient experience feedback is being introduced from January 2019. This will be accessible by wards and departments which will be able to record their own compliments and patient feedback. Following a trial in some ward areas in Prince Philip Hospital and Glangwili Hospital, this will be provided in all areas of the Health Board during 2019-2020.

NEW Putting Things Right Leaflets and Posters

NEW Putting Things Right Leaflets & Posters have been distributed to all wards, receptions and public areas in Primary Care. The replenishment of leaflets and posters is ongoing. Patients can easily access written information regarding the Putting Things Right process with the relevant contact information for our Health Board. The information is available in a wide range of alternative formats such as easy read, audit and large print and in a wide number of different languages or on request to the patient support team (details at end of document).
http://www.wales.nhs.uk/sites3/page.cfm?orgid=932&pid=50738

Welsh Community Care Information System

Welsh Community Care Information System gives community nurses, mental health teams, social workers and therapists the digital tools they need to work better together. Individual care is supported because it will be used by community health, mental health and social services, social workers and therapists to record the care they provide. Cases can be shared or transferred across regional and organisational boundaries if a patient is referred to new services or moved home.

Staff and Resources

Providing information about how we manage our resources and make careful use of them

We make sure that: we use NHS Wales' money in the best ways for people and to help them stay healthy; you can work with health services to help them use resources, like buildings and staff in a better way; and health care staff have good training and know how to care for you.

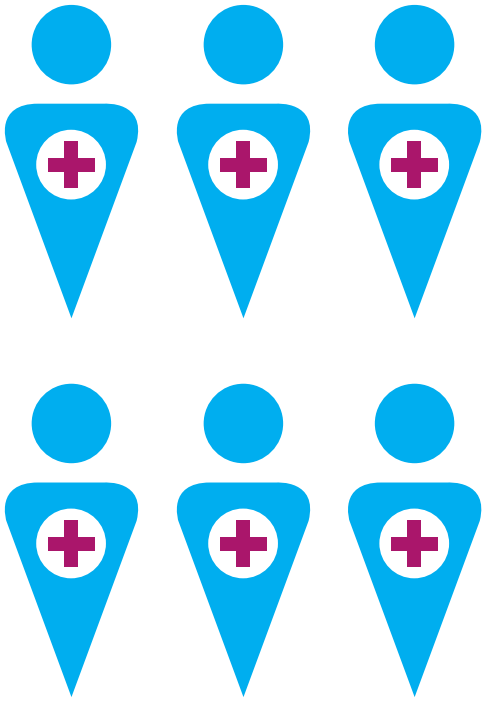
Our staff are the Health Board's most valuable resource and our priority is to ensure that the service has the right staff in the right place with the right skills. 2018 has presented real challenges in recruiting sufficient numbers of doctors, nurses and therapy staff due to national shortages across not just Wales but the UK. The recruitment teams use many ways to improve recruitment, such as advertising nationally and internationally, use of social media and London Transport advertising as well as recruitment events. Recruitment information has been produced including videos which can be found on the NHS Jobs website: **http://www.wales.nhs.uk/sitesplus/862/page/75205**

In 2018, 53 Consultants were offered positions within our Health Board (double the number in 2015). Some specific successes include recruiting experienced registered nurses from Australia, London, Birmingham, Cambridge, Scotland and Cardiff. Student Nurses from: Bristol and West Midlands. Medical Staff from Ireland, Cambridge, Egypt and Nigeria, and GPs from Worcester, Buckinghamshire and Telford. Allied health professionals have been attracted from as far afield as New Zealand.

Social media plays an important part in our recruitment attraction strategy and we have an active presence on Twitter @HywelDdaJobs. LinkedIn is also used as well as headhunting. A bilingual recruitment Facebook page will be launched in 2019 to complement Values Based Recruitment.

'Grow your Own' – A Workforce Development Strategy for Our Local Population

During 2018, we have continued to develop and are currently implementing our 'Grow Your Own' programmes. This programme is aimed at increasing the number of our registered nurses by creating opportunities for existing healthcare support workers and provides an attractive and alternative career pathway for our local population.



During 2018/19, we have supported 17 Health Care Support Workers to enrol on undergraduate nursing degree courses. Thirty six staff are participating in development as part of the scheme, 4 are learning with the Open University, and 32 have accessed the part-time programmes for adult mental health and learning disabilities through Swansea University and the University of South Wales.

We have supported 9 Registered Nurses to return to practice during 2018/19, and we are supporting staff who are Internationally Registered Nurses to undertake development to support an application to the Nursing and Midwifery Council register.

Aspiring Medical Leaders

We ran our first Aspiring Medical Leaders Programme in December with 20 doctors from each hospital site, across different specialities, and several GPs participating. The programme runs for 12 months, with a second programme starting in May.

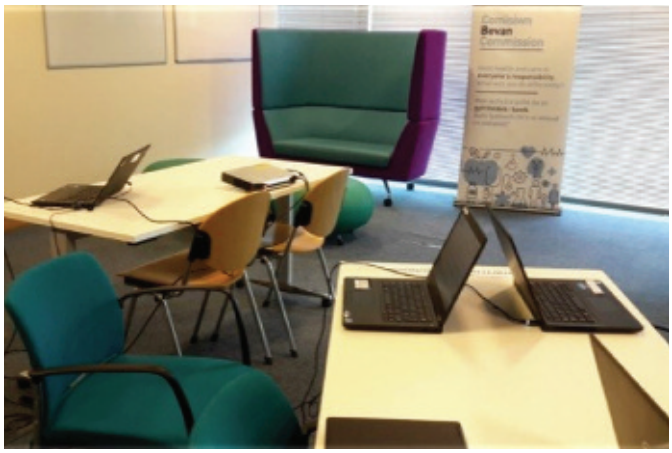
The Chief Medical Officer for Wales in dialogue with our Medical leaders below:

Professor Michael West from the Kings Fund has hosted workshops with our Board and Senior Managers on Compassionate Leadership and creating a culture of care. This has been followed by on-going action learning inquiry by groups of our senior leaders.

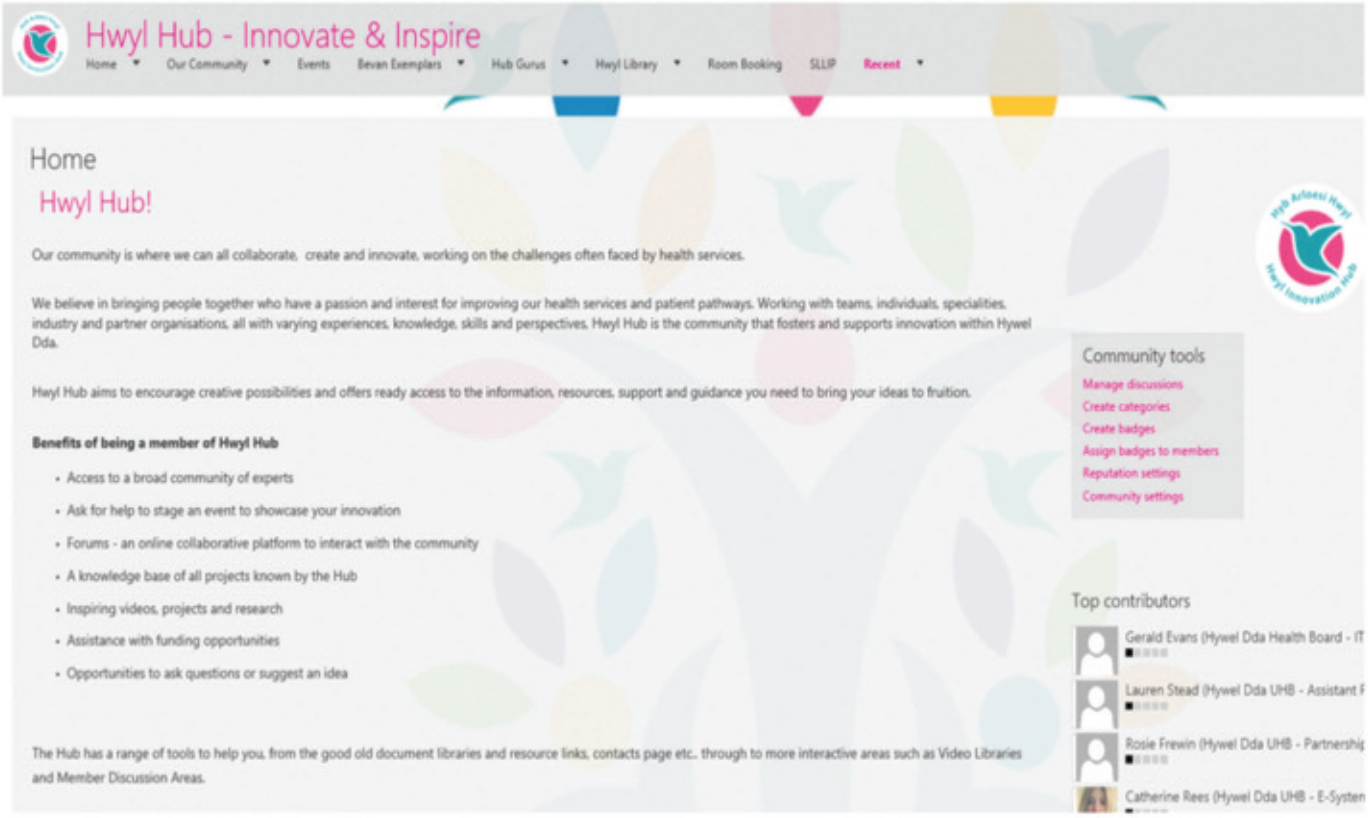
Hwyl Hub – Our Virtual Space

In 2018/19 we have continued to promote a culture of innovation and have had 7 Bevan Exemplar Projects and 3 Bevan Technology bids accepted. We also launched our Hwyl Innovation Hub in July, with a physical space and a virtual space on our intranet to encourage sharing of best practice.

Director General for Health & Social Services, Chief Executive of NHS Wales launching our Hwyl Hub



Part of the Hwyl Hub Physical Space



A Globally Responsible Wales

We are committed to global health and recognise the value of international health engagement for communities overseas and for our local population and staff. To improve staff engagement with international health partnership initiatives we are developing a framework which will integrate with the All Wales Charter for International Health Partnerships. This will provide clear guidance to demonstrate global citizenship whilst progressing professional development.

E-learning

Mandatory Training Compliance for our staff had increased by 12% this year.

Occupational Health Service

We are working nationally to looking at how Occupational Health will develop in the coming years. One of the main developments for the Occupational Health Service in 2019 includes the development of a new health screening programme.

Improving Quality Together

Improving Quality Together is the quality improvement training programme for NHS staff in Wales to improve the quality of services in NHS organisations across Wales by enabling individuals to improve the way they work to deliver better care for patients and service users. It also helps create a better working environment, making life at work less stressful and more fulfilling. Learners are taught a consistent approach to improve the quality of services which helps improvements take place much more quickly and spread effectively.

IQT is provided at 4 levels: Bronze, Silver, Gold and Board.

The Improvement and Transformation Team and the Quality Improvement Team have delivered IQT Bronze training to 81 staff, and 131 have completed the 2-3 day Silver course with an additional 64 employees completing the first day of the course.

Work with Disadvantaged Groups

The work undertaken with the Department for Work and Pensions enables applicants claiming Job Seekers' Allowance to access all our work experience information and opportunities. The Health Board continues to work with the 'Engage to Change' programmes in North Ceredigion and Carmarthenshire to offer opportunities for 6 month paid placements to young people aged 16-25 years who have a learning disability or Autistic Spectrum Disorder (ASD). During the past year, we have had 4 placements and based on the experiences to date, we aim to develop this work further in 2019/20.

Mid Wales Workforce Plan

We are developing a workforce plan for Mid Wales which is within the Health Board's workforce plans and which considers the rurality of Mid Wales. This will support the delivery of a Mid Wales workforce that is sustainable and has the ability to respond to staffing requirements across the area, ensuring Health Board boundaries are not a barrier to services.

The Nurse Staffing Act

The Nurse Staffing Act became law in March 2016 and requires the Health Board to ensure appropriate levels of nurse staffing are in place and to take action if the staffing levels are not maintained. This required that the Board undertook detailed calculations on a six monthly basis of the required nurse staffing levels of its adult medical and surgical wards. We were also required to take all reasonable steps to ensure that these levels were maintained. In April 2017, the first Section of the Act placed a duty on the Board to ensure it had regard to the importance of providing sufficient nurses to allow (the nurses) time to care for patients sensitively. The final Section of the Act will require that, by May 2021, the Board submits a Nurse Staffing levels report, covering the period 6th April 2019 – 5th April 2021, and outlining the extent to which Nurse Staffing levels have been maintained, any impact on patients of not maintaining these levels and the actions taken if levels have not been maintained. In response to this, we have:

- Appointed a dedicated role to lead the Nurse Staffing programme supported, by a senior nursing post to ensure that sufficient capacity is available to support the clinical teams in meeting their responsibilities.
- Undertaken the statutory 6-monthly review and recalculation of nurse staffing levels in adult medical and surgical wards (i.e. circa 32 wards) in Spring and Autumn 2018 and the Spring 2019 cycle has been started.
- For all adult medical and surgical wards, agreed a 2-3 year phased implementation for financial uplifts to each ward for workforce.

- Ten (of the 32) adult medical and surgical wards were identified as requiring prioritised funding uplifts: Across these wards over 40 additional health care support workers have been appointed together with an additional 9 dedicated rehabilitation and frailty workers.
- Across the 32 wards, an additional 13 Sisters have been appointed to strengthen the leadership at ward level whilst additional monies was made available to ensure that the Senior Sister for each ward had at least part of their working week 'protected' to enable them to fully focus on their leadership role.
- The Board and/or its Quality, Safety and Patient Experience Committee have received seven reports during the year to assure that we are meeting our requirements of the Act.
- We continue to work at an all Wales level through a 'Once for Wales' approach to ensure that systems are in place that allow us to review and record every occasion when the number of nurses deployed varies from the planned roster and the extent to which nurse staffing levels have been maintained.

Further to the significant action that has been undertaken during this year there have been no reportable incidents of patient harm in which nurse staffing levels were considered to be a factor have occurred during 2018/19.

Staff Awards and Achievements

We are so proud of our staff being honoured with various awards.

We had many successes at the Royal College of Nursing (RCN) Wales Awards.

Emma Thomas

Emma Thomas has won the RCM Midwife of the Year Award for Wales.

Nominated by local mum Emma Rees, Emma Thomas has been honoured as Emma's Diary Mums' Midwife of the Year 2019 for the Wales region. The prestigious award is one of the Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

On winning the award Emma Thomas, who works in Amman Valley Hospital adds: "What an absolute honour to have won this award. To say that I'm touched to have been nominated is an understatement! Hearing the news that I'd won brought me to tears, I was so shocked, it was so unexpected, it was a wonderful surprise. Emma is one special lady, she's been through such a difficult emotional and physical time over the last nine years. Her sheer determination and strength means she is how a proud mum to her beautiful twins.

Director of Nursing, Quality and Patient Experience, Mandy Rayani said "We cannot easily put into words how grateful we are to all our nursing and midwifery staff who continually demonstrate how they go above and beyond the call of duty to care for our patients. Emma has shown all these qualities and more, and is a shining example of our Midwifery team which provides an exceptional service and support to our pregnant mums in our Health Board area."

Evie Lightfoot – Winner of RCN Wales Nurse of the Year and Community Nurse of the Year

Evie Lightfoot, the RCN in Wales Nurse of the Year, is supporting community nursing staff to recognise and respond to the signs of sepsis, helping to save lives and improve outcomes.

Mandy Rayani, Director of Nursing, Quality and Patient Experience said "I am thrilled that Evie has been recognised for her passion and commitment to improving care for patients living in the community. The process and assessment enabling Evie to be awarded the title of RCN Nurse of the Year in Wales 2018 was gruelling but her genuine desire to make a difference and her ability as a professional nurse leader shone through. As a Health Board we look forward to supporting Evie in her continued development."

Claire Hurlin

Joint Winner of Improving Individual & Population Health Award.

Rachel Griffiths

Winner of Older People's Commissioner for Wales Award.

Janet Edmunds

Runner Up for Safeguarding Award.

Ginny Chappell

Runner Up for Primary Care Nurse Award.

Emma Booth

Runner Up for the Mentorship Award.

Other Awards/Achievements

Teresa Hassell, Community Learning Disability Nurse, won the **USW Nursing and Midwifery Student and Mentor Awards.** She was nominated by Lydia Marsden who said *"Teresa was really supportive and helped me build my confidence by letting me work more independently, and take part in a number of assessments I had not done previously. Teresa also ensured that I was made to feel part of the team and had the opportunity to learn from the multidisciplinary team by going out on a range of visits. Loved this placement and would love to go back".*

Assurance Safety and Improvement Team

The Assurance Safety & Improvement Team won the poster presentation at the National Patient Safety Conference for innovative ways to share learning following patient safety incidents.

Amman Valley Hospital receiving Bronze Award for Investors in Carers.

Psychiatric Team of the Year Award

Outstanding commitment to sustainable service development goes to **Transforming Mental Health.**

Bernardine Rees and Sarah Jennings

Congratulations to our Chair – Bernardine Rees and Sarah Jennings, Director of Strategic Partnerships on recently completing a Welsh course at Trinity Saint David's University.

Neonatal Outreach Service in NT Awards

Congratulations to our Neonatal Outreach Service and Nursing Lead, Kelly Brown on reaching the finals for the Nursing Times awards 2018 in the Child and Adolescent services category.

Puffin PACU WGH

Winners of the Early Years category of the Western Telegraph Health and Care Awards 2018.

Success for Solva Surgery

The Royal College of General Practitioners, at a recent awards ceremony, announced that Solva Surgery was to receive the highly prestigious RCGP Wales Practice Team of the Year Award, 2018. This is the second time that the Surgery has won the award where practices are nominated by patients. This award recognises the positive impact on patients' lives and outstanding level of care delivered by the whole healthcare team working within a practice including the practice nurses, community nurses, administration staff and the wide variety of other attached healthcare professionals.

What We Will Do In 2019/20

What We'll Do	How We'll Measure it
Staying Healthy	
Flu Vaccination: increase uptake of flu vaccination.	Monitoring update.
To reduce smoking rates in pregnancy.	Monitoring update.
Healty Child Wales Programme: Screening, immunication and supported child development.	Monitoring visits to mother and babies 10 to 14 days old and vaccination rates.
Safe Care	
Sepsis: early identification and staff education. Expansion of monitoring and escalation processes (NEWS) in community services.	Monitoring of compliance with sepsis 6 bundle. Evaluation of community NEWS.
Hospital Acquired Thrombosis: reduction in number of incidences.	Monitoring of the use of the risk assessment and incidence.
Pressure Damage: reduce the amount of avoidable incidents experienced by patients in our care.	Monitoring of number of incidents.
Improvment in the quality of clinical documentation.	Documentation Audit reports. Review of concerns investigation data.
Effective Care	
Ongoing implementation of hip fracture pathway.	Evaluation of the work underway within the Health Board.
Improvement in the quality of care and treatment plans within Mental Health Services.	Audit of the documentation and review of training.
Ensuring patients receive care in the most appropriate care setting and encounter minimal delays as they move through the different stages of care.	Review of monitoring and audit data. Review of concerns information.
Dignified Care	
Multi Agency Care Assessment Meeting (MACAM) project: continue with project and expand to other hospital areas.	Monitoring of complaints and compliments.
Establish a collaborative project to improve communication with patients, their families and carers.	Monitoring of complaints and incidents. Monitoring of project objectives and agreed actions. Evaluation of the impact. Patient experience feedback.

What We'll Do	How We'll Measure it
Timely Care	
Continue to improve access to Ophthalmology Care.	Monitoring of incidents, complaints and compliments. Monitoring of waiting times for glaucoma consultation.
Improve the waiting times for follow –up outpatient appointments.	Monitoring of waiting times and incident, complaints and compliments.
Reduce the waiting times for patients requiring assessment/treatment in emergency departments.	Monitoring of waiting times and complaints, compliments and incidents.
Improving access to Orthodontic & Dental assessment and treatment.	Montitoring of referral to treatment times.
Improving access to assessment and diagnosis for Autistic Spectrum Disorder/ Attention Deficit Hyperactivity Disorder.	Monitoring of waiting times and incident, complaints and compliments.
Treating People as Individuals	
Implementation of a Patient Experience Charter/ Children's Rights Charter.	Increase in feedback from patients, families and carers received; Improve engagement with children and young people.
Implement the revised Welsh Language Standards.	Compliance against the standard.
Our Staff	
Implementation of the Aspiring Medical Leaders Programme.	Monitor update and evaluation of the programme.
Implementation of the 'Grow your Own Programme'.	Monitor and evaluate the programme.

Engagement and Feedback

You can join our involvement and engagement scheme – Siarad Iechyd/Talking Health – by:

- visiting: **www.talkinghealth.wales.nhs.uk**
- calling: **01554 89905**
- writing to: **FREEPOST Hywel Dda Health Board**

If you would like to read a printed version in either Welsh, English or other language, or if you would prefer to receive the document in large print or alternative accessible formats, please contact us on **01267 239554** or Email: **communications.hdd@wales.nhs.uk**

Once again thank you for taking the time to read this. Please let us know if you have any questions or wish to receive more information.

Acknowledgements

We would like to thank and acknowledge our partners involved in the production of this report. Feedback from public reader panels, via our Siarad Iechyd/Talking Health membership scheme, gave us an excellent guide to ensure we kept this document as informative and understandable as possible. We would also like to thank our designer at Caerodor Design for working with us. Finally we would like to thank every member of staff who has contributed to this report. We are thankful too for the time given by our Independent Members and to the Quality, Safety and Experience Committee, and Audit, Risk and Assurance Committee for their endorsement.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit of Financial Statements Report – **Hywel Dda University Health Board**

Audit year: 2018-19

Date issued: May 2019

Document reference: 1266A2019-20

The team who delivered the work comprised Ann-Marie Harkin, Jeremy Saunders, Leanne Malough and the Hywel Dda University Health Board audit team.

Summary report

The Auditor General intends to issue a qualified[1] audit report on your financial statements and this will be supported by a substantive report. There are some issues to report to you prior to the Board's approval of the financial statements.

Summary report

Appendices

[1] The true and fair opinion is unqualified but the regularity opinion is qualified.

Introduction

1 The Auditor General is responsible for providing an opinion on whether the financial statements give a true and fair view of the financial position of Hywel Dda University Health Board at 31 March 2018-19 and its income and expenditure for the year then ended.

2 We do not try to obtain absolute assurance that the financial statements are correctly stated, but adopt the concept of materiality. In planning and conducting the audit, we seek to identify material misstatements in your financial statements, namely, those that might result in a reader of the accounts being misled.

3 The quantitative levels at which we judge such misstatements to be material for Hywel Dda University Health Board is £9.2 million. Whether an item is judged to be material can also be affected by certain qualitative issues such as legal and regulatory requirements and political sensitivity.

4 International Standard on Auditing (ISA) 260 requires us to report certain matters arising from the audit of the financial statements to those charged with governance of a body in sufficient time to enable appropriate action.

5 This report sets out for consideration the matters arising from the audit of the financial statements of Hywel Dda University Health Board for 2018-19, that require reporting under ISA 260.

Status of the audit

6 We received the draft financial statements for the year ended 31 March 2019 on 26 April 2019, the agreed deadline, and have now substantially completed the audit work.

7 We are reporting to you the more significant issues arising from the audit, which we believe you must consider prior to approval of the financial statements. The audit team has already discussed these issues with the Director of Finance and his team.

Proposed audit report

8 It is the Auditor General's intention to issue a qualified[2] audit report on the financial statements once you have provided us with a Letter of Representation based on that set out in Appendix 1.

9 The proposed audit report is set out in Appendix 2. The Auditor General will be issuing a substantive report alongside his audit report (also set out in Appendix 2). The report explains the two financial duties applicable from 2016-17, the

[2] The true and fair opinion is unqualified but the regularity opinion is qualified.

performance of the Health Board against them and implications for this year's regularity opinion.

Significant issues arising from the audit

Uncorrected misstatements

10 There are no misstatements identified in the financial statements, which remain uncorrected.

Corrected misstatements

11 There are misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process. They are set out with explanations in Appendix 3.

Other significant issues arising from the audit

12 In the course of the audit, we consider a number of matters both qualitative and quantitative relating to the accounts and report any significant issues arising to you. There were no issues arising in these areas this year:

We have no concerns about the qualitative aspects of your accounting practices and financial reporting

13 We found the information provided by the Health Board to be relevant, reliable, comparable, material and easy to understand. The Health Board has high quality working papers and quality assurance processes over the financial statements. We concluded that accounting policies and estimates are appropriate and financial statement disclosures unbiased, fair and clear.

14 As in previous financial years, there are a number of significant estimates made at the year-end when the financial statements are prepared. These, and our conclusions on them, are as follows:

Exhibit 1: significant estimates, assessment and conclusion

Significant estimates	Assessment and conclusion
Primary care accruals for year-end expenditure (eg enhanced services, prescribing and dental)	Processes and estimates are assessed as reasonable. This also forms part of the monthly financial reporting processes.

Significant estimates	Assessment and conclusion
Other health care providers accrual for year-end costs	Agreement with all Welsh health care providers is collated and arbitrated through the Welsh Government matrix of transactions and balances. These processes and estimates are robust.
Clinical negligence and personal injury claims	Estimates are reasonable – they are based on the Welsh Risk Pool's assessment and these processes are robust.
Retrospective continuing health care claims	The estimate and methodology for assessing the level of provision are reasonable.

We did not encounter any significant difficulties during the audit

15 There were no significant difficulties during the audit. We received information in a timely and helpful manner and were not restricted in our work. Indeed, remote read-only access to the Health Board's ledger reporting tool and working papers improved the efficiency of our audit work. The deadlines for submission of the financial statements are challenging and we would like to commend the Health Board's Finance team for the timing and quality of the accounts preparation work. The constructive but independent working relationships with the Director of Finance and his new team have developed quickly.

There were no significant matters discussed and corresponded upon with management which we need to report to you beyond those set out in the substantive report

16 The Auditor General's substantive report in Appendix 2 outlines the statutory financial duties in the NHS, and the fact that the Health Board did not meet its financial duty to have an approved three-year integrated medium term plan for the period 2018-19 to 2020-21. The report also identifies that for 2018-19, the Health Board did not meet its revenue resource allocation over the three-year period.

There are no other matters significant to the oversight of the financial reporting process that we need to report to you

17 The Health Board is required to prepare and include in its Accountability Report an Annual Governance Statement which sets out the Health Board's governance structures, systems of internal control and risk management and the effectiveness of these systems in operation during the year. We reviewed the Statement to consider its consistency with Manual for Accounts requirements and with other information known to us from our audit work. We identified a small number of minor narrative and presentational adjustments, which have been reflected in the final Statement, and we will continue to work with management to further develop the Statement in future years.

18 There are no other matters significant to the oversight of the financial reporting process that we need to report to you.

We did not identify any material weaknesses in your internal controls but we have identified some areas for improvement

19 We have not identified any matters which are material to the accuracy and completeness of the financial statements or any matters which are significant enough to bring to your attention. We will discuss and agree with management appropriate action for the relatively minor issues we have identified.

There are no other matters specifically required by auditing standards to be communicated to those charged with governance

20 There are no other matters (such as those relating to fraud, compliance with laws and regulations, or subsequent events) that we need to report to you.

Independence and objectivity

21 As part of the finalisation process, we are required to provide you with representations concerning our independence.

22 We have complied with ethical standards and in our professional judgment, we are independent and our objectivity is not compromised. There are no relationships between the Wales Audit Office and Hywel Dda University Health Board that we consider to bear on our objectivity and independence.

Appendix 1

Final Letter of Representation

Auditor General for Wales

24 Cathedral Road

Cardiff

CF11 9LJ

29 May 2019

Representations regarding the 2018-19 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Hywel Dda University Local Health Board (the Health Board) for the year ended 31 March 2019 for the purpose of expressing an opinion on their truth and fairness and their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts' directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- our knowledge of fraud or suspected fraud that we are aware of and that affects the Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- the identity of all related parties and all the related party relationships and transactions of which we are aware.
- our knowledge of all possible and actual instances of irregular transactions.

Financial statements representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

Significant assumptions used in making accounting estimates, including those measured at fair value, are reasonable.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and

accounted for and disclosed in accordance with the applicable financial reporting framework.

All contingent liabilities have been identified and properly assessed. Contingent liabilities are considered to be not material to the financial statements.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by those charged with governance

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for ensuring that the Health Board maintains adequate accounting records.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Health Board on 29 May 2019.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
[Officer who signs on behalf of management]	[Officer or Member who signs on behalf of those charged with governance]
29 May 2019	

Appendix 2

Proposed audit report of the Auditor General to the National Assembly for Wales

The Certificate and independent auditor's report of the Auditor General for Wales to the National Assembly for Wales

Report on the audit of the financial statements

Opinion

I certify that I have audited the financial statements of Hywel Dda University Health Board for the year ended 31st March 2019 under Section 61 of the Public Audit (Wales) Act 2004. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Tax Payers Equity and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Hywel Dda University Health Board as at 31st March 2019 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Chief Executive has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the board's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Chief Executive is responsible for the other information in the annual report and accounts. The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and, except to the extent

otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Qualified opinion on regularity

In my opinion, except for the irregular expenditure of £154.481 million explained in the paragraph below, in all material respects, the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities which govern them.

Basis for qualified opinion on regularity

The Health Board has breached its resource limit by spending £154.481 million over the £2,356.093 million that it was authorised to spend in the three-year period 2016-17 to 2018-19. This spend constitutes irregular expenditure. Further detail is set out in the attached Report.

Report on other requirements

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Performance Report specify the other information provided with the financial statements for the financial year for which the financial statements are prepared is consistent with the financial statements and the Performance Report the other information provided with the financial statements has been prepared in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- proper accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns;

- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed; or
- I have not received all the information and explanations I require for my audit.

Responsibilities

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities set out on pages 79 and 115 of the Accountability Report, the Directors and the Chief Executive are responsible for the preparation of financial statements which give a true and fair view and for such internal control as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors and Chief Executive are responsible for assessing the board's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities which govern them.

Adrian Crompton
Auditor General for Wales
11 June 2019

24 Cathedral Road
Cardiff
CF11 9LJ

Report of the Auditor General to the National Assembly for Wales

Introduction

Local Health Boards (LHBs) are required to meet two statutory financial duties – known as the first and second financial duties.

For 2018-19, Hywel Dda University Local Health Board (the LHB) failed to meet both the first and the second financial duty and so I have decided to issue a narrative report to explain the position.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to LHBs by allowing them to balance their income with their expenditure over a three-year rolling period. The second three-year period under this duty is 2016-17 to 2018-19, and so it is measured this year for the third time.

As shown in Note 2.1 to the Financial Statements, the LHB did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £2,356.093 million by £154.481 million. The LHB did not therefore meet its first financial duty.

Where an LHB does not balance its books over a rolling three-year period, any expenditure over the resource allocation (ie spending limit) for those three years exceeds the LHB's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires LHBs to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium term plan. This duty is an essential foundation to the delivery of sustainable quality health services. An LHB will be deemed to have met this duty for 2018-19 if it submitted a 2018-19 to 2020-21 plan approved by its Board to the Welsh Ministers who then approved it by 30 June 2018.

As shown in Note 2.3 to the Financial Statements, the LHB did not meet its second financial duty to have an approved three-year integrated medium term plan (IMTP) in place for the period 2018-19 to 2020-21.

Following discussion between Hywel Dda University Health Board and Welsh Government, the Health Board acknowledged that it was not in a position to submit an IMTP for the period 2018-19 to 2020-21 given the status of the Transforming Clinical Services and Turnaround Programmes. In the absence of an IMTP, the Health Board developed an Annual Plan that was submitted to Welsh Government by the Board on 29th March 2018.

Adrian Crompton
Auditor General for Wales
11 June 2019

24 Cathedral Road
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CF11 9LJ

Appendix 3

Summary of corrections made to the draft financial statements which should be drawn to the attention of Hywel Dda University Health Board

During our audit we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Value of correction	Nature of correction	Reason for correction
£634,000	Addition of property leases values to Note 8: Operating Leases	Property leases omitted from note
NA	Re-ordering of paragraphs in Note 31: Related party transactions and amendments to some figures	Increase clarity and accuracy of the disclosure
various	Some minor errors in remuneration disclosures to correct to actual figures	Remuneration report is material by nature
NA	Other minor narrative amendments	To improve clarity of the accounts

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HYWEL DDA UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st June 2009 and became operational on 1st October 2009 and comprises the former organisations of Hywel Dda NHS Trust and Carmarthenshire, Ceredigion and Pembrokeshire Local Health Boards.

Performance Management and Financial Results

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Other Comprehensive Net Expenditure

	2018-19	2017-18
	£'000	£'000
Net (gain) / loss on revaluation of property, plant and equipment	**(1,185)**	(14,435)
Net (gain) / (loss) on revaluation of intangibles	**0**	0
Net (gain) / loss on revaluation of available for sale financial assets	**0**	0
(Gain) / loss on other reserves	**0**	0
Impairment and reversals	**0**	1,053
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Other comprehensive net expenditure for the year	**(1,185)**	(13,382)
Total comprehensive net expenditure for the year	**861,229**	820,119

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2019

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2018-19			
Balance as at 31 March 2018	154,822	26,796	**181,618**
Adjustment for Implementation of IFRS 9	-82	0	**-82**
Balance at 1 April 2018	154,740	26,796	181,536
Net operating cost for the year	(862,414)		**(862,414)**
Net gain/(loss) on revaluation of property, plant and equipment	0	1,185	**1,185**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	1,175	(1,175)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2018-19	(861,239)	10	**(861,229)**
Net Welsh Government funding	874,071		**874,071**
Balance at 31 March 2019	167,572	26,806	**194,378**

The notes on pages 8 to 65a form part of these accounts

Statement of Cash Flows for year ended 31 March 2019

	notes	2018-19 £'000	2017-18 £'000
Cash Flows from operating activities			
Net operating cost for the financial year		**(862,414)**	(833,501)
Movements in Working Capital	27	**(27,602)**	6,595
Other cash flow adjustments	28	**56,848**	24,150
Provisions utilised	20	**(12,908)**	(8,194)
Net cash outflow from operating activities		**(846,076)**	(810,950)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(28,082)**	(17,373)
Proceeds from disposal of property, plant and equipment		**12**	276
Purchase of intangible assets		**(945)**	(229)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	(365)
Proceeds from disposal of other financial assets		**0**	289
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(29,015)**	(17,402)
Net cash inflow/(outflow) before financing		**(875,091)**	(828,352)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**874,071**	828,034
Capital receipts surrendered		**0**	0
Capital grants received		**952**	634
Capital element of payments in respect of finance leases and on-SoFP		**0**	0
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**875,023**	828,668
Net increase/(decrease) in cash and cash equivalents		**(68)**	316
Cash and cash equivalents (and bank overdrafts) at 1 April 2018		**1,528**	1,212
Cash and cash equivalents (and bank overdrafts) at 31 March 2019		**1,460**	1,528

The notes on pages 8 to 65a form part of these accounts

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income for LTA activity is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.
Only non-NHS income may be deferred.

1.4 Employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the LHB commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the LHBs accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme
The LHB has to offer an alternative pensions scheme for employees not eligible to join the NHS Pensions scheme. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses
Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure.

From 2015-16, the LHB must comply with IFRS 13 Fair Value Measurement in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the entity or the asset which would prevent access to the market at the reporting date. If the LHB could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, NHS bodies are required to get all All Wales Capital Schemes that are completed in a financial year revalued during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the LHBs business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the LHB; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Local Health Board as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The Local Health Board as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and

receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.
NHS Wales Technical Accounting Group members reviewed the IFRS 9 requirements and determined a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value
Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCNE
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had LHBs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP). The LHB accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is below 50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget
The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32.

The pool is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty
In the application of the LHB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Provisions
The Health Board provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the Health Board or Trust, the full

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHBs approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHBs criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a

IFRS14 Regulatory Deferral Accounts (The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.),
IFRS 16 Leases, HMT have confirmed that IFRS 16 Leases, as interpreted and adapted by the FReM is to be effective from 1st April 2020.
IFRS 17 Insurance Contracts,
IFRIC 23 Uncertainty over Income Tax Treatment.

1.30 Accounting standards issued that have been adopted early
During 2018-19 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31 Charities
Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as the LHB is the corporate trustee of the linked NHS Charity (Hywel Dda Charities), it is considered for accounting standards compliance to have control of Hywel Dda Health Charities as a subsidiary and therefore is required to consolidate the results of Hywel Dda Health Charities within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of Hywel Dda Charities or its independence in its management of charitable funds.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will [consolidate/disclose] the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2016-17	2017-18	2018-19	Total
	£'000	£'000	£'000	£'000
Net operating costs for the year	809,895	833,501	**862,414**	**2,505,810**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,086	1,956	**1,722**	**4,764**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	**0**	**0**
Total operating expenses	810,981	835,457	864,136	**2,510,574**
Revenue Resource Allocation	761,368	766,027	**828,698**	**2,356,093**
Under /(over) spend against Allocation	(49,613)	(69,430)	(35,438)	(154,481)

Hywel Dda UHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2016-17 to 2018-19.

The Health Board did not receive any repayable brokerage during the year.
The Health Board received £31.3 million repayable cash only support in 2018-19. The accumulated cash only support provided to the Health Board by the Welsh Government is £160.964 million as at 31 March 2019. The cash only support is provided to assist the Health Board with ensuring payments to staff and suppliers, there is no interest payable on cash only support. Repayment of this cash assistance will be in accordance with the Health Board's future Integrated Medium Term Plan submissions.

2.2 Capital Resource Performance

	2016-17	2017-18	2018-19	Total
	£'000	£'000	£'000	£'000
Gross capital expenditure	18,970	18,474	**31,820**	**69,264**
Add: Losses on disposal of donated assets	0	0	**0**	**0**
Less: NBV of property, plant and equipment and intangible assets disposed	(258)	(265)	**0**	**(523)**
Less: capital grants received	(9)	(11)	**0**	**(20)**
Less: donations received	(1,159)	(623)	**(952)**	**(2,734)**
Charge against Capital Resource Allocation	17,544	17,575	**30,868**	**65,987**
Capital Resource Allocation	17,574	17,613	**30,893**	**66,080**
(Over) / Underspend against Capital Resource Allocation	30	38	**25**	**93**

The LHB met its financial duty to break-even against its Capital Resource Limit over the 3 years 2016-17 to 2018-19.

2.3 Duty to prepare a 3 year plan

The NHS Wales Planning Framework for the period 2018-19 to 2020-21 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans (IMTP) to the Welsh Government.

Following discussion between Hywel Dda University Health Board and Welsh Government, the Health Board acknowledged that it was not in a position to submit an IMTP for the period 2018-19 to 2020-21 given the status of the Transforming Clinical Services and Turnaround Programmes. In the absence of an IMTP, the Health Board developed an Annual Plan that was submitted to Welsh Government by the Board on 29th March 2018.

The statutory financial duty under section 175 (2A) of the National Health Services (Wales) Act 2006 to prepare a three year plan was therefore not met.

	2018-19 to 2020-21
The Minister for Health and Social Services approval status	**Not Approved**

The LHB **has not** therefore met its statutory duty to have an approved financial plan for the period 2018-19 to 2020-21.

The LHB prepared an Annual Plan for 2017-18 therefore there **was not** an approved Integrated Medium Term Plan in 2017-18.

3.3 Expenditure on Hospital and Community Health Services

	2018-19 £'000	2017-18 £'000
Directors' costs	**2,451**	2,212
Staff costs	**400,701**	385,248
Supplies and services - clinical	**74,317**	67,363
Supplies and services - general	**5,547**	5,672
Consultancy Services	**1,691**	993
Establishment	**8,554**	8,357
Transport	**1,539**	1,245
Premises	**15,638**	13,653
External Contractors	**371**	1,646
Depreciation	**15,255**	15,347
Amortisation	**369**	352
Fixed asset impairments and reversals (Property, plant & equipment)	**4,979**	1,139
Fixed asset impairments and reversals (Intangible assets)	**0**	0
Impairments & reversals of financial assets	**0**	0
Impairments & reversals of non-current assets held for sale	**0**	0
Audit fees	**392**	387
Other auditors' remuneration	**0**	0
Losses, special payments and irrecoverable debts	**1,856**	1,648
Research and Development	**0**	0
Other operating expenses	**460**	1,168
Total	**534,120**	506,430

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2018-19 £'000	2017-18 £'000
Clinical negligence	**33,970**	5,289
Personal injury	**368**	(207)
All other losses and special payments	**167**	337
Defence legal fees and other administrative costs	**707**	267
Gross increase/(decrease) in provision for future payments	**35,212**	**5,686**
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**99**	38
Less: income received/due from Welsh Risk Pool	**(33,455)**	(4,076)
Total	**1,856**	**1,648**

Personal injury includes £20k (2017-18 £143k) in respect of permanent injury benefits.
Clinical Redress expenditure during the year was £352k in respect of 62 cases (2017-18 £225k re 93 cases).

5. Investment Revenue

	2018-19	2017-18
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	0	0

6. Other gains and losses

	2018-19	2017-18
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	13	11
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	13	11

7. Finance costs

	2018-19	2017-18
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts		
main finance cost	0	0
contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	0	0
Provisions unwinding of discount	9	3
Other finance costs	0	0
Total	9	3

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	£000	£000	£000	£000	£000	£000
Salaries and wages	320,784	3,743	15,009	4,999	**344,535**	332,172
Social security costs	31,219	0	0	274	**31,493**	30,077
Employer contributions to NHS Pension Scheme	38,566	0	0	11	**38,577**	36,677
Other pension costs	94	0	0	0	**94**	38
Other employment benefits	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	**0**	0
Total	390,663	3,743	15,009	5,284	**414,699**	398,964
Charged to capital					**464**	388
Charged to revenue					**414,235**	398,576
					414,699	398,964
Net movement in accrued employee benefits (untaken staff leave accrual included above)					(351)	7

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	1,545	35	3	0	**1,583**	1,498
Medical and dental	678	20	1	30	**729**	733
Nursing, midwifery registered	2,652	2	202	0	**2,856**	2,860
Professional, Scientific, and technical staff	306	0	0	0	**306**	281
Additional Clinical Services	1,692	0	3	0	**1,695**	1,675
Allied Health Professions	523	1	0	18	**542**	531
Healthcare Scientists	166	0	1	0	**167**	157
Estates and Ancillary	782	0	0	0	**782**	793
Students	11	0	0	0	**11**	16
Total	**8,355**	**58**	**210**	**48**	**8,671**	8,544

9.3. Retirements due to ill-health

During 2018-19 there were 15 early retirements from the LHB agreed on the grounds of ill-health (13 in 2017-18 - £597,853). The estimated additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) will be £567,507.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

Included in permanent staff in Note 9.2 above there are 577 (522, 2017-18) who are on Fixed Term temporary contracts of which 305 (261, 2017-18) are Medical and Dental

9.6 Remuneration Relationship

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 LHB in the financial year 2018-19 was £180,000-£185,000 (2017-18, £175,000 - £180,000). This was 6.16 times (2017-18, 7) the median remuneration of the workforce, which was £29,608 (2017-18, £26,624).

In 2018-19, 34 (2017-18, 39) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £17,460 to £307,299 (2017-18 £15,404 to £295,365).

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.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 5% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 2% of this. The legal minimum level of contribution level is due to increase to 8% in April 2019.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,032 and £46,350 for the 2018-19 tax year (2017-18 £5,876 and £45,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	25,661	196,113	7,494	10,771	65,016	245	22,810	5,821	**333,931**
Indexation	308	837	75	0	0	0	0	0	**1,220**
Additions									
- purchased	35	1,833	0	20,926	3,972	0	2,934	222	**29,922**
- donated	0	576	0	11	200	0	67	98	**952**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	9,632	0	(9,632)	0	0	0	0	**0**
Revaluations	0		0	0	0	0	0	0	**0**
Reversal of impairments	205	1,122	0	0	0	0	0	0	**1,327**
Impairments	0	(7,033)	0	0	0	0	0	0	**(7,033)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,494)	(5)	(4,950)	0	**(6,449)**
At 31 March 2019	26,209	203,080	7,569	22,076	67,694	240	20,861	6,141	**353,870**
Depreciation at 1 April 2018	0	7,511	343	0	51,822	244	15,092	4,524	**79,536**
Indexation	0	32	3	0	0	0	0	0	**35**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	44	0	0	0	0	0	0	**44**
Impairments	0	(771)	0	0	0	0	0	0	**(771)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,496)	(5)	(4,950)	0	**(6,451)**
Provided during the year	0	7,674	343	0	4,543	1	2,188	506	**15,255**
At 31 March 2019	0	14,490	689	0	54,869	240	12,330	5,030	**87,648**
Net book value at 1 April 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Net book value at 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Net book value at 31 March 2019 comprises :									
Purchased	25,954	184,872	6,880	22,076	11,819	0	8,398	893	**260,892**
Donated	255	3,718	0	0	1,006	0	107	215	**5,301**
Government Granted	0	0	0	0	0	0	26	3	**29**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Asset financing :									
Owned	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**

The net book value of land, buildings and dwellings at 31 March 2019 comprises :

	£000
Freehold	219,938
Long Leasehold	1,741
Short Leasehold	0
	221,679

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for whih as asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

i) Acquisitions shown as donated assets within Note 11 were bought using monies donated by the public into the Hywel Dda Charities and contributions from Ty Bryngwyn Hospice, League of Friends and other charities and organisations.

During 2018-19 fixed assets purchased to the following value were funded by the following:

Hywel Dda General Fund Charity (1147863) Plant and Machinery	£154,528
Hywel Dda General Fund Charity (1147863) Furniture and Fittings	£ 98,112
Hywel Dda General Fund Charity (1147863) Bulidings	£ 38,368
Hywel Dda General Fund Charity (1147863) Information Technology	£ 58,344
Ty Bryngwyn Hospice Committee	£547,482
League of Friends & Other Contributions	£54,952
Total Donated Assets	**£951,786**

Other Disclosures

i) The LHB is not carrying any temporary idle assets.
Gross carrying amount of all fully depreciated assets still in use as at 31st March 2019 is £52,203,495

IFRS 13 - Fair Value Measurement

AS at 31st March 2019, the Health Board does not hold any fixed assets at fair value as defined by IFRS 13.

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	2,548	0	79	0	0	0	**2,627**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- purchased	**945**	**0**	**0**	**0**	**0**	**0**	**945**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers		**0**	**0**	**0**	**0**	**0**	**0**
Disposals	(134)	**0**	(2)	**0**	**0**	**0**	(136)
Gross cost at 31 March 2019	**3,359**	**0**	**77**	**0**	**0**	**0**	**3,436**
Amortisation at 1 April 2018	1,511	0	71	0	0	0	**1,582**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	**361**	**0**	**8**	**0**	**0**	**0**	**369**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	(134)	**0**	(2)	**0**	**0**	**0**	(136)
Amortisation at 31 March 2019	**1,738**	**0**	**77**	**0**	**0**	**0**	**1,815**
Net book value at 1 April 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**
Net book value at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**
At 31 March 2019							
Purchased	**1,613**	**0**	**0**	**0**	**0**	**0**	**1,613**
Donated	**8**	**0**	**0**	**0**	**0**	**0**	**8**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**

Additional disclosures re Intangible Assets

Computer Software & Licences are capitalised at their purchased price.

Computer Software & Licences are not indexed as IT assets are not subject to indexation.

The assets are amortised monthly over their expected life.

The gross carrying amount of fully amortised intangible assets still in use as at 31 March 2019 was £964,805.

14.1 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	**3,776**	3,531
Consumables	**4,096**	4,153
Energy	**212**	191
Work in progress	**0**	0
Other	**0**	0
Total	**8,084**	7,875
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

16. Other Financial Assets

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	305	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**305**	**0**	**0**

17. Cash and cash equivalents

	2018-19	2017-18
	£000	£000
Balance at 1 April	**1,528**	1,212
Net change in cash and cash equivalent balances	**(68)**	316
Balance at 31 March	**1,460**	1,528
Made up of:		
Cash held at GBS	**1,347**	1,708
Commercial banks	**88**	(202)
Cash in hand	**25**	22
Current Investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**1,460**	1,528
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,460**	1,528

The movement relates to cash, no comparative information is required by IAS 7 in 2018-19.

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	**31 March 2019 £000**	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions (continued)

	At 1 April 2017	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2018
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence	14,119	0	0	9,206	8,723	(5,802)	(3,960)	0	**22,286**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	495	0	0	134	597	(268)	(413)		**545**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**19,015**	**0**	**0**	**9,340**	**12,319**	**(7,939)**	**(4,974)**	**3**	**27,764**
Non Current									
Clinical negligence	23,525	0	0	(9,206)	1,011	(231)	(485)	0	**14,614**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	432	0	0	(134)	84	(24)	(1)		**357**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**23,957**	**0**	**0**	**(9,340)**	**1,095**	**(255)**	**(486)**	**0**	**14,971**
TOTAL									
Clinical negligence	37,644	0	0	0	9,734	(6,033)	(4,445)	0	**36,900**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	927	0	0	0	681	(292)	(414)		**902**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**42,972**	**0**	**0**	**0**	**13,414**	**(8,194)**	**(5,460)**	**3**	**42,735**

21.2 Remote Contingent liabilities

	2018-19 £'000	2017-18 £'000
Guarantees	0	0
Indemnities	536	266
Letters of Comfort	0	0
Total	**536**	**266**

21.3 Contingent assets

	2018-19 £'000	2017-18 £'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2018-19 £'000	2017-18 £'000
Property, plant and equipment	28,124	16,100
Intangible assets	0	0
Total	**28,124**	16,100

24. Finance leases

24.1 Finance leases obligations (as lessee)

Amounts payable under finance leases:

Land	**31 March 2019 £000**	31 March 2018 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Finance leases obligations (as lessor) continued

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2019	31 March 2018
Gross investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25.3 Charges to expenditure	2018-19	2017-18
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

	31 March 2019	31 March 2018
PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract

27. Movements in working capital

	2018-19	2017-18
	£000	£000
(Increase)/decrease in inventories	**(209)**	201
(Increase)/decrease in trade and other receivables - non-current	**(28,486)**	8,888
(Increase)/decrease in trade and other receivables - current	**5,573**	(11,747)
Increase/(decrease) in trade and other payables - non-current	**0**	0
Increase/(decrease) in trade and other payables - current	**(1,606)**	10,125
Total	**(24,728)**	7,467
Adjustment for accrual movements in fixed assets - creditors	**(2,792)**	(872)
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**(82)**	0
	(27,602)	6,595

28. Other cash flow adjustments

	2018-19	2017-18
	£000	£000
Depreciation	**15,255**	15,347
Amortisation	**369**	352
(Gains)/Loss on Disposal	**(13)**	(11)
Impairments and reversals	**4,979**	1,139
Release of PFI deferred credits	**0**	0
Donated assets received credited to revenue but non-cash	**(952)**	(623)
Government Grant assets received credited to revenue but non-cash	**0**	(11)
Non-cash movements in provisions	**37,210**	7,957
Total	**56,848**	24,150

30. Events after the Reporting Period

The LHB **has not** experienced any events having a material effect on the accounts, between the date of the statement of financial position and the date on which these accounts were approved by its Board.

32. Pooled budgets

Hywel Dda University Health Board has entered into a pooled budget with Ceredigion County Council on the 1st April 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Ceredigion County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Ceredigion County Council and the Health Board. Payments for services provided by Ceredigion County Council in the sum of £306,000 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into a pooled budget with Carmarthenshire County Council on the 1st October 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Carmarthenshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Carmarthenshire County Council and the Health Board. Payments for services provided by Carmarthenshire County Council in the sum of £381,960 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into an agreement with Carmarthenshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of Carmarthenshire Community Health and Social Care services. The section 33 agreement itself will initially only provide the framework for taking forward future schedules and therefore references all community based health, social care (adults & children) and related housing and public protection services so that if any future developments are considered a separate agreement will not have to be prepared. There are currently no pooled budgets related to this agreement.

Hywel Dda University Health Board has entered into an agreement with Pembrokeshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store and from 1st October 2012 the agreement has operated as a pooled fund. The pool is hosted by Pembrokeshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Pembrokeshire County Council and the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement and the sum of £ £310,781 has been accounted for as expenditure in the accounts of the Health Board.

34. Other Information

IFRS15

Work was undertaken by the TAG IFRS sub group, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15. It was determined that the following types of consideration received from customers for goods and services (hereon referred to as income) fell outside the scope of the standard, as the body providing the income does not contract with the body to receive any direct goods or services in return for the income flow.

- Charitable Income and other contributions to Expenditure.
- Receipt of Donated Assets.
- WG Funding without direct performance obligation (e.g. SIFT/SIFT®/Junior Doctors & PDGME Funding).

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB & WHSCC LTA Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- ICR Income ;
- Training & Education income ;
- Accommodation & Catering income

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded (FCE's), as at period end, e.g. 31 March.

When calculating the income generated from these episodes, it was determined that it was appropriate to use length of stay as the best proxy for the attributable Work In Progress (WIP) value. In theory, as soon as an episode is opened, income is due. Under the terms and conditions of the contract this will only ever be realised on episode closure so the average length of stay would be the accepted normal proxy for the work in progress value.

For Hywel Dda University Health Board, the summary assessment of the impact of IFRS 15 is below -

Annual Accounts year looked at: 2016/17

Total Income per Accounts in the year 2016/17 :	£52.934m
Total Income looked at as part of the exercise:	£29.595m
Total Income looked at considered to be outside the scope of IFRS 15:	£ 3.873m
Total Income looked at that is inside the scope of IFRS 15	£25.722m
Total Income looked at that is inside the scope of IFRS 15 and potentially requires adjustment for incomplete service provision episodes	£15.014m
Total estimated adjustment required under IFRS 15	£ 0.059m

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009

HYWEL DDA UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st June 2009 and became operational on 1st October 2009 and comprises the former organisations of Hywel Dda NHS Trust and Carmarthenshire, Ceredigion and Pembrokeshire Local Health Boards.

Performance Management and Financial Results

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Expenditure on Primary Healthcare Services	3.1	**185,316**	183,962
Expenditure on healthcare from other providers	3.2	**200,169**	197,462
Expenditure on Hospital and Community Health Services	3.3	**534,120**	506,430
		919,605	887,854
Less: Miscellaneous Income	4	**(57,187)**	(54,345)
LHB net operating costs before interest and other gains and losses		**862,418**	833,509
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**(13)**	(11)
Finance costs	7	**9**	3
Net operating costs for the financial year		**862,414**	833,501

See note 2 on page 22 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 65a form part of these accounts

Other Comprehensive Net Expenditure

	2018-19	2017-18
	£'000	£'000
Net (gain) / loss on revaluation of property, plant and equipment	**(1,185)**	(14,435)
Net (gain) / (loss) on revaluation of intangibles	**0**	0
Net (gain) / loss on revaluation of available for sale financial assets	**0**	0
(Gain) / loss on other reserves	**0**	0
Impairment and reversals	**0**	1,053
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Other comprehensive net expenditure for the year	**(1,185)**	(13,382)
Total comprehensive net expenditure for the year	**861,229**	820,119

Statement of Financial Position as at 31 March 2019

	Notes	31 March 2019 £'000	31 March 2018 £'000
Non-current assets			
Property, plant and equipment	11	**266,222**	254,395
Intangible assets	12	**1,621**	1,045
Trade and other receivables	15	**43,183**	14,697
Other financial assets	16	**0**	0
Total non-current assets		**311,026**	270,137
Current assets			
Inventories	14	**8,084**	7,875
Trade and other receivables	15	**34,330**	39,598
Other financial assets	16	**0**	305
Cash and cash equivalents	17	**1,460**	1,528
		43,874	49,306
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**43,874**	49,306
Total assets		**354,900**	319,443
Current liabilities			
Trade and other payables	18	**(93,484)**	(95,090)
Other financial liabilities	19	**0**	0
Provisions	20	**(23,541)**	(27,764)
Total current liabilities		**(117,025)**	(122,854)
Net current assets/ (liabilities)		**(73,151)**	(73,548)
Non-current liabilities			
Trade and other payables	18	**0**	0
Other financial liabilities	19	**0**	0
Provisions	20	**(43,497)**	(14,971)
Total non-current liabilities		**(43,497)**	(14,971)
Total assets employed		**194,378**	181,618
Financed by :			
Taxpayers' equity			
General Fund		**167,572**	154,822
Revaluation reserve		**26,806**	26,796
Total taxpayers' equity		**194,378**	181,618

The financial statements on pages 2 to 7 were approved by the Board on 29th May 2019 and signed on its behalf by:

On Behalf of the Chief Executive and Accountable Officer ……..

29th May 2019

The notes on pages 8 to 65a form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2019

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2018-19			
Balance as at 31 March 2018	154,822	26,796	**181,618**
Adjustment for Implementation of IFRS 9	-82	0	**-82**
Balance at 1 April 2018	154,740	26,796	181,536
Net operating cost for the year	(862,414)		**(862,414)**
Net gain/(loss) on revaluation of property, plant and equipment	0	1,185	**1,185**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	1,175	(1,175)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2018-19	(861,239)	10	**(861,229)**
Net Welsh Government funding	874,071		**874,071**
Balance at 31 March 2019	167,572	26,806	**194,378**

The notes on pages 8 to 65a form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2018

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2017-18			
Balance at 31 March 2017	157,520	16,183	**173,703**
Net operating cost for the year	(833,501)		**(833,501)**
Net gain/(loss) on revaluation of property, plant and equipment	0	14,435	**14,435**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	(1,053)	**(1,053)**
Movements in other reserves	0	0	**0**
Transfers between reserves	2,769	(2,769)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2017-18	(830,732)	10,613	**(820,119)**
Net Welsh Government funding	828,034		**828,034**
Balance at 31 March 2018	154,822	26,796	**181,618**

The notes on pages 8 to 65a form part of these accounts

Statement of Cash Flows for year ended 31 March 2019

		2018-19	2017-18
		£'000	£'000
Cash Flows from operating activities	notes		
Net operating cost for the financial year		**(862,414)**	(833,501)
Movements in Working Capital	27	**(27,602)**	6,595
Other cash flow adjustments	28	**56,848**	24,150
Provisions utilised	20	**(12,908)**	(8,194)
Net cash outflow from operating activities		**(846,076)**	(810,950)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(28,082)**	(17,373)
Proceeds from disposal of property, plant and equipment		**12**	276
Purchase of intangible assets		**(945)**	(229)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	(365)
Proceeds from disposal of other financial assets		**0**	289
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(29,015)**	(17,402)
Net cash inflow/(outflow) before financing		**(875,091)**	(828,352)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**874,071**	828,034
Capital receipts surrendered		**0**	0
Capital grants received		**952**	634
Capital element of payments in respect of finance leases and on-SoFP		**0**	0
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**875,023**	828,668
Net increase/(decrease) in cash and cash equivalents		**(68)**	316
Cash and cash equivalents (and bank overdrafts) at 1 April 2018		**1,528**	1,212
Cash and cash equivalents (and bank overdrafts) at 31 March 2019		**1,460**	1,528

The notes on pages 8 to 65a form part of these accounts

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2018-19 Manual for Accounts. The accounting policies contained in that manual follow the European Union version of the International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income and funding

The main source of funding for the Local Health Boards (LHBs) are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the Local Health Board. Welsh Government funding is recognised in the financial period in which the cash is received.

Non discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.
Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers is applied, as interpreted and adapted for the public sector, in the Financial Reporting Manual (FReM). It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. Upon transition the accounting policy to retrospectively restate in accordance with IAS 8 has been withdrawn. All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.
A review consistent with the portfolio approach was undertaken by the NHS Technical Accounting Group members, which

- identified that the only material income that would potentially require adjustment under IFRS 15 was that for patient care provided under Long term Agreements (LTAs) for episodes of care which had started but not concluded as at the end of the financial period;
- demonstrated that the potential amendments to NHS Wales NHS Trust and Local Health Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income for LTA activity is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.
Only non-NHS income may be deferred.

1.4 Employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the LHB commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the LHBs accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme
The LHB has to offer an alternative pensions scheme for employees not eligible to join the NHS Pensions scheme. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses
Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment
Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the LHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the LHBs services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales bodies have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2017-18 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure.

From 2015-16, the LHB must comply with IFRS 13 Fair Value Measurement in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the entity or the asset which would prevent access to the market at the reporting date. If the LHB could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current
value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, NHS bodies are required to get all All Wales Capital Schemes that are completed in a financial year revalued during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the LHBs business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the LHB; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the LHB expects to obtain economic benefits or service potential from the asset. This is specific to the LHB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the LHB checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Local Health Board as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The Local Health Board as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories
Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

.1.13 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions
Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs
The Welsh Risk Pool (WRP) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was not implemented in 2018-19. The WRP is hosted by Velindre NHS Trust.

1.15 Financial Instruments

From 2018-19 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales bodies, will be to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.

1.16 Financial assets
Financial assets are recognised on the Statement of Financial Position when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease

receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.
NHS Wales Technical Accounting Group members reviewed the IFRS 9 requirements and determined a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value
Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCNE
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 Financial liabilities are initially recognised at fair value
Financial liabilities are classified as either financial liabilities at fair value through the Statement of Comprehensive Net Expenditure or other financial liabilities.

1.17.2 Financial liabilities at fair value through the Statement of Comprehensive Net Expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax
Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies
Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the LHB has no beneficial interest in them. Details of third party assets are given in Note 29 to the accounts.

1.21 Losses and Special Payments
Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had LHBs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP). The LHB accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is below 50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget
The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32.

The pool is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty
In the application of the LHB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Provisions
The Health Board provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the Health Board or Trust, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision Contingent Liability for all other estimated expenditure.
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of -0.75%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.25 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHBs approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHBs criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the LHB to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs Statement of Financial Position.

Other assets contributed by the LHB to the operator
Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the LHB through the asset being made available to third party users.

1.26 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.
Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.27 Carbon Reduction Commitment Scheme
Carbon Reduction Commitment Scheme allowances are accounted for as government grant funded intangible assets if they are not realised within twelve months and otherwise as current assets. The asset should be measured initially at cost. Scheme assets in respect of allowances shall be valued at fair value where there is evidence of an active market.

1.28 Absorption accounting
Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.
Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29 Accounting standards that have been issued but not yet been adopted
The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts (The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.), IFRS 16 Leases, HMT have confirmed that IFRS 16 Leases, as interpreted and adapted by the FReM is to be effective from 1st April 2020.
IFRS 17 Insurance Contracts,
IFRIC 23 Uncertainty over Income Tax Treatment.

1.30 Accounting standards issued that have been adopted early
During 2018-19 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31 Charities
Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as the LHB is the corporate trustee of the linked NHS Charity (Hywel Dda Charities), it is considered for accounting standards compliance to have control of Hywel Dda Health Charities as a subsidiary and therefore is required to consolidate the results of Hywel Dda Health Charities within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of Hywel Dda Charities or its independence in its management of charitable funds.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will [consolidate/disclose] the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	809,895	833,501	**862,414**	**2,505,810**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,086	1,956	**1,722**	**4,764**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	**0**	**0**
Total operating expenses	810,981	835,457	864,136	**2,510,574**
Revenue Resource Allocation	761,368	766,027	**828,698**	**2,356,093**
Under /(over) spend against Allocation	(49,613)	(69,430)	**(35,438)**	**(154,481)**

Hywel Dda UHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2016-17 to 2018-19.

The Health Board did not receive any repayable brokerage during the year.
The Health Board received £31.3 million repayable cash only support in 2018-19. The accumulated cash only support provided to the Health Board by the Welsh Government is £160.964 million as at 31 March 2019. The cash only support is provided to assist the Health Board with ensuring payments to staff and suppliers, there is no interest payable on cash only support. Repayment of this cash assistance will be in accordance with the Health Board's future Integrated Medium Term Plan submissions.

2.2 Capital Resource Performance

	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	18,970	18,474	**31,820**	**69,264**
Add: Losses on disposal of donated assets	0	0	**0**	**0**
Less: NBV of property, plant and equipment and intangible assets disposed	(258)	(265)	**0**	**(523)**
Less: capital grants received	(9)	(11)	**0**	**(20)**
Less: donations received	(1,159)	(623)	**(952)**	**(2,734)**
Charge against Capital Resource Allocation	17,544	17,575	**30,868**	**65,987**
Capital Resource Allocation	17,574	17,613	**30,893**	**66,080**
(Over) / Underspend against Capital Resource Allocation	30	38	**25**	**93**

The LHB met its financial duty to break-even against its Capital Resource Limit over the 3 years 2016-17 to 2018-19.

2.3 Duty to prepare a 3 year plan

The NHS Wales Planning Framework for the period 2018-19 to 2020-21 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans (IMTP) to the Welsh Government.

Following discussion between Hywel Dda University Health Board and Welsh Government, the Health Board acknowledged that it was not in a position to submit an IMTP for the period 2018-19 to 2020-21 given the status of the Transforming Clinical Services and Turnaround Programmes. In the absence of an IMTP, the Health Board developed an Annual Plan that was submitted to Welsh Government by the Board on 29th March 2018.

The statutory financial duty under section 175 (2A) of the National Health Services (Wales) Act 2006 to prepare a three year plan was therefore not met.

	2018-19 to 2020-21
The Minister for Health and Social Services approval status	**Not Approved**

The LHB **has not** therefore met its statutory duty to have an approved financial plan for the period 2018-19 to 2020-21.

The LHB prepared an Annual Plan for 2017-18 therefore there **was not** an approved Integrated Medium Term Plan in 2017-18.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2018-19 Total	2017-18
	£'000	£'000	£'000	£'000
General Medical Services	71,645		**71,645**	69,407
Pharmaceutical Services	19,453	(5,821)	**13,632**	13,354
General Dental Services	19,925		**19,925**	20,002
General Ophthalmic Services	1,238	4,099	**5,337**	4,983
Other Primary Health Care expenditure	3,943		**3,943**	4,806
Prescribed drugs and appliances	70,834		**70,834**	71,410
Total	**187,038**	**-1,722**	**185,316**	183,962

Staff Costs of £4.75m paid by the Health Board are included in General Medical Services (£4.93m 2017-18)

3.2 Expenditure on healthcare from other providers

	2018-19	2017-18
	£'000	£'000
Goods and services from other NHS Wales Health Boards	**38,754**	38,946
Goods and services from other NHS Wales Trusts	**7,324**	6,878
Goods and services from Health Education and Improvement Wales (HEIW)	**0**	0
Goods and services from other non Welsh NHS bodies	**1,189**	3,000
Goods and services from WHSSC / EASC	**85,495**	79,714
Local Authorities	**9,331**	9,179
Voluntary organisations	**1,970**	1,819
NHS Funded Nursing Care	**3,125**	3,744
Continuing Care	**47,012**	47,599
Private providers	**5,790**	6,430
Specific projects funded by the Welsh Government	**0**	0
Other	**179**	153
Total	**200,169**	197,462

Expenditure with Local Authorities in Note 3.2 includes expenditure on pooled budgets as reported in note 32.

3.3 Expenditure on Hospital and Community Health Services

	2018-19 £'000	2017-18 £'000
Directors' costs	2,451	2,212
Staff costs	400,701	385,248
Supplies and services - clinical	74,317	67,363
Supplies and services - general	5,547	5,672
Consultancy Services	1,691	993
Establishment	8,554	8,357
Transport	1,539	1,245
Premises	15,638	13,653
External Contractors	371	1,646
Depreciation	15,255	15,347
Amortisation	369	352
Fixed asset impairments and reversals (Property, plant & equipment)	4,979	1,139
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	392	387
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,856	1,648
Research and Development	0	0
Other operating expenses	460	1,168
Total	**534,120**	506,430

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	**2018-19 £'000**	2017-18 £'000
Clinical negligence	33,970	5,289
Personal injury	368	(207)
All other losses and special payments	167	337
Defence legal fees and other administrative costs	707	267
Gross increase/(decrease) in provision for future payments	**35,212**	**5,686**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	99	38
Less: income received/due from Welsh Risk Pool	(33,455)	(4,076)
Total	**1,856**	**1,648**

Personal injury includes £20k (2017-18 £143k) in respect of permanent injury benefits.
Clinical Redress expenditure during the year was £352k in respect of 62 cases (2017-18 £225k re 93 cases).

4. Miscellaneous Income

	2018-19	2017-18
	£'000	£'000
Local Health Boards	**18,730**	18,103
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**2,152**	2,071
NHS trusts	**3,837**	3,206
Health Education and Improvement Wales (HEIW)	**659**	0
Other NHS England bodies	**4,342**	4,503
Foundation Trusts	**0**	0
Local authorities	**4,535**	4,954
Welsh Government	**2,963**	1,706
Non NHS:		
Prescription charge income	**7**	6
Dental fee income	**3,276**	3,240
Private patient income	**15**	97
Overseas patients (non-reciprocal)	**334**	349
Injury Costs Recovery (ICR) Scheme	**1,272**	1,129
Other income from activities	**536**	556
Patient transport services	**0**	0
Education, training and research	**7,151**	8,087
Charitable and other contributions to expenditure	**779**	833
Receipt of donated assets	**952**	623
Receipt of Government granted assets	**0**	11
Non-patient care income generation schemes	**481**	399
NHS Wales Shared Services Partnership (NWSSP)	**0**	0
Deferred income released to revenue	**399**	371
Contingent rental income from finance leases	**0**	0
Rental income from operating leases	**356**	0
Other income:		
Provision of laundry, pathology, payroll services	**127**	78
Accommodation and catering charges	**1,459**	1,688
Mortuary fees	**145**	164
Staff payments for use of cars	**243**	251
Business Unit	**0**	0
Other	**2,437**	1,920
Total	**57,187**	54,345

Injury Cost Recovery (ICR) Scheme income is subject to a provision for impairment of **21.89%** re personal injury claims

5. Investment Revenue

	2018-19	2017-18
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	**0**	0

6. Other gains and losses

	2018-19	2017-18
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	13	11
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	**13**	11

7. Finance costs

	2018-19	2017-18
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts		
main finance cost	0	0
contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	**0**	0
Provisions unwinding of discount	9	3
Other finance costs	0	0
Total	**9**	3

8. Operating leases

LHB as lessee

As at 31st March 2019 the LHB had 24 operating leases agreements in place for the leases of premises, 209 arrangement in respect of equipment and 201 in respect of vehicles, with 1 premises, 10 equipment and no vehicle leases having expired in year. The periods in which the remaining 434 agreements expire are shown below:

Payments recognised as an expense	**2018-19**	2017-18
	£000	£000
Minimum lease payments	**3,881**	1,663
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**3,881**	1,663

Total future minimum lease payments	
Payable	**£000**	£000
Not later than one year	**1,197**	611
Between one and five years	**2,135**	297
After 5 years	**2,909**	0
Total	**6,241**	908

Number of operating leases expiring	**Land & Buildings**	**Vehicles**	**Equipment**	**Total**
Not later than one year	**3**	**59**	**12**	**74**
Between one and five years	**7**	**142**	**197**	**346**
After 5 years	**14**	**0**	**0**	**14**
Total	24	201	209	**434**
Charged to the income statement (£000)	**634**	**3,006**	**241**	**3,881**

There are no future sublease payments expected to be received

LHB as lessor

Rental revenue	**£000**	£000
Rent	**304**	0
Contingent rents	**0**	0
Total revenue rental	**304**	0

Total future minimum lease payments	
Receivable	**£000**	£000
Not later than one year	**303**	0
Between one and five years	**1,210**	0
After 5 years	**2,019**	0
Total	**3,532**	0

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	£000	£000	£000	£000	£000	£000
Salaries and wages	320,784	3,743	15,009	4,999	**344,535**	332,172
Social security costs	31,219	0	0	274	**31,493**	30,077
Employer contributions to NHS Pension Scheme	38,566	0	0	11	**38,577**	36,677
Other pension costs	94	0	0	0	**94**	38
Other employment benefits	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	**0**	0
Total	390,663	3,743	15,009	5,284	**414,699**	398,964
Charged to capital					**464**	388
Charged to revenue					**414,235**	398,576
					414,699	398,964
Net movement in accrued employee benefits (untaken staff leave accrual included above)					(351)	7

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	1,545	35	3	0	**1,583**	1,498
Medical and dental	678	20	1	30	**729**	733
Nursing, midwifery registered	2,652	2	202	0	**2,856**	2,860
Professional, Scientific, and technical staff	306	0	0	0	**306**	281
Additional Clinical Services	1,692	0	3	0	**1,695**	1,675
Allied Health Professions	523	1	0	18	**542**	531
Healthcare Scientists	166	0	1	0	**167**	157
Estates and Ancilliary	782	0	0	0	**782**	793
Students	11	0	0	0	**11**	16
Total	**8,355**	**58**	**210**	**48**	**8,671**	8,544

9.3. Retirements due to ill-health

During 2018-19 there were 15 early retirements from the LHB agreed on the grounds of ill-health (13 in 2017-18 - £597,853). The estimated additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) will be £567,507.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

Included in permanent staff in Note 9.2 above there are 577 (522, 2017-18) who are on Fixed Term temporary contracts of which 305 (261, 2017-18) are Medical and Dental

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2018-19 Number of compulsory redundancies	2018-19 Number of other departures	2018-19 Total number of exit packages	2018-19 Number of departures where special payments have been made	2017-18 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
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**	**1**	**1**	**1**	**1**

Exit packages cost band (including any special payment element)	2018-19 Cost of compulsory redundancies	2018-19 Cost of other departures	2018-19 Total cost of exit packages	2018-19 Cost of special element included in exit packages	2017-18 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**	**6,180**	**6,180**	**6,180**	**76,203**

Redundancy costs have been paid in accordance with the NHS Redundancy provisions, other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

9.6 Remuneration Relationship

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 LHB in the financial year 2018-19 was £180,000-£185,000 (2017-18, £175,000 - £180,000). This was 6.16 times (2017-18, 7) the median remuneration of the workforce, which was £29,608 (2017-18, £26,624).

In 2018-19, 34 (2017-18, 39) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £17,460 to £307,299 (2017-18 £15,404 to £295,365).

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.

9.7 Pension costs

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 5% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 2% of this. The legal minimum level of contribution level is due to increase to 8% in April 2019.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,032 and £46,350 for the 2018-19 tax year (2017-18 £5,876 and £45,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2018-19	**2018-19**	2017-18	2017-18
NHS	**Number**	**£000**	Number	£000
Total bills paid	**3,748**	**230,575**	3,908	219,791
Total bills paid within target	**3,451**	**227,570**	3,504	217,250
Percentage of bills paid within target	**92.1%**	**98.7%**	89.7%	98.8%
Non-NHS				
Total bills paid	**186,631**	**334,724**	177,339	315,875
Total bills paid within target	**179,436**	**326,310**	170,221	305,520
Percentage of bills paid within target	**96.1%**	**97.5%**	96.0%	96.7%
Total				
Total bills paid	**190,379**	**565,299**	181,247	535,666
Total bills paid within target	**182,887**	**553,880**	173,725	522,770
Percentage of bills paid within target	**96.1%**	**98.0%**	95.8%	97.6%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2018-19	2017-18
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	25,661	196,113	7,494	10,771	65,016	245	22,810	5,821	**333,931**
Indexation	308	837	75	0	0	0	0	0	**1,220**
Additions									
- purchased	35	1,833	0	20,926	3,972	0	2,934	222	**29,922**
- donated	0	576	0	11	200	0	67	98	**952**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	9,632	0	(9,632)	0	0	0	0	**0**
Revaluations	0		0	0	0	0	0	0	**0**
Reversal of impairments	205	1,122	0	0	0	0	0	0	**1,327**
Impairments	0	(7,033)	0	0	0	0	0	0	**(7,033)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,494)	(5)	(4,950)	0	**(6,449)**
At 31 March 2019	26,209	203,080	7,569	22,076	67,694	240	20,861	6,141	**353,870**
Depreciation at 1 April 2018	0	7,511	343	0	51,822	244	15,092	4,524	**79,536**
Indexation	0	32	3	0	0	0	0	0	**35**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	44	0	0	0	0	0	0	**44**
Impairments	0	(771)	0	0	0	0	0	0	**(771)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,496)	(5)	(4,950)	0	**(6,451)**
Provided during the year	0	7,674	343	0	4,543	1	2,188	506	**15,255**
At 31 March 2019	0	14,490	689	0	54,869	240	12,330	5,030	**87,648**
Net book value at 1 April 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Net book value at 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Net book value at 31 March 2019 comprises :									
Purchased	25,954	184,872	6,880	22,076	11,819	0	8,398	893	**260,892**
Donated	255	3,718	0	0	1,006	0	107	215	**5,301**
Government Granted	0	0	0	0	0	0	26	3	**29**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Asset financing :									
Owned	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**

The net book value of land, buildings and dwellings at 31 March 2019 comprises :

	£000
Freehold	**219,938**
Long Leasehold	**1,741**
Short Leasehold	**0**
	221,679

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for whih as asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	25,285	200,937	8,120	9,244	65,631	245	19,811	5,593	**334,866**
Indexation	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	0	1,711	0	10,217	2,510	0	2,983	190	**17,611**
- donated	0	204	0	0	376	0	5	38	**623**
- government granted	0	0	0	0	0	0	11	0	**11**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	842	3,746	0	(4,577)	(11)	0	0	0	**0**
Revaluations	657	397	(538)	0	0	0	0	0	**516**
Reversal of impairments	5	(4,857)	47	0	0	0	0	0	**(4,805)**
Impairments	(1,128)	(6,017)	(135)	(4,113)	0	0	0	0	**(11,393)**
Reclassified as held for sale	0	(8)	0	0	0	0	0	0	**(8)**
Disposals	0	0	0	0	(3,490)	0	0	0	**(3,490)**
At 31 March 2018	25,661	196,113	7,494	10,771	65,016	245	22,810	5,821	**333,931**
Depreciation at 1 April 2017	0	26,411	1,547	0	50,170	243	13,240	3,941	**95,552**
Indexation	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(12,391)	(1,528)	0	0	0	0	0	**(13,919)**
Reversal of impairments	0	(12,250)	4	0	0	0	0	0	**(12,246)**
Impairments	0	(1,764)	(19)	0	0	0	0	0	**(1,783)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,415)	0	0	0	**(3,415)**
Provided during the year	0	7,505	339	0	5,067	1	1,852	583	**15,347**
At 31 March 2018	0	7,511	343	0	51,822	244	15,092	4,524	**79,536**
Net book value at 1 April 2017	25,285	174,526	6,573	9,244	15,461	2	6,571	1,652	**239,314**
Net book value at 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Net book value at 31 March 2018 comprises :									
Purchased	25,411	185,355	7,151	10,771	12,053	1	7,604	1,139	**249,485**
Donated	250	3,247	0	0	1,141	0	73	153	**4,864**
Government Granted	0	0	0	0	0	0	41	5	**46**
At 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Asset financing :									
Owned	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**

The net book value of land, buildings and dwellings at 31 March 2018 comprises :

	£000
Freehold	**219,602**
Long Leasehold	**1,812**
Short Leasehold	**0**
	221,414

11. Property, plant and equipment (continued)

i) Acquisitions shown as donated assets within Note 11 were bought using monies donated by the public into the Hywel Dda Charities and contributions from Ty Bryngwyn Hospice, League of Friends and other charities and organisations.

During 2018-19 fixed assets purchased to the following value were funded by the following:

Hywel Dda General Fund Charity (1147863) Plant and Machinery	£154,528
Hywel Dda General Fund Charity (1147863) Furniture and Fittings	£ 98,112
Hywel Dda General Fund Charity (1147863) Bulidings	£ 38,368
Hywel Dda General Fund Charity (1147863) Information Technology	£ 58,344
Ty Bryngwyn Hospice Committee	£547,482
League of Friends & Other Contributions	£54,952
Total Donated Assets	**£951,786**

Other Disclosures

i) The LHB is not carrying any temporary idle assets.
Gross carrying amount of all fully depreciated assets still in use as at 31st March 2019 is £52,203,495

IFRS 13 - Fair Value Measurement

AS at 31st March 2019, the Health Board does not hold any fixed assets at fair value as defined by IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2018	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2019	0	0	0	0	0	**0**
Balance brought forward 1 April 2017	205	0	0	0	0	**205**
Plus assets classified as held for sale in the year	8	0	0	0	0	**8**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	(190)	0	0	0	0	**(190)**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	(23)	0	0	0	0	**(23)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2018	0	0	0	0	0	**0**

Assets sold in the period

Assets classified as held for sale during the year

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	2,548	0	79	0	0	0	**2,627**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- purchased	**945**	**0**	**0**	**0**	**0**	**0**	**945**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers		**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(134)**	**0**	**(2)**	**0**	**0**	**0**	**(136)**
Gross cost at 31 March 2019	**3,359**	**0**	**77**	**0**	**0**	**0**	**3,436**
Amortisation at 1 April 2018	1,511	0	71	0	0	0	**1,582**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	**361**	**0**	**8**	**0**	**0**	**0**	**369**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(134)**	**0**	**(2)**	**0**	**0**	**0**	**(136)**
Amortisation at 31 March 2019	**1,738**	**0**	**77**	**0**	**0**	**0**	**1,815**
Net book value at 1 April 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**
Net book value at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**
At 31 March 2019							
Purchased	**1,613**	**0**	**0**	**0**	**0**	**0**	**1,613**
Donated	**8**	**0**	**0**	**0**	**0**	**0**	**8**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	2,319	0	79	0	0	0	**2,398**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	229	0	0	0	0	0	**229**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Gross cost at 31 March 2018	**2,548**	**0**	**79**	**0**	**0**	**0**	**2,627**
Amortisation at 1 April 2017	1,172	0	58	0	0	0	**1,230**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	339	0	13	0	0	0	**352**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Amortisation at 31 March 2018	**1,511**	**0**	**71**	**0**	**0**	**0**	**1,582**
Net book value at 1 April 2017	**1,147**	**0**	**21**	**0**	**0**	**0**	**1,168**
Net book value at 31 March 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**
At 31 March 2018							
Purchased	1,026	0	8	0	0	0	**1,034**
Donated	10	0	0	0	0	0	**10**
Government Granted	1	0	0	0	0	0	**1**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**

Additional disclosures re Intangible Assets

Computer Software & Licences are capitalised at their purchased price.

Computer Software & Licences are not indexed as IT assets are not subject to indexation.

The assets are amortised monthly over their expected life.

The gross carrying amount of fully amortised intangible assets still in use as at 31 March 2019 was £964,805.

13 . Impairments

	2018-19 Property, plant & equipment £000	2018-19 Intangible assets £000	2017-18 Property, plant & equipment £000	2017-18 Intangible assets £000
Impairments arising from :				
Loss or damage from normal operations	**0**	**0**	0	0
Abandonment in the course of construction	**0**	**0**	0	0
Over specification of assets (Gold Plating)	**0**	**0**	0	0
Loss as a result of a catastrophe	**0**	**0**	0	0
Unforeseen obsolescence	**0**	**0**	0	0
Changes in market price	**0**	**0**	0	0
Others (specify)	**6,262**	**0**	9,633	0
Reversal of impairments	**(1,283)**	**0**	(7,441)	0
Total of all impairments	**4,979**	**0**	2,192	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	**4,979**	**0**	1,139	0
Charged to Revaluation Reserve	**0**	**0**	1,053	0
	4,979	**0**	2,192	0

The impairment charge for the above is made up of :-
Good housekeeping valuations undertaken on schemes completed and brought into use - £6,262K.

14.1 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	**3,776**	3,531
Consumables	**4,096**	4,153
Energy	**212**	191
Work in progress	**0**	0
Other	**0**	0
Total	**8,084**	7,875
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**1,679**	**1,222**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**95**	**450**
Welsh Health Boards	**1,403**	**1,183**
Welsh NHS Trusts	**910**	**404**
Health Education and Improvement Wales (HEIW)	**96**	**0**
Non - Welsh Trusts	**1**	**2**
Other NHS	**682**	**618**
Welsh Risk Pool	**21,892**	**27,639**
Local Authorities	**1,157**	**2,010**
Capital debtors	**0**	**0**
Other debtors	**5,499**	**5,299**
Provision for irrecoverable debts	**(1,053)**	**(872)**
Pension Prepayments	**0**	**0**
Other prepayments	**1,969**	**1,643**
Other accrued income	**0**	**0**
Sub total	**34,330**	39,598
Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
Welsh Risk Pool	**43,183**	14,697
Local Authorities	**0**	0
Capital debtors	**0**	0
Other debtors	**0**	0
Provision for irrecoverable debts	**0**	0
Pension Prepayments	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**43,183**	14,697
Total	**77,513**	54,295
Receivables past their due date but not impaired		
By up to three months	**279**	339
By three to six months	**71**	71
By more than six months	**30**	68
	380	478

Expected Credit Losses (ECL) / Provision for impairment of receivables		
Balance at 31 March 2018	(872)	
Adjustment for Implementation of IFRS 9	**(82)**	
Balance at 1 April 2018	(954)	(834)
Transfer to other NHS Wales body	**0**	**0**
Amount written off during the year	**55**	**5**
Amount recovered during the year	**0**	**0**
(Increase) / decrease in receivables impaired	**(154)**	**(43)**
Bad debts recovered during year	**0**	**0**
Balance at 31 March	**(1,053)**	(872)

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT		
Trade receivables	**582**	613
Other	**0**	0
Total	**582**	613

16. Other Financial Assets

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	305	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**305**	**0**	**0**

17. Cash and cash equivalents

	2018-19	2017-18
	£000	£000
Balance at 1 April	**1,528**	1,212
Net change in cash and cash equivalent balances	**(68)**	316
Balance at 31 March	**1,460**	1,528
Made up of:		
Cash held at GBS	**1,347**	1,708
Commercial banks	**88**	(202)
Cash in hand	**25**	22
Current Investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**1,460**	1,528
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,460**	1,528

The movement relates to cash, no comparative information is required by IAS 7 in 2018-19.

18. Trade and other payables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**4**	**1**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**1,148**	**133**
Welsh Health Boards	**1,113**	**1,318**
Welsh NHS Trusts	**1,345**	**790**
Health Education and Improvement Wales (HEIW)	**0**	**0**
Other NHS	**9,182**	**10,151**
Taxation and social security payable / refunds	**1,008**	**3,784**
Refunds of taxation by HMRC	**0**	**0**
VAT payable to HMRC	**0**	**0**
Other taxes payable to HMRC	**0**	**0**
NI contributions payable to HMRC	**1,317**	**4,550**
Non-NHS creditors	**6,157**	**4,283**
Local Authorities	**3,043**	**6,064**
Capital Creditors	**8,068**	**5,276**
Overdraft	**0**	**0**
Rentals due under operating leases	**0**	**0**
Obligations under finance leases, HP contracts	**0**	**0**
Imputed finance lease element of on SoFP PFI contracts	**0**	**0**
Pensions: staff	**0**	**0**
Accruals	**54,325**	**51,084**
Deferred Income:		
Deferred Income brought forward	**399**	**385**
Deferred Income Additions	**418**	**385**
Transfer to / from current/non current deferred income	**0**	**0**
Released to SoCNE	**(399)**	**(371)**
Other creditors	**6,356**	**7,257**
PFI assets –deferred credits	**0**	**0**
Payments on account	**0**	0
Total	**93,484**	95,090

Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS creditors	**0**	0
Local Authorities	**0**	0
Capital Creditors	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**0**	0
Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Total	**0**	0

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

Amounts falling due more than one year are expected to be settled as follows:	**31-Mar-19 £000**	**31-Mar-18 £000**
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	0	0

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	**31 March 2019 £000**	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2018	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2019
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	**22,286**	0	0	2,185	11,453	(9,094)	(9,225)	0	**17,605**
Personal injury	**3,299**	0	0	0	592	(530)	(224)	9	**3,146**
All other losses and special payments	**0**	0	0	0	167	(167)	0	0	**0**
Defence legal fees and other administration	**545**	0	0	129	827	(345)	(463)		**693**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**46**			0	13	(22)	0	0	**37**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**1,588**		0	0	2,391	(1,505)	(414)		**2,060**
Total	**27,764**	**0**	**0**	2,314	15,443	(11,663)	(10,326)	**9**	**23,541**
Non Current									
Clinical negligence	**14,614**	0	0	(2,185)	32,186	(1,123)	(444)	0	**43,048**
Personal injury	**0**	0	0	0	0	0	0	0	**0**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**357**	0	0	(129)	376	(122)	(33)		**449**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**0**			0	0	0	0	0	**0**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**0**		0	0	0	0	0		**0**
Total	**14,971**	**0**	**0**	**(2,314)**	**32,562**	**(1,245)**	**(477)**	**0**	**43,497**
TOTAL									
Clinical negligence	**36,900**	**0**	**0**	**0**	**43,639**	**(10,217)**	**(9,669)**	**0**	**60,653**
Personal injury	**3,299**	**0**	**0**	**0**	**592**	**(530)**	**(224)**	**9**	**3,146**
All other losses and special payments	**0**	**0**	**0**	**0**	**167**	**(167)**	**0**	**0**	**0**
Defence legal fees and other administration	**902**	**0**	**0**	**0**	**1,203**	**(467)**	**(496)**		**1,142**
Pensions relating to former directors	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Pensions relating to other staff	**46**			**0**	**13**	**(22)**	**0**	**0**	**37**
Restructuring	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Other	**1,588**		**0**	**0**	**2,391**	**(1,505)**	**(414)**		**2,060**
Total	**42,735**	**0**	**0**	**0**	**48,005**	**(12,908)**	**(10,803)**	**9**	**67,038**

Expected timing of cash flows:

	In year to 31 March 2020	Between 1 April 2020 31 March 2024	Thereafter	Total
				£000
Clinical negligence	17,605	43,048	0	**60,653**
Personal injury	3,146	0	0	**3,146**
All other losses and special payments	0	0	0	**0**
Defence legal fees and other administration	693	449	0	**1,142**
Pensions relating to former directors	0	0	0	**0**
Pensions relating to other staff	37	0	0	**37**
Restructuring	0	0	0	**0**
Other	2,060	0	0	**2,060**
Total	**23,541**	**43,497**	**0**	**67,038**

20. Provisions (continued)

	At 1 April 2017	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2018
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	14,119	0	0	9,206	8,723	(5,802)	(3,960)	0	**22,286**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	495	0	0	134	597	(268)	(413)		**545**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**19,015**	**0**	**0**	**9,340**	**12,319**	**(7,939)**	**(4,974)**	**3**	**27,764**
Non Current									
Clinical negligence	23,525	0	0	(9,206)	1,011	(231)	(485)	0	**14,614**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	432	0	0	(134)	84	(24)	(1)		**357**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**23,957**	**0**	**0**	**(9,340)**	**1,095**	**(255)**	**(486)**	**0**	**14,971**
TOTAL									
Clinical negligence	37,644	0	0	0	9,734	(6,033)	(4,445)	0	**36,900**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	927	0	0	0	681	(292)	(414)		**902**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**42,972**	**0**	**0**	**0**	**13,414**	**(8,194)**	**(5,460)**	**3**	**42,735**

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2018-19 £'000**	2017-18 £'000
Legal claims for alleged medical or employer negligence	**61,482**	53,939
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**1,691**	1,655
Continuing Health Care costs	**6,925**	13,600
Other	**0**	0
Total value of disputed claims	**70,098**	69,194
Amounts (recovered) in the event of claims being successful	**(59,534)**	(51,750)
Net contingent liability	**10,564**	**17,444**

21.2 Remote Contingent liabilities

	2018-19 £'000	2017-18 £'000
Guarantees	0	0
Indemnities	536	266
Letters of Comfort	0	0
Total	**536**	**266**

21.3 Contingent assets

	2018-19 £'000	2017-18 £'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2018-19 £'000	2017-18 £'000
Property, plant and equipment	28,124	16,100
Intangible assets	0	0
Total	**28,124**	16,100

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out or written-off during the financial year

	Amounts paid out during period to 31 March 2019		Approved to write-off to 31 March 2019	
	Number	**£**	**Number**	**£**
Clinical negligence	124	10,216,769	98	8,658,580
Personal injury	40	530,385	14	237,375
All other losses and special payments	295	167,037	295	167,037
Total	459	10,914,191	407	9,062,992

Analysis of cases which exceed £300,000 and all other cases

Cases exceeding £300,000	Case type	**Amounts paid out in year** £	**Cumulative amount** £	**Approved to write-off in year** £
07RR6MN0006	MN	1,394,905	1,578,905	0
09RYNMN0061	MN	35,000	665,000	0
12RYNMN0077	MN	1,300,000	1,615,021	0
13RYNMN0032	MN	650,000	980,000	0
13RYNMN0074	MN	0	819,000	819,000
14RYNMN0005	MN	680,000	695,000	695,000
14RYNMN0069	MN	2,280,000	2,810,000	2,810,000
14RYNMN0105	MN	0	850,000	850,000
15RYNMN0026	MN	0	362,698	362,698
15RYNMN0034	MN	323,345	573,345	0
16RYNMN0063	MN	100,000	310,000	0
18RYNMN0084	MN	422,000	423,920	0
19RYNMN0007	MN	370,950	370,950	0
Sub-total		**7,556,200**	**12,053,839**	**5,536,698**
All other cases		3,357,991	8,165,392	3,526,294
Total cases		**10,914,191**	**20,219,231**	**9,062,992**

24. Finance leases

24.1 Finance leases obligations (as lessee)

Amounts payable under finance leases:

Land	**31 March 2019 £000**	31 March 2018 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Finance leases obligations (as lessee) continue

Amounts payable under finance leases:

Buildings	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Finance leases obligations (as lessor) continued

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2019	31 March 2018
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has no PFI schemes which are deemed to be off-statement of financial position

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2019	31 March 2018
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element	**On SoFP PFI Imputed interest**	**On SoFP PFI Service charges**
	31 March 2019	**31 March 2019**	**31 March 2019**
	£000	**£000**	**£000**
Total payments due within one year	**0**	**0**	**0**
Total payments due between 1 and 5 years	**0**	**0**	**0**
Total payments due thereafter	**0**	**0**	**0**
Total future payments in relation to PFI contracts	**0**	**0**	**0**

	On SoFP PFI Capital element	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2018	31 March 2018	31 March 2018
	£000	£000	£000
Total payments due within one year	0	0	0
Total payments due between 1 and 5 years	0	0	0
Total payments due thereafter	0	0	0
Total future payments in relation to PFI contracts	0	0	0
Total present value of obligations for on-SoFP PFI contracts	**£0m**		

25.3 Charges to expenditure	2018-19	2017-18
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	31 March 2019 £000	31 March 2018 £000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2018-19	2017-18
	£000	£000
(Increase)/decrease in inventories	**(209)**	201
(Increase)/decrease in trade and other receivables - non-current	**(28,486)**	8,888
(Increase)/decrease in trade and other receivables - current	**5,573**	(11,747)
Increase/(decrease) in trade and other payables - non-current	**0**	0
Increase/(decrease) in trade and other payables - current	**(1,606)**	10,125
Total	**(24,728)**	7,467
Adjustment for accrual movements in fixed assets - creditors	**(2,792)**	(872)
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**(82)**	0
	(27,602)	6,595

28. Other cash flow adjustments

	2018-19	2017-18
	£000	£000
Depreciation	**15,255**	15,347
Amortisation	**369**	352
(Gains)/Loss on Disposal	**(13)**	(11)
Impairments and reversals	**4,979**	1,139
Release of PFI deferred credits	**0**	0
Donated assets received credited to revenue but non-cash	**(952)**	(623)
Government Grant assets received credited to revenue but non-cash	**0**	(11)
Non-cash movements in provisions	**37,210**	7,957
Total	**56,848**	24,150

29. Third Party assets

Hywel Dda University Health Board held £1,400,694 cash at bank and in hand at 31 March 2019 (31 March 2018, £1,178,113) which relates to monies held by the Health Board on behalf of patients. Cash held in Patient's Investment Accounts amounted to £666,248 at 31 March 2019 (31 March 2018, £664,921). This has been excluded from the Cash and Cash equivalents figure reported in the Accounts.

30. Events after the Reporting Period

The LHB **has not** experienced any events having a material effect on the accounts, between the date of the statement of financial position and the date on which these accounts were approved by its Board.

31. Related Party Transactions

A number of the LHB's Board members have interests in related parties as follows:

Name	Details	Interests	
Anna Lewis	Independent Member	Board Trustee	Spice Innovations Ltd
		Visiting Senior Lecturer	Swansea University
Julie James	Independent Member	Health Assessor	Welsh Government Health and Wellbeing at Work Corporate Standard
		Trustee	National Botanic Garden of Wales
		Member of Court	Swansea University
		Non-Executive Director	Welsh Government Dept for Education and Local Government & Communities
		External Voting Member	Carmarthenshire County Council Audit Committee
		Member	Carmarthenshire County Council's Standards Committee
Michael Hearty	Associate Member	Finance Advisor	Betsi Cadwaladr Health Board
		Non-Executive Director	HMRC
		Non-Executive Director	Blackpool Teaching Hospital Foundation Trust
		Non-Executive Director	Public Health England
Philip Kloer	Medical Director	Honorary Professor	Swansea University
Simon Hancock	Independent Member	Treasurer	Age Concern
		Member	Mencap
		Vice Chair	Pembrokeshire County Council
		Member of Court	Swansea University
Steve Moore	Chief Executive	Honorary Professor	University of Wales Trinity St David
Huw Thomas	Finance Director	Chair HFMA Wales Branch	Healthcare Financial Management Association (HFMA)

Total value of transactions are with entities at which Board members and key senior staff have influential interests in 2018-19

	Payments to related party	from related party	Amounts owed to related party	Amounts due from related party
	£000	£	£	£
Age Concern Pembrokeshire	85	0	0	0
Blackpool Teaching Hospitals Foundation Trust	16	0	0	0
Carmarthenshire County Council	12,961	1,983	1,017	765
HFMA	27	0	0	0
HMRC	2,325	0	37,507	0
Mencap	95	0	0	0
National Botanic Gardens of Wales	8	0	0	0
Pembrokeshire County Council	5,050	2,812	1,482	223
Public Health England	15	0	0	0
Spice Innovations Ltd	54	0	0	0
Swansea University	571	2	1,378	66
University of Wales Trinity St David	20	0	2	0

The Welsh Government is regarded as a related party. During the accounting period the Hywel Dda University Health Board has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body:

	Debtor @ 31 -Mar 19 £'000s	Creditor @ 31-Mar-19 £'000s	Income @ 31-Mar-19 £'000s	Expenditure @ 31-Mar-19 £'000s
Welsh Government	1,679	4	880,945	5
Abertawe Bro Morgannwg University Health Board	406	433	4,150	35,335
Aneurin Bevan University Health Board	23	74	762	808
Betsi Cadwaladr University Health Board	237	27	4,522	410
Cardiff & Vale University Health Board	187	165	553	6,359
Cwm Taf University Health Board	87	76	445	529
Powys Local Health Board	463	339	8,299	580
Public Health Wales NHS Trust	60	225	2,067	2,078
Velindre University NHS Trust	5,061	1,107	2,157	12,051
Welsh Ambulance Services Trust	40	12	178	3,093
Welsh Health Specialised Services Committee	95	1,148	2,152	85,495
Health Education and Improvement Wales (HEIW)	96	0	3,187	0
Total £'000s	8,434	3,611	909,417	146,743

32. Pooled budgets

Hywel Dda University Health Board has entered into a pooled budget with Ceredigion County Council on the 1st April 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Ceredigion County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Ceredigion County Council and the Health Board. Payments for services provided by Ceredigion County Council in the sum of £306,000 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into a pooled budget with Carmarthenshire County Council on the 1st October 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Carmarthenshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Carmarthenshire County Council and the Health Board. Payments for services provided by Carmarthenshire County Council in the sum of £381,960 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into an agreement with Carmarthenshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of Carmarthenshire Community Health and Social Care services. The section 33 agreement itself will initially only provide the framework for taking forward future schedules and therefore references all community based health, social care (adults & children) and related housing and public protection services so that if any future developments are considered a separate agreement will not have to be prepared. There are currently no pooled budgets related to this agreement.

Hywel Dda University Health Board has entered into an agreement with Pembrokeshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store and from 1st October 2012 the agreement has operated as a pooled fund. The pool is hosted by Pembrokeshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Pembrokeshire County Council and the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement and the sum of £ £310,781 has been accounted for as expenditure in the accounts of the Health Board.

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

The Hywel Dda University Health Board has identified the organisations full Board as the Chief Operating Decision Maker (CODM) under IFRS 8. Only the full Board can allocate resources to the various services. The organisation is constituted as an integrated Local Health Board with seamless service delivery.

The management and reporting for the operations of Hywel Dda University Health Board to the CODM is through Acute Care and Counties. Whilst these may be seen as segments they each provide the same spectrum of integrated services and therefore the Local Health Board has aggregated them into one healthcare segment as provided for under IFRS 8. The Local Health Board has no non healthcare activities.

34. Other Information

IFRS15

Work was undertaken by the TAG IFRS sub group, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15. It was determined that the following types of consideration received from customers for goods and services (hereon referred to as income) fell outside the scope of the standard, as the body providing the income does not contract with the body to receive any direct goods or services in return for the income flow.

- Charitable Income and other contributions to Expenditure.
- Receipt of Donated Assets.
- WG Funding without direct performance obligation (e.g. SIFT/SIFT®/Junior Doctors & PDGME Funding).

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB & WHSCC LTA Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- ICR Income ;
- Training & Education income ;
- Accommodation & Catering income

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded (FCE's), as at period end, e.g. 31 March.

When calculating the income generated from these episodes, it was determined that it was appropriate to use length of stay as the best proxy for the attributable Work In Progress (WIP) value. In theory, as soon as an episode is opened, income is due. Under the terms and conditions of the contract this will only ever be realised on episode closure so the average length of stay would be the accepted normal proxy for the work in progress value.

For Hywel Dda University Health Board, the summary assessment of the impact of IFRS 15 is below -

Annual Accounts year looked at: 2016/17

Total Income per Accounts in the year 2016/17 :	£52.934m
Total Income looked at as part of the exercise:	£29.595m
Total Income looked at considered to be outside the scope of IFRS 15:	£ 3.873m
Total Income looked at that is inside the scope of IFRS 15	£25.722m
Total Income looked at that is inside the scope of IFRS 15 and potentially requires adjustment for incomplete service provision episodes	£15.014m
Total estimated adjustment required under IFRS 15	£ 0.059m

34. Other Information (continued)

IFRS 9

For consistency across Wales, the practical expedient provision matrix was used to estimate expected credit losses (ECLs) based on the 'age' of receivables as follows:

- Receivables were segregated into appropriate groups

- Each group, was analysed:

a) age-bands

1-30 days (including current)
31-60 days
61-90 days
91-180 days
181- 365 days
> 1 year

b) at historical back-testing dates (data points)

- For each age-band, at each back-testing date the following were determined:
  a) the gross receivables
  b) the amounts ultimately collected/written-off. If material, adjustments should be made to exclude the effect of non-collections for reasons other than credit loss (e.g. credit notes issued for returns, short-deliveries or as a commercial price concession)

The average historical loss rate by age-band was calculated, and adjusted where necessary e.g. to take account of changes in:
a) economic conditions
b) types of customer
c) credit management practices

Consideration was given as to whether ECLs should be estimated individually for any period-end receivables, e.g. because information was available specific debtors.

Loss rate estimates were applied to each age-band for the other receivables.

The percentages calculated have been applied to those invoices outstanding as at 31st March 2018 (which don't already have a specific provision against them) to recalculate the value of the HB/Trust non-specific provision under IFRS9.

BREXIT UPDATE

On 29 March 2017, the UK Government submitted its notification to leave the EU in accordance with Article 50. The triggering of Article 50 started a two-year negotiation process between the UK and the EU. On 11 April 2019, the government confirmed agreement with the EU on an extension until 31 October 2019 at the latest, with the option to leave earlier as soon as a deal has been ratified.

In 2018-19 the NHS Estate has been valued using indices provided by the District Valuer and disclosed in the Manual For Accounts.

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Head of Internal Audit Annual Report and Opinion 2018 -19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Head of Internal Audit
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Internal Audit

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Head of Internal Audit Annual Report and Opinion provides specific information for the University Health Board covering the following key areas:

- Overall Annual Assurance Opinion and supporting Information
- Details of individual assurance domain opinions, audit assignment objectives and outcomes
- Details of how the audit work is delivered in conformance with the Public Sector Internal Audit Standards.

Cefndir / Background

The work undertaken by Internal Audit is in accordance with its plan of work, which is prepared following a detailed planning process and subject to Committee approval.

The Head of Internal Audit Annual Report and opinion provides an overall assurance rating as the adequacy of the risk, governance and control environment.

Asesiad / Assessment

The Head of Internal Audit Annual Report and opinion provides an overall assurance rating for 2018/19 of Reasonable Assurance.

Argymhelliad / Recommendation

For Assurance - The Audit & Risk Assurance Committee is asked to receive the Head of Internal Audit Report and Opinion for 2018/19.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Internal Audit plan. Evidence gathered as part of the delivery of audit assignments.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Directors and Senior managers relevant to the individual audits. Board Secretary. Audit & Risk Assurance Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not applicable
Gweithlu: **Workforce:**	Not applicable
Risg: **Risk:**	Not applicable

Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

Hywel Dda University Health Board

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2018/19

May 2019

NHS Wales Shared Services Partnership

Audit & Assurance Services

CONTENTS

Report status: FINAL
Draft report issued: April 2019
Final report issued: 21st May 2019
Author: James Johns, Head of Internal Audit
Lead Executive : Joanne Wilson (Board Secretary)
Audit & Risk Assurance Committee: 29th May 2019

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit (HIA) opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved internal audit plan is biased towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion has been formed by summarising audit outcomes across eight key assurance domains. The overall opinion is then based upon these grouped findings. In a change to previous years all domains now carry equal weighting.

In my opinion 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. Several significant matters require management attention with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The internal audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit & Risk Assurance Committee. Regular audit progress reports have been submitted to the Audit & Risk Assurance Committee during the year.

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2018/19.

We are now able to state that our service 'conforms to the Institute of Internal Audit's (IIA's) professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

The report summarises the outcomes from the internal audit plan undertaken in the year and, recognising audit provides a continuous flow of assurance, includes the results of legacy audit work reported subsequent to the prior year opinion. The report also references assurances received through the internal audit of control systems operated by NWSSP for transaction processing on behalf of the Health Board.

The audit coverage in the plan agreed with management has been deliberately focussed on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

In overall terms we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Corporate governance, risk management and regulatory compliance;
- Strategic planning, performance management and reporting;
- Financial governance and management;
- Clinical governance, quality and safety;
- Information governance and security.
- Operational services and functional management; and
- Capital and Estates management.

However, the significance of the matters identified in those areas where there are improvements to be made in governance, risk management and control impacts upon our overall audit assessment in the following assurance domain:

- Workforce management.

There were in total five individual audits issued across the overall plan where a Limited Assurance rating was allocated: IT Security Follow Up, Records Management, Cleaning Standards, Water Safety Management and PADRs.

Management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where appropriate.

Please note that our assessment across each of the domains has also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (see also Section 2.4.1)

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the PSIAS, the HIA is required to provide an annual opinion, based upon and limited to, the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit & Risk Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit & Risk Assurance Committee, will need to consider the Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Hywel Dda University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Wales Audit Office in the context of their external audit.

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.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide the forming of the opinion for 2018/19.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix D**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the eight assurance domains that were used to frame the internal audit plan at its outset. The aggregation of audit results by these domains gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process, to ensure the assurance domain ratings and overall opinion are consistent with the underlying audit evidence and in accordance with the criteria for judgement at **Appendix E**.

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit & Risk Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below:

 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. More significant matters require management attention with **low to moderate impact on residual risk** exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any *limited* or *no-assurance* reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the opinion the Head of Internal Audit has applied both professional judgement and the Audit & Assurance "*Supporting criteria for the overall opinion*" guidance produced by the Director of Audit & Assurance and shared with key stakeholders, see **Appendix E**.

In reaching the over Reasonable Assurance Opinion I have identified that the majority of reviews during the year concluded positively with sound control arrangements operating in some areas.

As well as the overall opinion, I have also concluded that seven of the eight individual assurance domains are also be classified with a reasonable assurance opinion.

However, the Workforce domain was allocated Limited Assurance when also taking in to account the relevant control weaknesses identified in the two directorate audits.

From the Internal Audit work performed during the year the majority of audits were allocated either Substantial or Reasonable assurance opinions.

It is also noted that the majority of follow up audits identified progress being made implementing the previous recommendations with an improved assurance rating allocated in a number of cases.

In addition however, it is also important to highlight that five Limited assurance reports have been issued during the year, with these individual Limited assurance reports in four separate assurance domains.

From review of the Annual Governance Statement it was considered it to be on the whole consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents. In addition a review of the Governance, Leadership and Accountability Standard again noted that we considered it to be on the whole consistent with our knowledge of the UHB.

The summary of assurance outcomes is set out in Appendix B.

This opinion will need to be reflected within the Annual Governance Statement, along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any limited assurance reports issued during the year and the significance of the recommendations made.

The audit work undertaken during 2018/19 and reported to the Audit & Risk Assurance Committee has been aggregated at **Appendix B**.

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

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit & Risk Assurance Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module;
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

As stated above these detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed. Where there is insufficient evidence to draw a firm conclusion the assurance domain is not rated.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited or no assurance was reported. Furthermore, a number of audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. Where changes were made to the audit plan then the reasons were presented to the Audit & Risk Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which

were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings in each of the domains is set out below, with commentary on pertinent audits where applicable. Each domain heading has been colour coded to show the overall assurance for that domain.

Corporate Governance, Risk Management and Regulatory Compliance

The audits of the consultancy Service follow up and Welsh Risk Pool Claims both concluded positively with Substantial Assurance. The Governance of Single tender Actions audit was allocated Reasonable Assurance. The audit of the Health and Care Standards has also concluded positively. A review of both the Annual Governance Statement and Governance, Leadership and Accountability Standard highlighted that they were considered it to be on the whole consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

The audits of Homecare Services Follow up and the Annual Plan were given Substantial Assurance, with the ICF Follow up allocated Reasonable Assurance.

Financial Governance and Management

The audits of the main financial systems were operating to a good standard, with Treasury Management and Charitable Funds assigned Substantial Assurance and Accounts Receivable and Financial Ledger Reasonable Assurance. The audit of the Cost Improvement Programme (Draft) and Budget Planning (Draft) both concluded positively with Reasonable Assurance.

Clinical Governance, Quality & Safety

The audits of Concerns, Safeguarding and Management of Controlled Drugs were allocated Reasonable Assurance. Further to this a review of actions form an Ombudsman Case was also given Reasonable Assurance.

Information Governance & IT Security

The audit of GDPR was given Substantial Assurance.

Three follow up audits, Freedom of Information Act Follow up, IMT Security Policies and Procedures and Procurement and Disposal of IT assets were given reasonable Assurance, indicating an improvement from the previous audits.

However, the follow up audit of IT/PC/ Laptop Security still concluded Limited Assurance.

Operational Service and Functional Management

Audits of the Radiology Directorate, the IM&T Directorate, the Royal College of Physicians Medical Records Standards and also the Discharge Follow up audit were each allocated a Reasonable Assurance Rating.

However, it is important to note that the audits of Records Management and National Cleaning Standard both concluded with a rating of Limited Assurance.

Workforce Management

The audit of Personal Appraisal and Development Reviews (PADRs) across the UHB has concluded with Limited Assurance.

In considering the rating for this domain the weaknesses identified within the two main directorate audits where the specific workforce/payroll elements of the audits were both given Limited Assurance, has been taken in to account.

The audit of the Nurse Staffing Act has been allocated rating of Substantial Assurance. Health Board findings relating to the audit of Payroll Services (undertaken by NHS Wales Shared Services Partnership) was given Reasonable Assurance.

Capital & Estates Management

The majority of audits in this domain have concluded positively, with six audits having Reasonable Assurance and one Substantial Assurance.

It is important to note that the audit of Water Safety Management was allocated a rating of Limited Assurance.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above, the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance, risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board, and subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement, a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, all other work in progress will be rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2018/19 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods, and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews which remain relevant to the reporting of the Annual Report required to be published by 30 June 2018. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed and reported to management and the Audit & Risk Assurance Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance work completed as part of this current year's plan albeit relating to the 2017/18 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2018/19 Annual Report and Quality Statement.

2.5 Required Work

There are a number of pieces of work that Welsh Government has previously required that Internal Audit should review each year, where applicable. These pieces cover aspects of:

- Health & Care Standards, including the Governance, Leadership and Accountability standard;
- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report;
- Carbon Reduction Commitment; and
- Welsh Risk Pool Claims.

Where appropriate, our work is reported in Section 5 – Risk-based Audit Assignments, and at **Appendix B**.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms to all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit & Assurance Services can assure the Audit Committee that it has conducted its audit at Hywel Dda University Health Board in conformance with the Public Sector Internal Audit Standards for 2018/19.

Our conformance statement for 2018/19 is based upon:

- The results of our internal Quality Assurance and Improvement Programme (QAIP) for 2018/19 which will be reported formally in the summer of 2019;
- The results of the work completed by Wales Audit Office; and
- The results of the External Quality Assessment undertaken by the IIA.

We have set out, in Appendix A, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2018/19 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and Risk Management;
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. The Head of Internal Audit has had regard to these audits, which are listed below.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

- Procurement – Accounts Payable -Reasonable
- Employment Services – Payroll - Reasonable
- Primary Care Services – General Medical Services - Substantial
- Primary Care Services – General Pharmaceutical Services - Substantial
- Primary Care Services – General Dental Services – Substantial
- Primary Care Services – General Ophthalmic Services – Substantial.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme.

The overall Head of Internal Audit Opinion for NWSSP has given an overall rating of Reasonable Assurance.

In addition, as part of the internal audit programme at Cwm Taf UHB a number of audits were undertaken in relation to both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialised Services Committee

- High cost drugs review (Reasonable)
- Review of network groups and advisory boards (Reasonable)
- Risk management (Reasonable)
- Governance arrangements (Reasonable)

Emergency Ambulance Services Committee

- Non-emergency patient transport service – follow up of baseline review (No opinion given)
- Governance and performance (Reasonable)

NHS Wales Informatics Service (NWIS)

We have also undertaken two audits relating to the processes and operations of NWIS.

- Business Continuity Planning – Reasonable Assurance
- Change Control Management – Limited Assurance

While these audits do not form part of the annual plan for Hywel Dda University Health Board, they are listed here for completeness as they do impact on the Health Board's activities, and the Head of Internal Audit does consider if any issues raised in the audits could impact on the content of our annual report.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report, along with the NWIS Audits; the WHSSC and EASC audits are detailed in the Cwm Taf UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit & Risk Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit & Risk Assurance Committee during the year. Audits which remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2019/20 operational audit plan.

The assignment status summary is reported at section 5 and **Appendix B**.

In addition, throughout the year we have responded to requests for advice and/or assistance across a variety of business areas. This advisory work undertaken in addition to the assurance plan is permitted under the standards to assist management in improving governance, risk management and control. This activity has been reported during the year within our progress reports to the Audit & Risk Assurance Committee.

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. The key performance indicators are summarised in Appendix C.

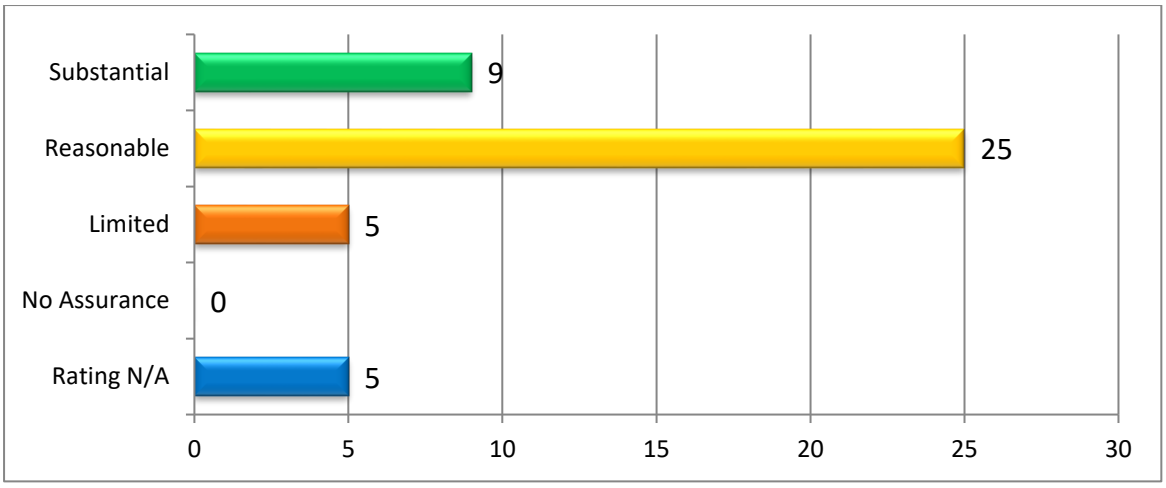
5. RISK-BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 44 audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



The assurance ratings and definitions used for reporting audit assignments are included in **Appendix D**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management, as it was recognised that there was action required to address issues / risks already known to management and an audit review at that time would not add additional value. Such audits were replaced.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Consultancy Services Follow up	The scope of the audit was restricted to a review of evidence demonstrating progress against previous Internal Audit report recommendations for the governance arrangements in place surrounding the appointment and utilisation of external consultancy services.
Welsh Risk Pool Claims	The objective of the review was to ensure that the WRP Claims Management function within the Health Board is operating effectively.
Homecare Services (Follow up)	The review has considered the progress against the recommendations made in the previous audit of Homecare Services in 2015, reference HDUHB1516-43 and the follow-up carried out in 2016/17, reference HDUHB1617-37.
Treasury Management	The overall objective of the review was to ensure that the financial stability of the organisation is attained and then constantly monitored and maintained to enable the organisation to achieve its business plan.
Charitable Funds	The overall objective of the audit is to provide assurance that Health Board property and potential Health Board property is being identified and properly safeguarded, recorded and accounted for, and is being used, invested and expended in accordance with the requirements of the donors, of the relevant legislation, of the Charity Commission and of the NHS Executive.
Aberaeron Integrated Care Centre	The scope and remit of the audit was directed to the following areas: Strategy, Project Governance, Project Management, Appointments, Design development.

Review Title	Objective
Annual Plan	The main areas reviewed during this audit include: • The delivery and development of the Health Board's Annual Plan 2019/20 is appropriately aligned to the relevant elements of the NHS Wales Planning Framework where appropriate to its current status; • The Annual Plan 2019/20 has been developed to ensure delivery of the Health Board's short and medium-term strategy, with the development process ensuring engagement across the organisation to address key challenges, including Finance, Performance, Quality and Workforce. • The Annual Plan 2019/20 has been aligned to the Transforming Clinical Services agenda; and • The Health Board has established appropriate reporting, governance and assurance processes.
Nurse Staffing Act	The scope of the review is to establish if the Health Board has appropriate processes in place to ensure that it is complying with the requirements of the Nurse Staffing Levels (Wales) Act 2016.
GDPR	The objectives of the review were: • to consider if appropriate action has been taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have; • to establish what local governance controls and measures have been implemented; and • a register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.

5.3 Reasonable Assurance

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Follow-up of Single Tender Actions	The review considered progress against the recommendations made in the previous review of Single Tender Actions The objective of the review was to provide assurance that arrangements in place within the Health Board concerning Single Tender Actions are robust and that the recommendations previously made by Internal Audit have been successfully implemented.
Accounts Receivable	The overall objective of the audit is to give assurance that all income due to the Health Board is properly identified, collected and accounted for under management control. Timely and adequate information should be received by management to confirm this.
Financial Ledger	The overall objective of the audit is to give assurance that the Health Board maintains records of all financial transactions and ensures their completeness and integrity, with the aim of providing the basic data from which management accounts, final accounts and financial returns can be prepared.
Concerns	The review will consider the arrangements in place for effective handling and management of complaints and incidents; ensuring compliance with the requirements of Welsh Government regulations as well as internal Health Board policies and procedures. In addition, the assignment will also consider the effectiveness of information sharing throughout the Health Board to ensure lessons are learned from addressed concerns.
Safeguarding	The review will consider the following in line with Standard 2.7 of the Health and Care Standards, Safeguarding Children and Safeguarding Adults at Risk.

Review Title	Objective
Ombudsman Case	For the specific Ombudsman case brought against the Health Board, the review will look at the following: How the original complaint was handled prior to the referral to the Ombudsman and whether lessons could be learnt; The action plan produced in response to the recommendations made in the Ombudsman report; ensuring satisfactory responses were given in the timeframe requested; and Evidence that the recommendations have been followed through.
Management of Controlled Drugs	The overall objective of this review was to consider the internal controls put in place for the management of controlled drugs within the organisation. The scope of this review was limited to Amman Valley, South Pembrokeshire and Tregaron Hospitals, and two central Pharmacy Departments at Prince Philip and Withybush Hospitals.
IM&T Security Policies & Procedure Follow up	The objective of the review is to assess whether the Health Board has implemented the Internal Audit recommendations made following the review in 2016/17 reference HDUHB1617-17 where we gave an opinion of 'Limited Assurance'.
Procurement of and disposal of IT Assets follow up	The objective of the review is to assess whether the Health Board has implemented the agreed Internal Audit recommendations made following the review in 2016/17 reference HDUHB1617-26 which was given a 'Limited Assurance' rating.
Freedom of Information Act follow up	The review will consider progress against the recommendations made in the previous review of Freedom of Information in 2017/18, reference HDUHB1718-29.

Review Title	Objective
Radiology Directorate	To establish whether this overall objective is being achieved, Internal Audit reviewed the following areas: • Corporate governance; • Stores; • Non pay; • Charitable Funds; • Financial reporting; • Treasury Management; • Income; • Patients' monies; • Asset management; and • Payroll.
Royal College of Physicians Medical Records Standard	This review has considered the application of Royal College of Physicians approved "General Medical Record Keeping Standards" in the Health Board's clinical note keeping arrangements. The objective of the audit was to provide a baseline that the Health Board can use to measure and demonstrate its compliance with the above standards. This work has also evaluated the adequacy of the systems and controls in place for the management of clinical note keeping, compliance with Regulations and the requirements of internal Hywel Dda University Health Board policies and procedures.
IM&T Directorate	To establish whether this overall objective is being achieved, Internal Audit has reviewed the following areas: • Corporate governance; • Stores; • Non pay; • Financial reporting; • Asset management; and • Payroll
UHB Payroll	The purpose of this report is to highlight those issues identified during the audit of NWSSP Employment Services, which impact upon the overall system of internal control.
Fire Precautions	This review encompassed an evaluation of the actions taken by the UHB to address previously agreed recommendations identified by audit for management action.

Review Title	Objective
Informatics Project Data Centre	The main areas that the review seeks to provide assurance on are: -there is a robust implementation strategy in place to address identified risks; -appropriate project governance is in place; -the project has been subject to appropriate scrutiny and approval; -compliance with national and local procurement requirements is -demonstrated in respect of the procurement arrangements; and -appropriate arrangements are in place to monitor project objectives, -including time and cost performance, against key assumptions as defined at the Business Case.
Follow up Capital	The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified at previous capital audits.
Follow up Estates Assurance	The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified at previous estates audits.
Cardigan Integrated Care Centre	The scope and remit of the audit was directed to the following areas: Project Governance, Project Management, Reporting and approvals and Change Management.
Withybush wards 9&10	The scope and remit of the audit was directed to the following areas: Project Governance, Project Management, Reporting and approvals and Change Management.
Cost Improvement Programme (Draft)	The overall objective of the review was to ensure that the Health Board has systems in place to support the effective identification, planning, monitoring and delivery of CIP's designed to assist the organisation in achieving its statutory responsibility to deliver services whilst remaining within its resource limit.
Review of Discharge Procedures	The overall objective of this audit is to provide assurance that the discharge planning processes in place across the acute sector in Hywel Dda University Health Board are effective and compliant with the Discharge and Transfer of Care Policy.

Review Title	Objective
Integrated Care Fund follow up	The objective of the review was to establish progress made by management to implement actions agreed to address key issues identified during the 2016/17 review of governance arrangements in place surrounding the ICF programme to ensure that monies are being utilised in line with Welsh Government guidance.
Budget Plan (draft)	The overall objective of the audit is to ensure that there are adequate systems in place to enable the Health Board develops and agrees a robust budget plan.
Health & Care Standards (draft)	The objectives were to ensure that processes were in place for the utilisation of the Standards; and a review of the Governance, Leadership & Accountability Standard.

5.4 Limited Assurance

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

Review Title	Objective
IT/ PC / Laptop Security Arrangements	The main control areas reviewed were: • Corporate responsibilities for managing and using desktop and mobile computing facilities were clearly defined; • Access to IT equipment such as PCs and Laptops and to the data and software stored on them is confined to authorised personnel and is appropriate to operational needs; and • IT Equipment is used in a secure manner and is well protected.

Review Title	Objective
National Standards for Cleaning in Wales	The scope of the review is to identify how the Health Board is meeting its requirements in relation to the National Standards for Cleaning in NHS Wales. This review is limited to reviewing Standard VII - Monitoring of Cleaning Outcomes – of the National Standards and concentrates on Internal Technical Audits.
Water safety Management	The scope and remit of the audit was directed to the following areas: • Governance • Procedures. • Monitoring and Reporting • Management • Risk Management
Records Management	The main areas reviewed during this audit include: Implementation of the Records Management Strategy; • Accountabilities for the implementation of the Records Management Strategy; • Storage, Retention and Destruction of Records; • Security Arrangements in place with respect to access to Records; • Records Management Training and Guidance; • Audit of Records Management; and • Performance Indicators in respect of Records Management.
PADRs	The overall objective of this audit is to confirm the level of PADR compliance within the Health Board, and to recommend how the overall score could be improved. The objectives of this review will be to confirm that: • Performance figures reported to the Health Board are accurate and correct; and • Actions to improve compliance figures have been communicated to the Health Board.

5.5 No Assurance

There are no audited areas in which the Board has **no assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively, or where action remains to be taken to address the whole control framework with high impact on residual risk exposure until resolved.

5.6 Assurance Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Review Title	Objective
Carbon Reduction Commitment (CRC)	This review sought to provide the Health Board with assurance that operational procedures were compliant with the CRC Scheme guidelines, including mandatory and best practice elements.
Sustainability Reporting for Annual Report	The overall objective of the review was to assess the adequacy of management arrangements for the production of the sustainability report within the Annual Report. This included whether the form and content of the statement complied with the Welsh Government requirements. Specifically whether the information published provided an accurate, and representative, picture of the quality of services provided, together with the improvements committed.
Governance in IT	Review of specific governance process with the IT directorate.
Asset Register	The overall objective of the audit is to give advice that the systems in place for the management capital assets are in line with current good practice.
Annual Governance Statement	To review the content of AGS for appropriateness and reasonableness.

Additionally, the following audits were deferred for reasons outlined below. The reason for deferment is outlined for each audit together with any impact on the Head of Internal Audit Opinion.

Review Title	Objective

Nurse Medication Errors	Following discussions with management it was agreed that this audit be deferred. It is considered that there would not have been any material impact on the opinion as a result of the deferment.
Consultants Job Planning	Following discussions with management it was agreed that this audit be deferred. It is considered that there would not have been any material impact on the opinion as a result of the deferment.
Business Continuity Planning	Following discussions with management it was agreed that this audit be deferred. It is considered that there would not have been any material impact on the opinion as a result of the deferment.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by directors and staff of the Health Board to support the delivery of the Internal Audit assignments undertaken within the 2018/19 plan.

James Johns

Head of Internal Audit

Audit & Assurance Services

NHS Wales Shared Services Partnership

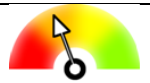
May 2019

ATTRIBUTE STANDARDS:	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing Orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and Code of Ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is a professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. WAO complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS:	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk-based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with WAO and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and each report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN (DRAFT)

Assurance domain		Overall rating	Not rated	No	Limited assurance	Reasonable assurance	Substantial assurance
Corporate governance, risk and regulatory compliance	5		AGS			Governance- STA *H&C Standards(draft)*	Consultancy follow up WRP Claims
Strategic planning, performance management and reporting	**3**					ICF follow up	Homecare Services (Follow-up) Annual Plan
Financial governance and management	7		*Asset Register (advisory)*			Accounts Receivable Financial Ledger *Cost Improvement Plans* (draft) *Budget Plan(draft)*	Treasury Management Charitable Funds
Clinical governance quality and safety	4					Concerns Safeguarding Ombudsman Medicines Management	
Information governance and security	6		Governance in IT		IT Security Follow up	IM&T Security Policies and Procedures (Follow-up) Procurement and Disposal of IT Assets (Follow-up)	GDPR

Assurance domain		Overall rating	Not rated	No	Limited assurance	Reasonable assurance	Substantial assurance
						Freedom of Information Act (Follow-up)	
Operational service and functional management	6				Records Mgt. Cleaning Standards	Radiology Directorate Royal College of Physicians Medical Records Standard IM&T Directorate Discharge Process Follow up	
Workforce management	3	 *			PADR	UHB Payroll	*Nurse Staffing Act)*
Capital and estates management	10		Environmental sustainability Carbon Reduction Commitment		Water Management	Fire Precautions Informatics Project Data Centre Capital Follow up Estates Follow up Cardigan Integrated Care Centre Withybush Wards 9&10	Aberaeron Integrated Care Centre
	44		**5**		**5**	**25**	**9**

Key to symbols:
*** - Domain outcome has also taken in to account the workforce/payroll findings in the two Directorate Reviews where those specific areas of audit coverage were allocated Limited assurance.**

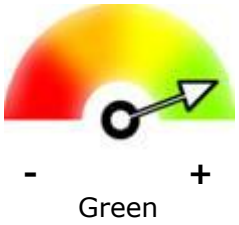
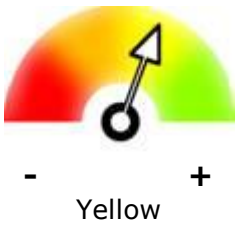
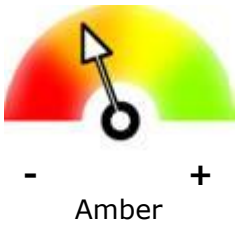
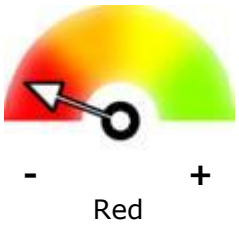
●	Audit undertaken within the annual Internal Audit plan
Italics	Reports not yet finalised but have been issued in draft

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	March 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2018/19	A	97%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	93%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	78%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

2018/19 Audit Assurance Ratings

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

Overall opinion assessment matrix

Supporting criteria for the overall opinion

Criteria	Substantial Assurance	Reasonable Assurance	Limited assurance	No assurance
Audit results consideration				
Overall results				
Assurance domains rated green	≥5 green; and			
Assurance domains rated yellow	≤3 yellow; and	≥5 yellow; and		
Assurance domains rated amber	No amber; and	≤ 3 amber; and	≥5 amber; and	
Assurance domains rated red	No red	No red	≤3 red	≥4 red
Audit scope consideration				
Audit spread domain coverage	All domains must be rated	No more than 1 domain not rated	No more than 2 domains not rated	3 or more domains not rated

Note: The overall opinion (see section 2.4.2) is subject ultimately to professional judgement notwithstanding the criteria above.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies, procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
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