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Hywel Dda
University Health Board

Hywel Dda University Health Board

Annual Report and Accounts 2020/2021




Carew Castle image courtesy of Pembrokeshire Tourism
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DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

What will this Annual Report tell you?

Our Annual Report suite of documents tell you about your Health Board, the care we provide and what we do to plan, deliver, and improve healthcare for you.

Due to the extraordinary nature of the year of 2020/21, this year's reports are written in the context of how we have planned, responded, and delivered care during the COVID-19 pandemic.

The Annual Report is made up of three parts:

Performance report - This report will tell you about the challenges we have faced and how we have addressed them, as well as achievements and progress made. It includes information about the direct response provided to COVID-19, along with the impacts on other areas of health and care. It details how we have performed against Welsh Government targets and our actions to improve. It also describes how we have maintained a focus on safety and quality during the pandemic and considers what we have learnt and how this will inform future work.

Accountability report - This report details our key accountability requirements under the Companies Act 2006 and The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (as adapted for public sector organisations). It includes our Annual Governance Statement (AGS), which provides information about how we manage and control our resources and risks and comply with governance arrangements.

Financial accounts - Our summarised Financial Statements detail how we have spent our money and met our obligations under The National Health Service Finance (Wales) Act 2014.

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Hywel Dda University Health Board is a Local Health Board established under section 11 of the National Health Service (Wales) Act 2006.

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Welcome from our Chair and Chief Executive

As we come to the financial close of the year 2020/21 it is a moment to reflect on what we have lived through side-by-side as colleagues, friends, and members of our communities. It has been an extraordinary year, where many of us as individuals and together as communities, have faced the COVID-19 global pandemic - one of the biggest challenges of our lifetime.

To be part of the National Health Service during this time has been a challenge and a privilege. We are so proud of the efforts made by our staff, partners, and communities to keep everyone safe. Your hard-work and contributions have undoubtedly made a positive difference and we may have experienced far more loss and sacrifice without your efforts – a heartfelt thanks to you all.

As we write this welcome, we also mark the anniversary of the first UK lockdown on a national Day of Reflection (23 March 2021). On this day we remembered the 474* people who died from COVID-19 in the Hywel Dda University Health Board area since the start of the pandemic. Loved ones lost before their time, but always remembered, and our thoughts and sympathies are with those they left behind grieving.

Alongside remembrance and reflection, we have also turned our attentions to the recovery and learning that is necessary as we start to emerge out of the pandemic. The hugely successful COVID-19 vaccination programme, which is saving lives and helping protect us, has given us all hope and the opportunity to plan and be ready for a brighter future.

But we have a lot of work to do to re-build and reinstate planned and non-urgent work, which had to be paused because of the pandemic and restrictions. We are particularly saddened that there are far more of you waiting longer for planned surgery, and we are aware of the detrimental impact this can have on your quality of life. We are writing to people on waiting lists (starting with those waiting the longest first) to apologise and ensure you know how and when to report any worsening of your condition which may affect our prioritisation. You can keep up to date with the re-starting and expansion of planned care services here: https://hduhb.nhs.wales/healthcare/covid-19-information/restarting-services/

We are also about to launch a pilot Waiting List Support Service, at first in a single specialty, with the aim of rolling out to all specialities later in the year. Patients will be provided with a single point of contact and enhanced support while they wait. General advice to people on how to remain well while they are awaiting surgery, which can improve results after surgery, is available here: https://hduhb.nhs.wales/healthcare/covid-19-information/preparing-for-treatment-lifestyle-advice/

Without the pandemic we would unlikely have seen the speed of the digital roll out and community-based care that we have been able to provide to people in their own homes, or closer to them. For example, in March 2020 only 1% of outpatient appointments took place online, but as at January 2021, 28% of outpatient appointments were carried out this way, with valuable feedback from patients. Although many people can access services digitally, we know there are some who cannot and we will continue to engage with patients through a variety of ways, including non-digital.

We are also continuing to support staff with their own health and well-being with a range of psychological and well-being services. Many are exhausted and they and their families have made great personal sacrifices. It has been humbling and inspirational to listen to their

experiences and see how they have looked after each other as well as their patients. They need some time to rest and recover before the full resumption of all services.

The COVID-19 pandemic and our response to it has underlined the need for clarity in setting out our objectives as a Health Board. Indeed, one of the key lessons learnt from staff feedback so far is the importance of having a small number of clear organisational objectives.

Between the first and second waves of the pandemic, we completed a piece of work to listen to staff and to take stock of the decisions made by the Board during the past three years, our progress so far in achieving our strategic vision, as set out in our long-term health and care strategy, A Healthier Mid and West Wales: Our Future Generations Living Well, along with learning from the first wave of the pandemic.

The result has been a refreshed set of strategic objectives to set-out what we are driving towards during the next three years. They are a combination of already existing organisational values and objectives around your services:

1. Putting people are the heart of everything we do
2. Working together to be the best we can be
3. Striving to deliver and develop excellent services
4. The best health and well-being for our communities
5. Safe, sustainable, accessible, and kind care
6. Sustainable use of resources

The Annual Plan for 2021/22 is a recovery plan which focuses on how we will recover from the pandemic, how we will support staff to recover, and how we lay the foundations to recover NHS and care services and support our communities. Following the revision of instructions in March 2021 from Welsh Government to all Health Boards and Trusts across Wales, all plans for 2021/22 were to be submitted in draft form by the end of March 2021. We presented our draft plan at our Public Board in March 2021, and this was approved for onward submission to Welsh Government. Final plans are expected to be submitted following Board approval by the end of June 2021.

We will use what we have learnt from you all and all our experiences to inform what we do and how we do things moving forward. To this end, we want to make things better together for our communities, our staff and our patients so we can all live in a healthier mid and west Wales.

Maria Battle, Chair **Steve Moore**, **Chief Executive**

Signed: _____ _____

Date: _____ _____

*figure correct as at 23 March 2021

Chapter 1

Performance Report

About us

Hywel Dda University Health Board plans and provides NHS healthcare services for Carmarthenshire, Ceredigion, Pembrokeshire, and bordering counties. Our 12,476 members of staff provide primary, community, in-hospital, mental health and learning disabilities services for a quarter of the landmass of Wales. We do this in partnership with three local authorities and public, private and third sector colleagues, including our volunteers, through:

- **Four** main hospitals: Bronglais General in Aberystwyth, Glangwili General in Carmarthen, Prince Philip in Llanelli and Withybush General in Haverfordwest.
- **Five** community hospitals: Amman Valley and Llandovery in Carmarthenshire; Tregaron in Ceredigion; and Tenby and South Pembrokeshire Hospital Health and Social Care Resource Centre in Pembrokeshire.
- **Two** integrated care centres, Aberaeron and Cardigan in Ceredigion.
- **48** general practices (**four** of which are Health Board managed practices), **49** dental practices (including **three** orthodontic), **98** community pharmacies, **44** general ophthalmic practices (**44** providing Eye Health Examination Wales and **30** low vision services), domiciliary only providers and health centres.
- Numerous locations providing mental health and learning disabilities services.
- Highly specialised services commissioned by Welsh Health Specialised Services Committee.

The population we serve

Population projection: our total population is estimated at 387,300 and by 2028 is predicted to rise in Carmarthenshire (+2.4%) and Pembrokeshire (+2.1%) but decrease in Ceredigion (-3.3%).

Ageing population: The average age of people in the three counties is increasing steadily, with all three local authority areas projected to have an increase of people aged 65 and over by 2028. The largest predicted increase in this age group is for Pembrokeshire (+18.8%).

Changing patterns of disease: As our population ages there are an increasing number of people in our area with one or more chronic condition. In 2019, dementia, Alzheimer's disease, heart disease, respiratory disease, stroke, and cancer were the main causes of death in England and Wales.

Tobacco: Almost one in five adults (19%) in our area smoke. Smoking is a significant risk factor for many diseases and early death. Making Every Contact Count (MMEC) has been used primarily to encourage behaviour change on smoking, weight, alcohol, and physical activity. However, we envisage a broader conversation picking up any one of the many factors that influence health and well-being relevant to each person. Having a brief non-judgemental conversation, when the appropriate opportunity comes up, can support people to take responsibility for their own health and well-being. MECC can lead to improvements in people's health, help people consider their health behaviour, and make changes.

Food: Three in every four people in our area do not eat enough fruit and vegetables, and almost 3 in 5 people (59%) are overweight or obese. The Health Board is using the Obesity Pathway Transformation Fund monies for 2020/21 to further strengthen of our specialist MDT weight management service in line with National Standards to enable improved access and equity.

Physical activity: Over 40% of adults in our area do not take enough regular physical activity to benefit their health. Over a quarter of our population are inactive.

Social isolation and loneliness: 16.2% of our population report feeling lonely. Providing single points of access for Information, Advice and Assistance, in line with the Social Services and Well-being Wales Act for the public that facilitates access to a directory of services in their local community, such as DEWIS Cymru.

Welsh language: The proportion of residents who can speak Welsh is 47%.

Health inequalities: Variation in healthy behaviours leads to variation in health outcomes, this is also influenced by levels of deprivation.

Introduction

Hywel Dda University Health Board has had to carefully monitor and forecast potential impacts of the COVID-19 pandemic on our population so that we respond effectively to keep our communities safe.

All NHS and care services have had to adapt to the aim of keeping as many people at home as possible but also making sure that those needing timely healthcare (including screening, diagnosis, testing, and treatment) receive it. This process and our responses had to change often during 2020/21. This was the case during the first and second 'peaks' of high COVID-19 infection rates in our communities and in response to the subsequent pressure on our NHS staff and services. This was particularly the case during and following the second wave in late 2020.

In this report we outline how we have worked within the NHS Wales Operating Framework to keep essential services within community, primary, and secondary care, and allowed for flexibility and adaptability to respond to peaks of community transmission rates, as well as any specific impacts we have seen because of changes.

In this context, quality and safety of our community has been of paramount importance. Indeed, to ensure this focus and the close monitoring to support it, we increased the opportunity for additional scrutiny through our Quality, Safety and Experience Assurance Committee. Clinical leadership has been strengthened, as detailed later in this report, along with the introduction of a Clinical Ethics Panel to consider the ethical challenges our frontline clinicians face and those faced by local authorities in relation to visiting in care homes. We have also, through our planning and quarterly updates to the Welsh Government, considered and addressed at all stages, four types of harm from the pandemic:

1. Harm from COVID-19 itself
2. Harm from an overwhelmed NHS and social care system
3. Harm from reduction in non-COVID-19 activity
4. Harm from wider societal actions/lockdown

Throughout this report we have identified some of the actions we have taken to avoid these four harms.

Similarly, we have referenced where we are meeting the requirements of the Health and Care Standards and thus improving the quality of care and patient experience. The Health and Care Standards themes are as follows:

- Staying Healthy – how we ensure people in Carmarthenshire, Ceredigion and Pembrokeshire are well informed to manage their own health and well-being.
- Safe Care – how we ensure people in the three counties are protected and supported from harm, as well as supported to protect themselves from known harm.

- Effective Care – the arrangements we have in place for people in the three counties to receive the right care and support as locally as possible, along with being able to contribute to making that care successful.
- Dignified Care – how we make sure people in the three counties are treated with dignity and respected and treat others the same.
- Timely Care – the arrangements we must ensure that people in the three counties have timely access to services based on clinical needs and are actively involved in decisions about their care.
- Individual Care – how we treat people in the three counties as individuals, reflecting their own needs and responsibilities.
- Staff and Resources – the information we have available for people in the three counties to understand how their NHS is resourced and make clear how we make careful use of them.

This report will detail the extraordinary response, achievements and innovation that have been achieved as we have responded to the global pandemic. For example, following the first wave of the pandemic we undertook a piece of 'discover' work to understand and learn from changes to services and teams because of the pandemic response.

We learnt that some of our long-term ambitions in our strategy, A Healthier Mid and West Wales, have been partly delivered through necessity. A demonstration of this in action is the shift towards delivering some services virtually through online platforms. This could have a positive impact on access to services for patients, as well as improve the productivity of health services and reduce our carbon footprint by avoiding the need for patients to travel. We recognise, however, that not everyone has the means to access virtual services and we will continue to engage with patients through a variety of ways, including non-digital.

You can read more about our learning and how it will inform our work going forward in our Annual Plan.

Impact of COVID-19 on our delivery of services

We had to respond quickly to the pandemic. This meant changing many aspects of how we work to keep people safe. It is testament to the skill, knowledge and professionalism of our staff that this was achieved in weeks and months as opposed to years.

We worked with partners involved in health and care, as well as communities themselves, at a scale never seen before. Our staff, partners and communities in Carmarthenshire, Ceredigion, Pembrokeshire and borders worked together to keep each other safe, and we saw commitment, innovation and kindness.

At the start of the COVID-19 pandemic, Welsh Government issued guidance for essential services that had to continue to ensure patients had access to necessary care and treatments in a safe environment. The guidance can be found here: www.wales.nhs.uk/COVID19essentialservicesguidance

Risks

Below is a summary of the risks we identified as having the potential to impact our delivery of essential services and performance against targets, along with some of our mitigations to manage and reduce the risk. Some of these risks are new COVID-19 related risks, while others are previously existing risks that have been exacerbated due to COVID-19.

This section gives our position and risk scores as at 31 March 2021. For further details see:

- The Delivery of essential services section on page 36 of this document.
- Risk Profile section of the Annual Governance Statement chapter in this report.
- Corporate Risk Register update prepared for March 2021 Board meeting, which is available here: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-march-2021/25th-march-2021-documents/item-3-6-corporate-risk-register/

Harm from COVID-19 itself

Risk 1017 - Test, Trace and Protect (TTP) Programme being unable to quickly identify and contain local outbreaks	High (10)

At times during 2020 there was insufficient laboratory testing capacity available to meet the significant rise in demand for COVID-19 tests. This resulted in the public being unable to book testing locally, if at all, and delays of up to 10 days for test results. This had serious implications for the TTP programme. Access to testing has been resolved with no delays in accessing tests. Test turnaround times have also improved greatly. As a result, the risk score was reduced from 15 to 10. (Health and Care Standards: Safe Care)

Harm from an overwhelmed NHS and social care system

Risk 1018 - Insufficient workforce to support delivery of essential services	Extreme (16)

Workforce was a key constraint in our ability to respond effectively to COVID-19 surges and maintain essential services. Challenges included COVID-19 infections and outbreaks within acute, community and social care facilities, which could lead to increased sickness absence directly due to COVID-19 and/or self-isolation of staff, as well as the ability to recruit new staff quickly for support. This could in turn impact/affect our ability to staff field hospitals, manage surge capacity within general hospitals, effectively manage the impact from COVID-19 outbreaks, and deliver a mass vaccination programme. Our pandemic Command structure is monitoring and managing this risk. (Health and Care Standards: Staff and Resources)

Risk 853 - Our COVID-19 response will be insufficient to address peaks in demand (bed space, workforce, equipment/consumables)	Moderate (5)

This risk could lead to an impact/effect on difficult triaging decisions for our clinicians, poor quality and safety for patients and an inability to accommodate every patient that needs us. A series of processes and controls are in place to mitigate the risk. These include the establishment of a modelling cell to provide forecasts of expected COVID-19 cases and admissions, and opening field hospital beds to support the acute sites. (Health and Care Standards: Timely Care)

Risk 854 - Our COVID-19 response proves to be larger than needed for actual demand	Low (3)

This risk could be impacted by inaccurate modelling assumptions, or changes in the progression of the pandemic. The direction from Welsh Government was to over rather than under provide. Our modelling cell is linked to the Welsh Government modelling group and other Health Boards to ensure our models are regularly updated to incorporate the latest intelligence as the pandemic progresses. (Health and Care Standards: Staff and Resources)

Harm from a reduction in non-COVID-19 activity

Risk 684 - Lack of agreed replacement programme for radiology equipment across the Health Board	Extreme (20)

Our imaging equipment requires significant periods of urgent and planned maintenance, creating downtime in use, which puts significant pressures on all diagnostic, resulting in delays for some patients in diagnosis and treatment. At the end of March 2021, equipment failure resulted in up to a week downtime, which put significant pressures on all diagnostic services. Welsh Government has agreed funding for one new CT scanner and one new MRI scanner in 2021/22 (out of 5 scanners required). In the meantime, controls and processes are in place to mitigate the risk, such as service maintenance contracts, daily quality assurance checks, and disaster recovery plan. (Health and Care Standards: Effective Care)

Risk 855 - We will be unable to address the issues that arise in non-COVID-19 related services and support functions	Extreme (16)

A winter surge in COVID-19 demand, coinciding with usual winter pressures and the rapid roll out of a Mass Vaccination Programme, led to all non-essential services being suspended with staff redeployed to where needed and only the most urgent surgery being undertaken. Our clinicians continue to review patients on a case-by-case basis to ensure those at greatest clinical risk or risk of harm are seen first. We are using all available capacity at Werndale Hospital to support cancer and urgent surgery. (Health and Care Standards: Timely Care)

Risk 1032 - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Extreme (16)

Referrals for autism spectrum disorder (ASD) have continued throughout the pandemic at approximately the same level as pre-COVID-19. The service was experiencing significant waiting times because of demand levels. Due to the constraints to undertake the required face-to-face assessments, the implementation of social distancing and, in some instances, patients' reluctance to attend clinics due to the risk of COVID-19, there had been an impact on the service's ability to see the same volume of service users. IT / virtual platforms are used where appropriate. Patients are prioritised on clinical need. Individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in their condition. (Health and Care Standards: Timely Care and Safe Care)

Risk 1027 - Delivery of integrated community and acute unscheduled care services	Extreme (16)

This risk could lead to an impact on the quality of care provided, significant clinical deterioration of patients, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays at the front door and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence, and increased scrutiny from regulators. As such, a wide range of processes and controls are in place to mitigate. For example, daily virtual meetings for all sites, review of patients admitted to surge areas to ensure their acuity and dependency is monitored and controlled, discharge lounge for patients about to be discharged, joint workplan with the Wales Ambulance Service Trust. Due to the uncertainty surrounding any data modelling and the implications of restrictions lifting on future COVID-19 and non-COVID-19 demand, the situation remains fluid and changeable. (Health and Care Standards: Timely Care and Safe Care)

Risk 1048 - Risk to the delivery of planned care services set out in the Quarter 3/4 Operating Plan	Extreme (16)

Work to re-start elective surgery began in June 2020. During the summer/autumn period, significant progress was achieved in recovering cancer pathway surgical backlogs, which had developed earlier in the pandemic. Our surgical response was significantly restricted over the Christmas/new year period due to a significant increase in COVID-19 cases and admissions. Surgery for emergency and urgent cases recommenced in January 2021 and we plan to restart other elective surgery as soon as it is safe and practical to do so. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021. (Health and Care Standards: Timely Care)

Risk 633 - Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	High (12)

This risk is caused by a lack of capacity to meet an expected increase in demand for diagnostics and treatment delays at our tertiary centre. Recommendations from the Royal College of Physicians to suspend diagnostics and some surgery that are aerosol generating during COVID-19 also impact on our ability to meet the SCP target. To help mitigate this risk we have used Werndale Hospital, near Carmarthen, for surgery. We have a COVID-19 escalation plan in place. We are working jointly with regional partners to offer patients on a tertiary pathway surgery within the three counties. (Health and Care Standards: Timely Care)

Harm from wider societal actions/lockdown

Risk 1016 - Increased COVID-19 infections from poor adherence to social distancing	High (10)

This could lead to an impact on increased levels of staff absence due to COVID-19 infection and self-isolation, which in turn could lead to some essential services being closed. Social distancing guidance and signs are available for staff, patients, and visitors. Safety screens have been installed in our hospital, ward, and clinic reception areas. Hand sanitiser stations are available across all sites. (Health and Care Standards: Staying Healthy)

Modelling cell

In addition to Imperial College London's modelling of COVID-19 cases, and in response to potential impacts from Government restrictions, we re-directed some of our resource to form a Hywel Dda University Health Board modelling cell. The role was to use national modelling and adapt it for our communities so we could predict future demand and align our capacity accordingly. This proved enormously beneficial to our operational teams.

Making Data Count in Hywel Dda

Making Data Count is an approach based on the use of statistical process control (SPC) charts to tell a story with data. SPC charts are beginning to be used in the NHS for quality control and to help understand whether system changes result in improvement. Plotting data over time, instead of using a RAG (red amber green) rating, can help inform better decision-making. SPC charts help change the discussion at Board and Committees to richer conversations, using the data to drive improvement rather than judgement. In 2020/21, our Board agreed a shift to using SPC reporting. We started using some SPC charts for performance reporting in February 2020 and aim to shift performance reporting to full SPC reporting by summer 2021.

Planning and delivery of safe, effective and quality services for COVID-19 care

Command Centre

A Command Centre was set up as part of our COVID-19 response to provide staff with a single place for authoritative, up-to-date information. It has been hugely successful in replying to enquiries through telephone and email. The Command Centre houses specialist 'stations' that are staffed by subject specialists for primary care, public health, workforce, occupational health, infection prevention and control and COVID-19 testing. All contacts are logged on to a specially designed database and given to the right specialty team for response and action. The service was targeted at staff and stakeholders during the first phase of the pandemic but has developed and grown to support the wider public on testing and vaccination, which ensures our staff, and the wider public, are informed to manage their own health, have the right support and contribute to making care successful.

One of the critical roles of the Command Centre was the development of a team to manage and co-ordinate the significant, and rapidly evolving, information, guidance and clinical advice received in relation to COVID-19. We developed a process to ensure that specialist information and new clinical guidance was appropriately approved, updated and available. This included the consideration of national COVID-19 guidance by clinical leads, assessing any impact on local pathways and services, and the development of local guidance, as necessary. All approved guidance and resources were then made available to clinical and operational teams on specially developed internal webpages and communicated via daily emails to all staff. All clinical guidance is logged on a dedicated register capturing approval status and other key details, which sits in alignment with the Command Centre database. Through this process, the Health Board has considered 110 pieces of national clinical guidance and 79 pieces of local guidance to date.

See more on the future of this function on pages 78-80.

(Health and Care Standards: Safe Care; Effective Care and Staff and Resources)

Clinical Ethics Panel

Clinically led decision-making and scrutiny has been at the forefront of our duty and commitment to maintain quality and safety of care. In response to the onset of the COVID-19, the Hywel Dda Ethics Panel was established in April 2020 to ensure decisions about care are made ethically and in accordance with Health Board values. Further details about the role of the Panel are available in the Annual Governance Statement.

(Health and Care Standards: Dignified Care)

A regional response to Test Trace Protect (TTP)

The NHS Wales Test Trace Protect (TTP) service was introduced in June 2020 across Carmarthenshire, Ceredigion and Pembrokeshire to identify and contact trace SARS-coronavirus-2, which cause COVID-19, to protect our communities, and provide advice and support.

Three county-specific Incident Management Teams (IMTs) and a Regional IMT were set up within the area. These enabled excellent engagement and partnership working to respond to increases in transmission in a collaborative and co-ordinated way.

The Health Board's Command Centre provided a regional co-ordination hub, bringing together teams from the Health Board, Public Health Wales, and the area's three local authorities to work together to contain the spread of the virus.

The Health Board, Public Health Wales and local authorities also produced a joint Hywel Dda Area Local COVID-19 Prevention and Response Plan to set out our direction and delivery mechanisms. It was supported by a joint communication plan to deliver, amplify, or adapt at a local level, the Welsh Government's Keep Wales Safe, and Test Trace Protect communication strategies. A Regional Communications Group was set up with representation from local authorities, the police, and higher education providers to enable a collaborative approach to informing and communicating with our communities in a consistent and engaging way.

(Health and Care Standards: Staying Health; Effective Care; Timely Care; and Individual Care)

Testing

See pages 21-23 for information on COVID-19 associated testing.

Contact tracing

Hywel Dda University Health Board collaborated with partners, particularly Public Health Wales and the local authorities, to deliver regionally co-ordinated local contact tracing teams. They comprise a mix of clinical and non-clinical staff who support those who test positive, and their close contacts, to isolate and stay safe.

Contact tracing trials began prior to the formal TTP launch date in June, most notably in Ceredigion. The national Case Management & Contact Tracing system (known as the CRM system) came into effect on 9 June 2020 allowing monitoring of data, trends and reporting to further inform the region's response to the pandemic.

Through strong contact tracing, testing response and multi-agency focus (via both IMTs or Hospital Outbreak Control Teams) we have been able to respond to situations rapidly and robustly as needed. Effective local and regional communications planning has also ensured consistent and clear messaging across the partner agencies and sharing of resources, such as videos of healthcare staff and local community influencers, while maintaining the key campaign focus.

This resulted in a mostly positive response from the public in terms of compliance with isolation and 'stay safe' requests. However, we have also seen evidence on social media particularly about people's fears, anxiety or misunderstanding. All partner agencies worked hard to respond to concerns, inaccuracies and misinformation, encouraging people to get their information from official sources.

We continue to work collaboratively on contact tracing in the region and to rapidly address emerging concerns, and to share learning and intelligence. This strong partnership work ensures we are aligned, correct and consistent in our regional approach to TTP, and in line with Welsh Government and Public Health Wales policy and campaigns.
(Health and Care Standards: Staying Health; Effective Care; and Individual Care)

Redesigning our primary care services

Our primary care services have played a crucial role in the response to the COVID-19 pandemic.

We ensured all primary care staff were provided with the necessary personal protective equipment (PPE). We also encouraged all primary care contractors to use the national escalation and reporting tools to help identify and address any rising levels of pressure as they started to occur.

A GP Cluster is a group of GP practices from a close geographical location. Financial support was offered to clusters to purchase additional IT equipment to enable staff to work effectively from home. IT has been a critical enabler for maintaining essential services during the pandemic. We will continue to build on the digital advances in 2021/22 to allow our contractors to work as efficiently as possible whilst ensuring patients only travel when necessary and have access to timely and appropriate care.
(Health and Care Standards: Safe Care; and Staff and Resources)

GP practice

All GP practices within Hywel Dda maintained the delivery of essential services throughout 2020/21. Business continuity planning underpinned the protection of all core services.

The GP practices were also provided with a local pathway for rapid COVID-19 testing of symptomatic frontline staff. Whilst a small number of practices were affected by staff infection rates, all apart from one remained open throughout 2020/21.

Our aim for 2020/21 was to tender expressions of interest in returning the Health Board Managed Practices back to independent contractor status but this work stalled due to the pandemic. The four managed practices played a key role in our COVID-19 vaccination programme through early trialling and sharing their rapid learning with other practices; enabling many patients to be able to access vaccination as close to home as possible. All GP practices in the three counties signed up to deliver the COVID-19 vaccination for priority groups 1-6. Practices were encouraged to work together to maximise the use of vaccine supplies and they worked collaboratively to vaccinate care home residents.

During the pandemic we have seen several GPs relocate to the area to take up partnerships and salaried positions within some of our GP practices that had historically found it difficult to recruit to vacancies.
(Health and Care Standards: Staying Healthy; and Staff and Resources)

Pharmacy

Even though the community pharmacies were significantly impacted early in the first wave with an increased demand for repeat medication, they all sustained service delivery throughout. To maintain and deliver pharmacy enhanced services, all pharmacies were offered access to the NHS Video Consulting Service so that this could be used as an option where needed. Our Clusters were asked to support community pharmacies during the first wave of the pandemic. This was supplemented with a small level of financial support to recognise the additional work pressure experienced during the early weeks / months to dispense repeat medications.

A small number of pharmacies were affected by staff infection rates, but all managed to maintain service provision throughout 2020/21.

(Health and Care Standards: Timely Care; and Staff and Resources)

Dentistry

The Community Dental Service played a key role in supporting the provision of urgent dental care to patients during the pandemic through the development of Urgent Dental Centre (UDC). A review of each community dental site identified a need to install air change systems. The air change system reduces the length of time that the surgery needs to be empty between patients to reduce risk so that more patients can access care. To support the dental practices to return to an improved level of patient flow, the Health Board match funded the allocation from Welsh Government to assist practices in their purchase of these air flow systems and return to normal patient activity levels from April 2021.

A small number of dental practices were affected by staff infection rates and two had to close for a period. Alternative arrangements were put in place for the patients of those dental practices for the duration of the closures.

From 1st July 2020, all dental practices carried out an assessment of clinical and oral risk on each patient seen. This will inform commissioning of services moving forward.
(Health and Care Standards: Staying Healthy; Timely Care; and Staff and Resources)

Optometry

During the initial phase of the pandemic, we developed our pathways and services to enhance local provision of optometry services for patients. In line with the national guidance, we implemented four optometric pathways, which ran successfully, allowing many patients to be seen at a local optometric practice rather than in a GP or hospital setting. Only a small percentage of these patients then required onwards referral. A proposal has been submitted to mainstream these services as part of the ongoing development of eye care pathways.

A small number of practices were affected by staff infection rates, but no optometric practices were required to close. Some optometrists have been delivering the COVID-19 vaccine through our Mass Vaccination Centres.
(Health and Care Standards: Effective Care; Timely Care and Staff and Resources)

Therapy services

Our acute, community and locality teams worked together to develop a plan for delivering therapy services during the pandemic. In line with the Welsh pandemic response, direct therapy service provision was limited to urgent or essential services, such as tissue viability/wound care, rehabilitation/obviating functional decline, and patients not appropriate or responsive to virtual or digital support.

Some examples to highlight:

- Occupational therapy - we maintained occupational therapy capacity in the community to support surge/additional capacity in step down beds (community and field hospitals). We also prioritised occupational therapy support for care home residents.
- Physiotherapy – in quarter two we increased face to face community support to rapid response, such as rehabilitation at home to support those at high risk of functional decline, falls or hospital admission.
- Dietetics – our specialist nurses supported those patients in the community on tube feeding to avoid escalation and presentation at A&E.

(Health and Care Standards: Safe Care; Timely Care and Staff and Resources)

Redesigning our community services

During the past year, our community services in Carmarthenshire, Ceredigion, and Pembrokeshire have supported delivery of a whole-system response. This means we have put people at the centre of what we do. The aim has been to surround them with resilient primary, community and hospital-based care through better integration between services, including social care and third sector. This provides 'seamless' care for the person, as close to (or within) home, whenever possible.

This way of working is in line with national, regional and local direction and policy, including the Welsh Government's plan for health and social care – A Healthier Wales, and the Health Board's long-term vision for health and care – A Healthier Mid and West Wales.

The COVID-19 pandemic presented our community services with extremely challenging issues to respond to, but our approach to support people in this way continued and is outlined below. The NHS Wales Operating Framework from the Welsh Government in response to the pandemic, outlined the need to maintain essential services in the community as well as in hospitals. We have needed to be flexible and adaptable to respond to transmission rates of COVID-19 in our communities.
(Health and Care Standards: Safe Care; Timely Care; and Staff and Resources)

We outline below how we have considered and addressed the four types of harm outlined in the Operating Framework.

Many of our integration projects are funded through the Welsh Government's Integrated Care Fund and Transformation Fund, which are delivered through the West Wales Care Partnership (more information on this can be found in our chapter on Delivering in Partnership on page 62).

To build strong communities - reducing harm from wider societal actions/lockdown

- We worked with partners to help voluntary services and community groups to provide support to local people – through the Connect to Kindness programme, support hubs and volunteer programmes – and we want to build on this in the future.
- Community connectors and social prescribers, people who link others to activities and organisations to improve their quality of life, have been supporting people.
- The Delta Connect project was rolled out to all counties and is using technology at home (Technology Enabled Care/TEC) to support more than 2,500 people to live independently, and to connect users with families and healthcare professionals for a response if needed.

For prevention and to help yourself - reducing harm from reduction in non-COVID-19 activity

- New support, such as tests you can carry out at home, were provided to measure oxygen levels in the blood for some patients recovering from COVID-19. This has helped people coming out of hospital to self-manage at home and for them and their health professionals to be aware if their condition worsened.
- Pembrokeshire Falls Service became fully established in 2020 and developed a Staying Fit and Healthy support package. Delivered through Connect Pembrokeshire, it helps people improve strength and fitness, and is particularly aimed at people who were shielding or in lockdown.
- We started to develop Integrated Community Networks launching in Milford Haven opportunities for the wide range of partner organisations in the network area to come together, share expertise, knowledge and skills to benefit the population.
- We implemented virtual and digital solutions to Education Programmes for Patients.
- We rolled out digital solutions to support Community Nursing Teams manage their visits and caseloads more effectively.

Help when you needed it - reducing harm from an overwhelmed NHS and social care system

- We worked with hospital teams to ensure community resources and buildings were used to support urgent outpatient care and clinics as much as possible.
- Phlebotomy services previously provided in acute or community hospitals were transferred to community-based locations, such as the Antioch Centre, Llanelli, and managed by appointments only to ensure social distancing and maintain safety.
- We increased the number of beds in the community where we could assess people's needs in a more homely setting and to ensure we could meet their future needs in the most appropriate way.
- Dedicated nursing teams, such as the Acute Response Teams have been providing care traditionally provided in hospitals to avoid admissions to hospitals or reduce lengths of stay.
- We provided people with the equipment they needed to help them stay at home safely.
- Video lines were provided for access to bereavement care for people during this crisis.
- Our clinical and support staff used online and telephone to contact people, which helped reduce delays in providing people with the support they need.
- A community nursing 'hub' was set up in Pembrokeshire to join-up patient care in cluster areas – it can receive up to 760 calls per month with more than 500 referrals.
- In April 2020, the Pembrokeshire Intermediate Care Team was established to help patients remain or return home by providing a joined-up way to receive and screen referrals; and provide therapy led reablement support or step-down beds.

Help long term - reducing harm from an overwhelmed NHS and social care system

- In partnership with our local authorities and allied health professionals in primary and secondary care, we supported care homes on the prevention and management of COVID-19 outbreaks. This helped ensure continuity of care for residents and support for staff working in the sector. In-reach support was provided to reduce unnecessary admissions of COVID-19 positive residents to hospitals, enabling them to remain within their home environments.
- Hospice at home with clinical nurse specialist availability 24/7 and access to consultant specialist palliative care and geriatricians.
- Step-up or step-down to community pathways were used in field and community hospitals to support the wider NHS and social care system.
- To support carers for and people with dementia, we are introducing Admiral Nurses across the Health Board to provide increased care and support.

Help in hospital - reducing harm from COVID-19 itself

- We increased bed numbers in our community hospitals to provide additional capacity so we could care for patients during the pandemic.
- This included providing additional inpatient beds at Cleddau Ward, in South Pembrokeshire Hospital, Pembroke Dock; at Tregaron Hospital, in Ceredigion.
- Pembrokeshire community team, GP practices and out-of-hours services worked together to convert Haverfordwest Health Centre as an area where COVID-19 positive patients could be seen (stood down in March 2021).

Emergency and urgent care needs have continued to be met in the community in unprecedented circumstances. However, during times when the pandemic has had the highest impact, we have needed to withdraw some community-based clinics and services or change the way they are accessed. For example, to keep people safe during the pandemic and align our resources where they were needed most, we have had to:

- Temporarily close our Minor Injury Unit, in Cardigan, Ceredigion, and Llandovery, Carmarthenshire.
- Prioritise Community Nurse activity to urgent and essential care, reducing more routine treatments.
- Visit fewer people at home and introduce community-based clinics for those people who can travel to receive treatment.
- Re-deploy school nurses (due to schools being closed) to support testing and vaccination activities.
- Establish urgent dental centres in the community dental service while the general dental service provided advice, analgesia, and antibiotics only.
- Invest in the air change systems in the community dental service clinics to allow for urgent patients to be treated.
- Set up patient pathways to support the delivery of timely and urgent optometry care when patients could not be seen face-to-face.

Throughout the year, close monitoring has taken place and we have re-instated services as soon as we have been able to, communicating this to our local communities.

Design and implementation of testing and immunisation for COVID-19

COVID-19 Testing

Hywel Dda University Health Board first began antigen testing, which detects if a person has the virus, in February 2020. This was first within people's own homes and then within our first two Coronavirus Testing Units (CTUs) in Cardigan and Carmarthen.

Our aim was to provide COVID-19 testing to anyone who needed it and to make it as accessible as possible for our rural communities. Provision for testing has grown and adapted through-out the pandemic.
(Health and Care Standards: Effective Care; and Staff and Resources)

Testing staff and other critical workers

Early in the pandemic, and in accordance with the Chief Medical Officer's advice in March 2020, we tested symptomatic Health Board staff. We also worked closely with other public bodies in the three counties, making local arrangements to allow symptomatic critical workers, such as those in wider health and social care, ambulance service, local authorities, police, fire, education, food, retail, transport, public services, and unpaid carers, to get quick access to a free test. This allowed them to return to work as soon as they felt better, if their result was negative, which helped maintain critical services to our population.
(Health and Care Standards: Individual Care; and Staff and Resources)

Community testing

We have since developed a hybrid model of testing to protect our wider communities. This has been delivered between Health Board managed and delivered services, and through the UK-model delivery. Additional community testing units, including mobile testing units, have been provided throughout Carmarthenshire, Ceredigion and Pembrokeshire. Locations of units have changed during the pandemic to respond effectively to clusters or outbreaks in specific areas. People have been able to book a test by visiting the Welsh Government website (www.gov.wales/apply-coronavirus-test) and choosing either an appointment at a drive-through testing centre or ordering a home testing kit. Those without digital access were able to book a test by calling the free 119 number.

We regularly reviewed our testing capacity across the region, including neighbouring areas, such as Powys, and continually worked with our partners and other Health Boards in relation to mutual aid and supporting people who live or work across our boundaries or travel into our communities, such as for students. We also put in place a pathway for visitors and tourists to the area to appropriate access testing and supported this with communication campaigns and working with tourist providers during peak visiting season.

Our current testing units are in:

- Carmarthen Showground, Carmarthen (drive-through)
- Local Authority Car Park, Canolfan Rheidol, Aberystwyth (drive-through and walk-in)
- Pembrokeshire Archives Car Park, Haverfordwest (drive-through and walk-in)
- Dafen Yard, Heol Cropin, Dafen, Llanelli (drive-through)

From 1 March 2020 to 31 March 2021, 181,983 people within the three counties were tested with 15,879 receiving positive COVID-19 antigen test results (8.7% positivity rate).

The total number of tests completed will differ and are likely to be higher than the number of individuals tested. Antigen lateral flow tests are not included in these figures. [Source: Public Health Wales]

As could be expected given the unprecedented pandemic situation, we faced some challenges and opportunities along the way as the testing need changed. We have been able to respond quickly and appropriately to meet local demand and keep communities safe. For example, when there was a high increase in demand for tests across the UK in September 2020, people experienced problems in booking a test via the UK portal. We quickly reassured people that there was local testing capacity within Carmarthenshire, Ceredigion and Pembrokeshire (providing a temporary local route through for people experiencing problems) and reassuring people that they should not need to travel excessive distances to access a test.

We have communicated with our local community through-out the pandemic on the criteria for testing (and its importance in keeping people safe). We have also provided practical information on how to access testing and the need for self-isolation whilst results are awaited or following a positive result. We used a combination of updates through traditional media and with key stakeholders, web resources, social media advertising and promotion, and production of hard copy information and radio adverts for those not using digital media. We also used and signposted to British Sign Language resources and guidance in alternative languages.

Use of case studies was helpful in raising awareness among our Black, Asian and Minority Ethnic communities. For example, a local couple, critical in the NHS response to COVID-19, shared their story of how testing helped give them, their families and their work colleagues peace of mind, whilst also allowing them to get back to delivering frontline care to patients at Glangwili Hospital, Carmarthen.

The national NHS COVID-19 app was launched on 24 September 2020 across Wales and England. We encouraged people in Wales to download and use the app to help reduce and manage the spread of COVID-19. It also allowed people to book a test and get their result quickly, working alongside the existing manual contact tracing system.
(Health and Care Standards: All Standards)

Care home testing

We deployed staff members and worked with the military to enable testing within the care home sector.

We underwent a phased and targeted approach to both symptomatic and mass testing across the care home sector, beginning with those homes that had experienced the first outbreaks of COVID-19, and then moving onto all 'closed-settings'. During 2020/21 tests were carried out for 9,802 care home staff and 14,254 care home residents (note: this testing does not include routine weekly PCR staff testing through the UK portal.)

This approach helped the care homes to identify residents and staff who tested positive for the virus, to appropriately zone positive patients, to advise staff to self-isolate and reduce the risk of spread across the home (and possibly the wider care home sector). More information on support for care homes is available on page 63 onwards.
(Health and Care Standards: Safe Care; Individual Care; and Staff and Resources)

Antibody testing (have I had the virus?)

In June 2020, the Chief Medical Officer asked Health Boards in Wales to start antibody testing, which tests whether someone has been exposed to the coronavirus infection and developed antibodies.

Within the three counties, we began a programme of antibody testing to help us better understand the prevalence of COVID-19 in different work groups and how the disease spreads.

A huge amount of effort, at pace, was put into introducing antibody testing as a phased approach across the region, beginning in mid-June 2020. We provided the first drive-through antibody testing service in the UK. Teachers and other school staff operating school hubs were the first group of key workers to be offered the test, followed by other priority groups including healthcare workers, primary care staff, social care workers and residents, and patients as directed by clinicians for patient management.

Due to the rise in cases in the autumn, our focus increased on antigen testing for staff and to do this effectively, we paused the antibody test for staff at the beginning of October.
(Health and Care Standards: Individual Care)

Asymptomatic testing

In March 2021, we began a phased programme of asymptomatic (no symptoms) staff testing for COVID-19 using Lateral Flow Devices (LFD). The intention is to roll out the offer of LFD test kits to all staff and students in the three counties by 31 May 2021. The aim is to help to reduce onward transmission of COVID-19 by identifying asymptomatic positive staff, and thus enabling self-isolation and tracing to take place as early as possible and provide confidence to our staff and the public.

Additionally, we put in place a system to test patients due to attend hospital for a procedure or treatment in line with infection prevention and control measures and to aid a gradual return of services where appropriate.
(Health and Care Standards: Safe Care; Individual Care and Staff and Resources)

COVID-19 vaccination programme

Faced with the biggest contribution to population health in decades, the largest vaccination programme ever delivered by the NHS began in the Hywel Dda area on 8 December 2020.

The Hywel Dda University Health Board COVID-19 Vaccination Delivery Group is chaired by our Director of Public Health and includes representatives from across health, local government and partner agencies. The COVID-19 vaccination programme for the three counties supports the wider Welsh Government Strategy for Vaccination, which includes the priorities, vaccination infrastructure, and vaccination community strategy.

The aim of our COVID-19 vaccination programme is to protect those who are at most risk from serious illness or death from the virus and deliver the vaccine to them and those who are at risk of transmitting infection to multiple vulnerable persons or other staff in a health or care environment.

Based on the advice from the Joint Committee on Vaccination and Immunisation (JCVI), we aim to offer everyone in group 10 their first dose of the vaccine by the end of July, subject to supply.

To offer protection and vaccinate people as quickly as we can, we are using different, complementary ways to deliver COVID-19 vaccinations. In this way, we use all our strengths to offer vaccination to our community.

This means some people have or will receive their vaccinations through their GP surgery, whilst others will be invited to their nearest Mass Vaccination Centre, where vaccine is delivered by Health Board staff.

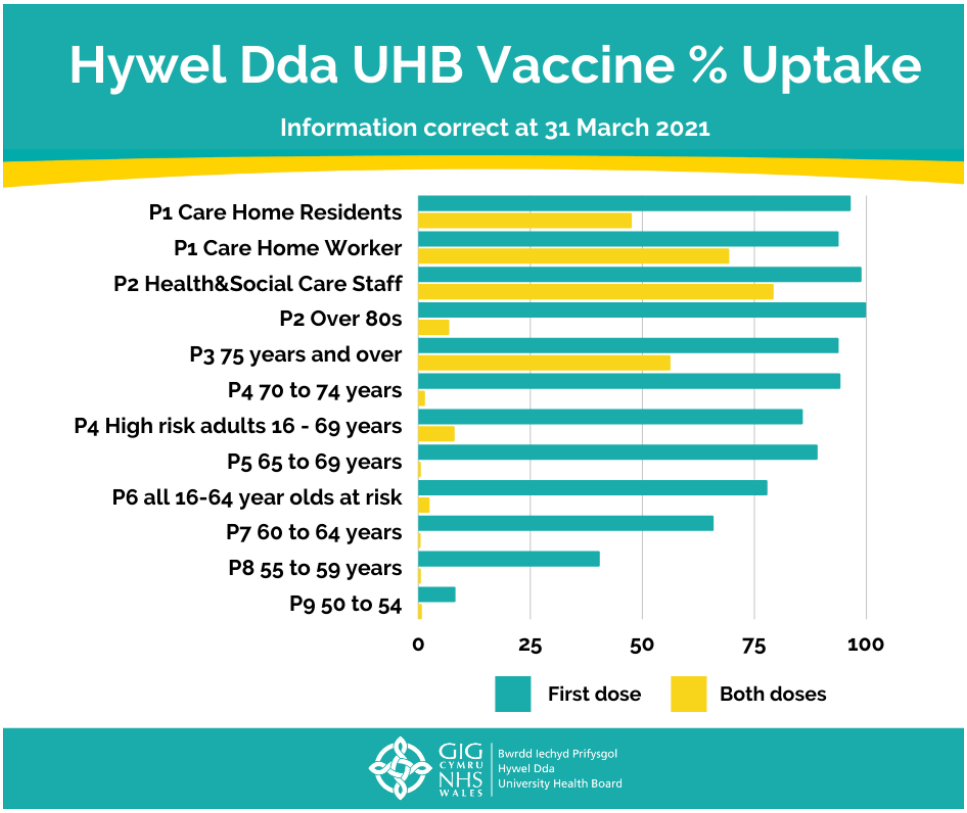
We also vaccinate target groups in other ways where necessary, for example we have undertaken vaccination in the hospital to care for long term patients or service users. We have also held ‘pop-up’ clinics for certain communities, such as travellers, unpaid carers and those people who are homeless. This aims to minimise any impact of health inequalities and ensure no one is left behind in our communities.

We also, in the future, plan to work with partners, such as community pharmacists, on delivery of the vaccination programme.

Sometimes two priority groups will be invited in for vaccination at the same time so that we can make maximum use of the vaccine supplies provided to us.

Uptake of the vaccine has been exceptionally high to date and as the vaccine programme moves into the younger and healthier groups, we will continue to work to protect as many people as possible and ensure all residents can access a vaccine. We have also the lowest wastage rates in Wales.

As at 31 March 2021, we had delivered 224,309 COVID-19 vaccinations – 185,005 first doses and 39,301 second doses. The detail as per JCVI priority group is shown in the image below:



We were especially proud of our vaccination teams – made up of immunisers from across acute, primary and community settings and supported by administrative teams and volunteers – when they were able to respond to vaccine availability, enabling us to be the first Health Board in the UK to offer the Moderna vaccination at the start of April 2021. (Health and Care Standards: All Standards)

Seasonal flu

There was concern that a challenging flu season, in addition to the COVID-19 pandemic and associated vaccination programme, could have resulted in significant additional pressure and overwhelmed the NHS and care system. Therefore, a revised strategy was developed to deliver the flu vaccine in a safe and timely manner to protect eligible groups in the community.

Partners in primary care adapted their plans to accommodate social distancing requirements, enhanced infection prevention and control measures, as well as appointment only systems with the aim of vaccinating as many people as possible.

The contribution of the Health Board's School Nursing Service resulted in the programme for primary school children being delivered within the severe constraints of access to pupils. But despite this, our team delivered the highest percentage uptake in this group of any Health Board in Wales.

This was complemented by an external communications and public relations exercise that aligned with Welsh Government's Beat Flu strategy. Part of this campaign included a significant investment to reach the non-digital audience, such as newspaper adverts across

the three counties for the first time in several years, along with radio adverts. Meanwhile, all schools were provided with flu promotion materials to issue directly to parents.

Overall, the provisional data for the 2020/21 programme has shown increased demand for flu vaccination in our communities and a significant increase in uptake in all eligible groups:

Cohort	Hywel Dda Uptake 2020-21	Change from last season	Wales uptake 2020-21
Over 65s	73.6%	Up 8.7%	76.5%
Under 65s with chronic conditions	49.8%	Up 9.5%	51%
2-3-year-olds	55.1%	Up 6.6%	56.3%
School aged children (4-11-year-olds)	87.1%	Up 15.9%	72.4%
Hywel Dda staff (direct patient contact)	55.1%	Up 5.7%	65.2%

This combined effort resulted in the following:

- Vaccinated a whole new cohort of people in our communities aged between 50-64 years old following new guidance from Welsh Government.
- Began and finished the programme early (99% uptake completed by the end of December 2020).
- Improved our uptake rates in all eligible cohort groups by 6-16%.
- Vaccinated more people than ever against seasonal flu despite being the middle of a global pandemic.

Meanwhile, our Occupational Health Team, supported by peer vaccinators, led on the roll out of the flu vaccine to staff. The logistical issues of delivering a vaccination programme within the constraints of COVID-19 guidance was managed through exceptional partnership working and the need to be as flexible and responsive as possible.

The programme was delivered over an expedited timeframe in preparation for the launch of the COVID-19 vaccination programme. It was supported by a communications and staff engagement campaign, which highlighted available clinics and how to access vaccines. The result was 6,653 staff receiving a flu vaccination. This was an increase of 789 on the previous season.

(Health and Care Standards: Staying Healthy; Timely Care and Staff and Resources)

Redesign of acute services to provide COVID-19 care

Field hospitals

At the start of the COVID-19 pandemic, we worked to Welsh Government guidance in relation to the number of beds required. Nine field hospitals providing 915 beds were set up across the three counties, as a precautionary measure to help ensure we had enough capacity to treat a potential increase in hospital admissions. The hospitals were constructed and commissioned rapidly - within one month. This was achieved by not only the hard work and dedication of our staff but also the remarkable efforts of our partners, contractors, local communities and volunteers. From the outset it was clear that we could not predict the way the virus would spread and affect our local population, and we knew that being flexible in our use of these facilities would be key to the way we cared for patients. We are proud to have been able to have brought some of our field hospitals into operational use to help manage acute and community demand, particularly during the second wave and to have done so with a high degree of positive patient experience feedback. The key sites included Ystwyth Enfys Caerfyrddin (Carmarthen Leisure Centre), Ysbyty Enfys Selwyn Samuel (Selwyn Samuel Centre), and Ysbyty Enfys Carreg Las (Bluestone). While patients were not treated at all sites, they each played an important role in our response to the pandemic, from clinical use and training, to testing and vaccination. At the end of March 2021, Ysbyty Enfys Selwyn Samuel remains open to inpatients. The field hospital campaign received positive feedback from Health Inspectorate Wales following its field hospital inspections carried out in autumn 2020. Thankfully, most of the field hospitals were not needed. Taking a pragmatic and cautious approach, we have returned most field hospitals to their original use whilst retaining some to have access to beds if there is a future demand in the event of a possible third wave of the virus. A summary is provided below:

County	Field hospital site	Beds initially set up	Position as at 31 March 2021
Carmarthenshire	Carmarthen Leisure Centre	93	Standby with potential to open 24 beds
	Selwyn Samuel Centre	120	Retained as a surge facility with 28 beds
	Llanelli Leisure Centre	95	Returned to former use
	Parc-y-Scarlets Barn	253	Returned to former use
	Parc-y-Scarlets Stadium	80	Returned to former use
Ceredigion	Cardigan Leisure Centre	48	Retained as a Test Trace & Protect and Mass Vaccination facility
	Aberystwyth Leisure Centre	51	Returned to former use
	Aberystwyth School	52	Returned to former use
Pembrokeshire	Bluestone, Narberth	123	Returned to former use

(Health and Care Standards: All Standards)

Critical care

As part of our COVID-19 response, the number of critical care ventilated beds increased across our four acute hospitals. However, this increase was subject to available staffing levels and enough medical stock.

Following a review of recommendations from The Faculty of Intensive Care Medicine on staffing levels and after an internal review of our critical care staff, their skills and those staff who could be redeployed back into critical care from external roles, it was assessed that 33 advanced respiratory support (level 3) beds could be supported with safe staffing levels and the recommended skill set. This is compared to 22 level 3 beds pre-pandemic. The increase was subject to all staff being released from their main core roles, all planned (elective) surgery suspended, availability of agency staff and was dependent on the availability and presence of health care support workers. This also assumed that the nurse / patient ratio moved from the traditional one critical care skilled nurse per one level 3 patient, to one critical care skilled nurse per one level 3 patient and supervising a non-critical care skilled nurse with a second level 3 patient.

Critical care medical stock to support the ventilated beds was calculated based on every ventilated patient requiring average daily dose as per guidelines from the Royal College of Anaesthetists and stock was moved rapidly across acute sites where required.
(Health and Care Standards: Safe Care; and Staff and Resources)

Emergency care

COVID preparedness through winter

The six goals for urgent emergency care (UEC) were first published by Welsh Government in the NHS Wales COVID-19 Operating Framework for Quarters 3 and 4 of 2020/2021. The framework allows us to describe our whole system approach to ensuring patient flow through acute hospitals is as efficient as it can be and enhance access to emergency services routinely and at times of escalated demand and pressure.

Our planned regional outcomes for the six goals are as follows:

1. **Co-ordination for at risk groups** - planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

2. **Signposting** - information, advice or assistance to signpost people who want, or need, urgent support or treatment to the right place, first time.

3. **Preventing admission or attendance** - community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.

4. **Rapid response in crisis** - the fastest and best response at times of crisis for people who are in imminent danger of loss of life, are seriously ill or injured, or in mental health crisis.

5. **Great hospital care** - optimal hospital-based care for people who need short term, or ongoing, assessment / treatment for as long as it adds benefit.

6. **Home first approach and reduce risk of readmission** - a home-from-hospital when ready approach, with proactive support to reduce chance of readmission.

To support a rapid and effective response to COVID-19, our acute hospital teams significantly reconfigured the way in which care, clinical pathways and staffing resources were organised across each of our hospital sites. Examples include:

- Reconfiguration of existing emergency departments and hospital facilities to support COVID-19 (red), non-COVID-19 (green) and suspected (amber) streams. We triaged at hospital front doors initially using 'tents' which were replaced with cabins as we entered the winter period.
- Use of digital technology to support virtual board rounds & multi-disciplinary team discussions whilst supporting social distancing measures.
- Redirection of pathways to support opening of Continuous Positive Airway Pressure (CPAP) designated and COVID-19 wards.
- In March 2020, the Paediatric Ambulatory Care Unit (PACU) at Withybush General Hospital, also known as Puffin Ward, was converted into a green pathway Minor Injuries Unit for adults and children. Families with children suffering minor injuries are still able to access care at Withybush via the MIU. Those children with acute illness, including those who need to stay in hospital overnight, are cared for in Cilgerran children's ward at Glangwili Hospital.
- Structured daily clinical handover & briefing sessions between staff in red and green zones with a focus on new admissions, discharge planning, PPE, equipment, oxygen usage, staff resources and clinical education based on experience of managing COVID-19 patients.
- We introduced single medical rotas to ensure the red and green zones could be managed as the original split rotas for these areas were unsustainable.
- We reviewed and amended the use of our community hospitals to meet the changing needs, such as opening a 25-bed ward in South Pembrokeshire Hospital and eight additional beds in Tregaron Hospital for step-down and discharge to facilitate better hospital flow.

(Health and Care Standards: All Standards)

Development of new emergency care measures

New measures are being developed for emergency care, as part of the Welsh Government's Change the conversation initiative, which is outlined in this YouTube video. The measures will attempt to change the conversation of what good looks like for a patient journey through an emergency department (ED) that is supplementary to the traditional four hour and 12 hour wait targets.

Three experimental measures were introduced in November 2020 across our three major emergency departments as part of the National Emergency Department Quality & Delivery Framework Programme (EDQDF). These measures will help to better describe and understand what happens to patients between the front and back doors of emergency departments, and support improvements to patient and staff experiences, clinical outcomes and value. The measures are:

- Time from patient arrival at A&E to triage-by-triage category.
- Time from patient arrival to contact with an A&E clinical decision maker.
- A record of the A&E discharge time and destination of every patient when they leave.

We set up a working group to develop our approach and to start capturing data around these measures. We acknowledged there is still some data clarification and refinement required both locally and at a national level. In March 2021, a national "next steps" improvement plan session was held, and the following actions were agreed for 2021/22:

- Digital Health and Care Wales (DHCW) is a new special health authority (established on 1 April 2021) created to take forward the digital transformation needed for better health and care in Wales. DHCW will share the new measures production plan on a regular basis to resolve any potential future quality assurance issues with the reporting of these measures as they arise.
- Regular engagement with Heads of Information through the national group to support local improvement plans.
- Monthly communications to ensure key stakeholders are kept informed of developments and improvements in the data each month.

(Health and Care Standards: Safe Care; Effective Care; Timely Care and Staff and Resources)

'Contact First' with 111 service and Physician Triage & Assessment & Streaming with WAST

In December 2020, the Chief Executive of NHS Wales requested that all Health Boards:

- Work with the 111 service to deliver 'Contact First'.
- Support the Welsh Ambulance Service Trust (WAST) in providing clinical resource for Physician Triage Assessment & Streaming (PTAS).

'Contact First' with the 111 service

The 'Contact First' service is for people who were not requiring emergency care but need urgent care (within the next 8 hours). People who need this urgent care currently telephone the 111 service and may be given the advice to attend an Accident and Emergency (A&E) department or a Minor Injury Unit (MIU).

'Contact First' will stream these calls through to a local hub to schedule attendance at A&E/MIU. This helps limit the number of people waiting in A&E/MIU due to the environmental constraints that COVID-19 placed on those services. To meet this request, we formed an Urgent Care Working Group to oversee progress and to drive and manage our local response. The group had representation from clinicians and managers across our whole system and included national 111, Urgent Primary Care and Contact First leads, GP Out of Hours, GP Leads, Welsh Ambulance Service Trust, Secondary Care clinicians and Local Authorities. A model was developed that considered the opportunities given the established 111 service in Hywel Dda, the local need and a whole-system urgent care approach.

The progression of this urgent care model will bring together various projects, to enable significant transformation of our pathways and in delivering 'Contact First' we aim to:

- Develop a local Urgent Care Streaming Hub to manage individuals from 111 and provide scheduled appointments for these and other services inclusive of Same Day Emergency Care, Hot Clinics*, and Urgent Primary Care access.
- Manage more effectively those who self-present to A&E and MIU.
- Reduce demand in A&E and MIU.
- Develop a local directory of services (including alternate pathways) to support the hub and 111.

We are developing a phased approach to deliver 'Contact First' in line with the national timescales with phase 1 commencing in April 2021.

* A Hot Clinic is a consultant-led clinic that provides rapid access to assessment and is generally condition / speciality based e.g. respiratory, cardiac.

Physician Triage & Assessment & Streaming with WAST
All Health Boards were requested to support Welsh Ambulance Service Trust (WAST) in providing clinical resource, Physician Triage Assessment & Streaming (PTAS) to remotely clinically review individuals who were waiting on the WAST queue. When an individual dials 999, the calls flow through a control room and are placed in a queue or stack according to their clinical need awaiting an ambulance. At the time of the request, WAST was seeing very high numbers of individuals waiting for ambulances and numbers of ambulances delayed outside of emergency departments across Wales. The intended outcome was to reduce the number of individuals requiring onward transport via ambulance to an emergency department and as such this would reduce delays.

We have been working closely with WAST to develop this GP-led triage service in the three counties. Remote working GPs have been employed in readiness to launch and a standard operation procedure and a memorandum of understanding are currently being agreed with WAST. Once operational we hope this service will support and be integral to our Urgent Care Streaming Hub.
(Health and Care Standards: Safe Care; Effective Care; Timely Care; and Staff and Resources)

COVID-19 mortality reporting and surveillance

To ensure appropriate monitoring and reporting processes were in place in relation to COVID-19 deaths at our hospital sites, we put in place new protocols for relevant clinical staff. This included new documentation and guidelines for reporting COVID-19 deaths and completing the COVID-19 mortality surveillance in the Welsh Clinical Portal (WCP) digital patient record. This information was distributed to staff and made available on the intranet.

During the year, we carried out a mortality-based review of the impact of COVID-19 on those waiting at home for treatment, as well as comparisons to All Wales performance and time-trend analysis. Our analysis of reported COVID-19 deaths in the three counties has shown a trend consistent with the bed capacity at each hospital and the age profile of inpatient deaths is consistent between hospital sites. The total number of COVID-19 deaths here, both PHW reported and the Office for National Statistics (ONS), are significantly lower than the Wales average and the distribution is consistent with the rest of Wales and the reported number of confirmed cases per 100,000 population.

We will be reviewing this information against patient outcome, patient experience, carer feedback and staff experience during the pandemic to gain a more informed picture of the impact on the population of the three counties.
(Health and Care Standards: Safe Care)

Planning and delivery of safe, effective and quality services for non-COVID-19 care

Delivery of infection control measures to deliver both COVID-19 and non-COVID-19 care

Management of safe PPE - training and supplies

At the early stages of the pandemic in 2020 there were numerous changes to national guidance in relation to Personal Protective Equipment (PPE). This impacted on healthcare staff confidence across the UK, with concerns being raised in relation to effectiveness (efficacy) of the PPE. There were also concerns about supply of PPE due to the increase in demand globally.

We responded by establishing both internal (organisational) and regional PPE 'cells' or working groups. The cells addressed emerging issues and coordinated demand and supply, as well as monitored effectiveness and appropriate use.

Local PPE hubs were established and a strong process for buying (procurement) and distributing PPE in collaboration with our partners. Throughout the pandemic the Health Board has been able to sustain the supply of PPE to our frontline workers, despite times where such supply was limited. This has required, frequently adapting local policy in response to changes in the evidence base and national guidance.

This also necessitated strong and regular communication and training and education with the workforce. Throughout the year, training has been delivered to all healthcare staff in relation to putting on (donning) and taking off (doffing) PPE safely to minimise the risk of transmission of infection. This training has been supplemented by videos and training resources available on internal communication platforms.
(Health and Care Standards: Safe Care; and Staff and Resources)

Redesign of local estate to deliver safe services during COVID-19

Early in the pandemic, the Welsh Government introduced regulation on social and physical distancing measures aimed at reducing social interaction between people to reduce the transmission of COVID-19. This regulation included maintaining two metres away from others when outdoors and in enclosed spaces outside the home setting.

This included healthcare environments and as such a social distancing working group (cell) was established to progress the recommendations and to keep patients and staff safe. This group also worked closely with the three bronze groups for acute, community and primary care services, which have met throughout the pandemic.

These forums have constantly considered the healthcare environment and adapted processes so that we can sustain services safely, wherever possible, keeping both patients and staff safe. They have been constant and flexible in their approach so that they can respond to changing legislation, guidance and service demand.

To comply with guidance and re-mobilise our core healthcare services, and as part of business continuity, high, medium and low risk areas were established in all our healthcare

facilities. This helped minimise the risk of transmission of infection to patients and staff. Parts of our current estate are older with more than half of our buildings over 30 years old, which can present additional challenges around the management of infection prevention and control. Some services have been re-located away from acute hospital sites to dedicated testing units, such as COVID-19 testing and phlebotomy services. Some facilities have been changed to enable separation of 'green' and 'red' activity and pathways. For example, theatre recover areas were changed to 'green' Critical Care Units.

A tremendous amount of time and effort, as well as required investment, has been put towards this effort. This has included:

- Re-designing our hospitals, community and primary care settings to include 'green' 'amber' and 'red' areas, segregated entrances, exits and one-way systems, and designating maximum numbers of people allowed in different areas.
- Training for staff in how they can maintain a safe distance whilst undertaking working practices (including for newly recruited staff).
- Screens set up as physical barriers between bed spaces or working areas to avoid transmission.
- A visibility campaign including erections of large signage, floor stickers and posters.

(Health and Care Standards: Safe Care; and Staff and Resources)

Local communication with the community to support them making the right choices

The success of infection control measures to deliver both COVID-19 and non-COVID-19 care relies on our communities, both staff and the wider population, being aware of and complying with the measures in place to protect us all.

Having clear and up-to-date information has been a pivotal part of our approach, and a consistent consideration due to both changes in guidance and how we have experienced the pandemic within the three counties. The regional communications response has played a fundamental role, with support from partners in local authorities and the wider public sector, in being able to respond to and target priority audiences and specific issues at different points of the pandemic.

For example, the first wave did not impact our communities as quickly as other areas of the UK, and we spent this time learning from others experiences and preparing our staff and public around COVID-19 infection prevention and control measures. This included production of multiple internal staff-facing, and external public-facing resources and campaigns. Examples include:

- Local videos with staff experts on correct use of PPE for health, nursing home and social care staff.
- Formation of a clinical communications group to ensure appropriate clinical sign-off, including infection prevention and control, to products (such as posters and videos being produced at a local level).
- A web resource to provide specific local amplification and addendums connected with national policy and in line with specific experience and access to PPE locally.
- Production and distribution of materials for the visibility campaign on our sites and within primary care settings.

We also needed to respond to emerging issues and enquiries, which were unforeseen. For example, we were overwhelmed at the amazing response from our communities to assist

and help the NHS and our staff. However, we needed to help manage these offers of help to protect individuals from risk of infection and to adhere to compliance with government restrictions of the time. This led to us, in conjunction with Hywel Dda Health Charities, launching a 'Spread the Kindness campaign' to encourage support of the nature that kept people at home and provided us with donations through centralised systems, such as online giving, so we could protect people from risk of harm.

As we started to see an increase in the impact of COVID-19 on our communities, we were able to use feedback from staff and the public to inform our communication activity. This was collected over channels, such as social media, but also from patient experiences shared or seen by Hywel Dda Community Health Council. This helped us to address specific fears and anxieties seen in our own communities around infection prevention control measures. For example, we produced:

- A video used on social media and digital screens in health settings to prepare patients for what to expect when they came to hospital and to reduce anxiety and fear.
- A targeted video for people with learning difficulties around the pathways and what to expect in terms of use of PPE and patient pathways into health settings.
- Hard copy patient leaflets for both inpatients and outpatients, and a web resource, on necessary arrangements for distancing and hygiene.
- An 'explainer' animation used by Family Liaison Officers with patients to foster understanding and compliance.

Through intelligence provided by contact tracing teams and Incident Management Teams we have been able to align resource to specific geographical or demographic issues. For example, targeted communication and engagement campaigns around the need for distancing and compliance with other government measures took place in towns such as Llanelli and Cardigan. Other campaigns focused on risk factors and increases in cases connected with communities. For example, we provided supportive communication materials and supported online events and direct communication on the need and benefits of distancing with students in Aberystwyth and amongst our traveller community in Pembrokeshire.

We have been grateful to our communities for engaging in our communication campaigns and encouraging others to follow official sources of communication. We have benefitted from good working relationships with local traditional media, as well as with social media groups and individuals. This has helped us grow our audience and ensure more people have access to official sources of information. For example, we have more than four times as many Facebook followers now (55,581 as at 31 March 2021) than prior to the peak of the first wave of the pandemic (when there were 13,722 as at March 14 2020).
(Health and Care Standards: All Standards)

Summary of implications from infection control measures

This has been a year like no other for the global population, including those working in healthcare. Huge resources have been diverted to the COVID-19 effort, and we have faced significant challenges in both the first and second wave of the pandemic. This has included the challenge of our own healthcare staff being required to shield or self-isolate following exposure to the virus.

We have worked alongside our partners in health and social care to support the care home sector throughout this pandemic and have faced significant challenges in managing the flow of patients and residents through the healthcare system as COVID-19 has resulted in temporary closure of facilities. We are also mindful that restrictions to hospital visiting, and for people accompanying loved ones to health care appointments (such as scans) has had an impact on individuals and the well-being of some of our patients. These restrictions were put in place due to the difficulties in maintaining social distancing in these environments at given times (see more on page 61 of this report)

As part of Infection Prevention & Control measures, we are providing every doctor with up to five sets of dark grey scrub suits for use in clinical areas outside of theatres, and outbreak areas. All doctors are encouraged to wear their new scrubs whilst on clinical sites. This will:

- Allow clinical staff to adhere to infection prevention and control protocols.
- Enable clinical staff to be bare below the elbow in the workplace to enable effective hand washing techniques.
- Differentiate between staff working in different clinical areas and clearly identify outbreak areas.

We have been fortunate that other communicable diseases have not added a significant burden this year. It is possible that precautions implemented to control the spread of COVID-19 has also controlled the transmission of seasonal flu and norovirus.
(Health and Care Standards: Safe Care; and Staff and Resources)

Delivery of essential services

Welsh Government issued guidance for the essential services that must continue throughout the COVID-19 pandemic to ensure patients have access to necessary care and treatments in a safe environment. That guidance can be viewed here: www.wales.nhs.uk/COVID19essentialservicesguidance.

A summary of our essential services provisions as at 31 March 2021 is included below:

Normal services that are continuing

Emergency ambulance services

Intermediate services that are being delivered

Maternity services

Essential services that are being maintained in line with guidance

Access to primary care services - General Medical Services, community pharmacy, red alert urgent / emergency dental services, optometry services, community nursing / allied health professionals and 111

Acute services - urgent eye care, urgent surgery and urgent cancer treatments

Additional services - health visiting, community neurorehabilitation, self-management & well-being and school nursing

Blood and transfusion services

Diagnostics

Life-saving/impacting paediatric services - paediatric intensive care and transport, paediatric neonatal emergency surgery, paediatric services for urgent illness, immunisations / vaccinations, infant screening and community paediatric services for children

Life-saving medical services - interventional cardiology, acute coronary syndromes, gastroenterology, stroke care, diabetic care, neurological conditions and rehabilitation

Mental health, learning disability services & substance misuse

Neonatal services - surgery for neonates, isolation facilities for COVID-19, access to neonatal transport and retrieval services

Other infectious conditions

Palliative care

Renal care-dialysis

Safeguarding services

Termination of pregnancy

Therapies

Urgent supply of medications and supplies

Essential services we are currently unable to maintain

GP out-of-hours services

Although we were unable to meet all elements of the essential services guidance, we continued to provide GP out-of-hours care and took actions to address the gap. These included:

- During 2020/21 overall demand reduced by 12% and calls completed by telephone consultation increased by 26%. Face-to-face consultations reduced by 66% in treatment centres and 48% home visits.
- Staff moved base to spread cover in a geographically appropriate way.
- We are working to employ salaried GPs.
- We are investigating options for virtual consultations.
- Our new clinical operating system (Salus) has a projected go live date of September 2021.
- We are developing a new IT rota system (RotaMaster), which will allow vacant shifts to be advertised and booked 24 hours a day.

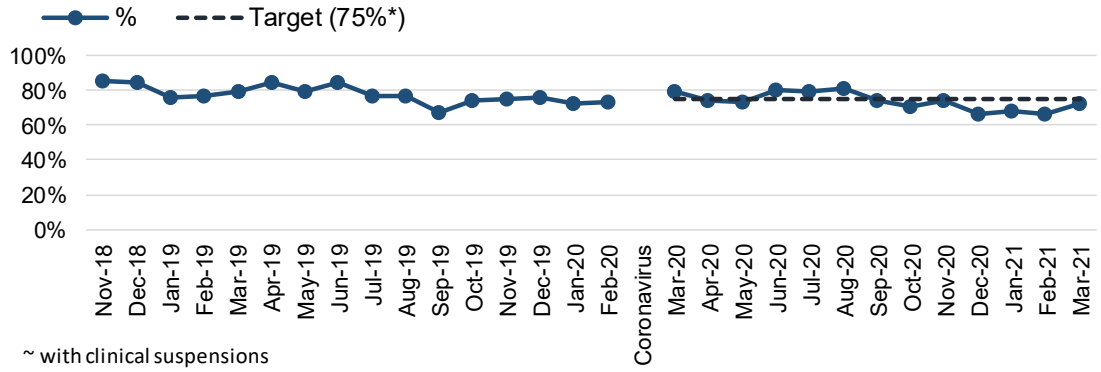
Cancer

The national guidance for cancer services during the COVID-19 pandemic requires us to:

- Ensure urgent cancer diagnosis, treatment and care continue as well as possible to avoid preventable morbidity and mortality.
- Treat cancer patients in line with the prioritisation categories set out by the Wales Cancer Network.
- Reinstate all cancer services as soon as it is safe and feasible to do so.

We did not consistently meet target for cancer patients commencing treatment within 62 days from point of suspicion. The biggest decline in performance was seen during the second COVID-19 wave (December 2020 and January 2021) when some cancer surgery had to be suspended due to a lack of availability of critical care beds. The requirement for cancer patients to self-isolate pre-treatment also impacted on performance across Wales.

Patients starting first definitive cancer treatment within 62 days~



~ with clinical suspensions

* target changed from 12 month improvement to 75% in February 2020

Key issues and risks

The COVID-19 pandemic has affected our delivery of essential cancer services:

- At the beginning of March 2020, we saw a 49% reduction in urgent suspected cancer referrals when compared with the same period in 2019. By the end of August 2020, the number of referrals had increased to almost normal numbers.
- Some cancer surgery was suspended in 2020/21 for patients requiring intensive care / high dependency support post operatively due to limited availability of critical care beds.
- Due to an increase in COVID-19 cases and the impact of the critical care pathway, a temporary pause was put on a number of elective cancer operations from 18 December 2020 until 20 January 2021 with only a limited number of life-threatening clinically prioritised operations being undertaken.
- All tertiary (specialist) cancer surgery was suspended in March 2020 for a period of time.
- Bronchoscopies were limited in-line with national guidance.

In addition to the points highlighted above, we experienced an increase in demand beyond available capacity for cancer patients requiring diagnostic investigations.

Key actions taken to ensure continued delivery of essential cancer services

- At the start of the pandemic, a telephone helpline for concerned cancer patients was introduced, to provide advice and support. A patient information leaflet for cancer patients including helpline numbers was also developed and widely circulated.
- Since April 2020, we have commissioned Werndale Private Hospital to support our urgent cancer outpatient and surgical pathways.
- We have been working with multi-disciplinary teams across the three counties and Swansea Bay University Health Board to enable tertiary centre surgeons to provide outreach surgery for both gynaecology and urology.
- We are investigating required diagnostics capacity levels to ensure a 7-day turnaround.
- Plans are being progressed in accordance with the Welsh Government guidance to further increase the volume of cancer diagnostic and surgical cases undertaken at our four acute hospital sites.

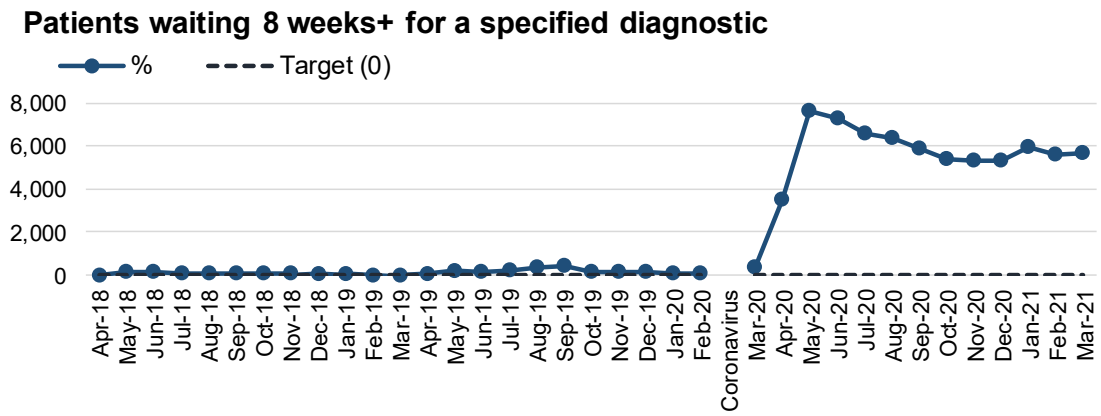
(Health and Care Standards: All Standards)

Diagnostics

The national diagnostic essential services guidance requires us to:

- Minimise the risks associated with COVID-19.
- Look for local flexible solutions to safely maximise capacity.
- Provide timely imaging and diagnostic tests for eligible emergency (within 24 hours) and urgent (within 72 hours) diagnostics, such as major trauma, cancer, cardiac, gastroenterology and stroke patients.
- Ensure patients have access to the necessary information to enable them to make an informed decision on whether to proceed with a planned diagnostic test and/or surgery.

Due to restrictions imposed at the start of the COVID-19 pandemic, the number of patients waiting longer than 8 weeks for a diagnostic test increased sharply from 54 breaches in February 2020 to 7,615 in May 2020. Improvements were then seen with breaches reducing month-on-month. However, the number of breaches has steadied since January 2021.



Key issues and risks

As seen in the chart above, the COVID-19 pandemic has impacted on our performance for the delivery of diagnostic services:

- Capacity has significantly reduced due to the required infection control measures.
- Towards the end of the financial year there was an increase in urgent cancer and cardiology referrals, possibly due to late presentation due to anxiety around COVID-19.
- Unable to provide trans-oesophageal echo or dobutamine stress echo tests due to staff capacity and space constraints.
- Capacity pressures, equipment failure and COVID-19 precautions are all potential risks that could impact our ability to meet target.

Key actions taken to ensure continued delivery of essential diagnostic services

- Continuous demand and capacity optimisation, investigation of outsourcing options, clinical validation, recruitment and revising pathways to meet changing needs throughout the year.
- Maintained services for urgent and suspected cancer work.
- Linked with colleagues across Wales for a review of the overall picture and possible solution to assist with post COVID-19 recovery.
- Additional capacity for computerised tomography (CT) was acquired, with staff undertaking extra sessions to provide the required additional capacity.
- Some cardiology services were moved off-site to facilitate social distancing.
- 7-day working established to maintain social distancing and increase the number of cardiology diagnostic tests undertaken.
- Robust triage of cardiology diagnostic waiting list to ensure the most urgent cases are prioritised first.
- Planning to implement a capsule endoscopy service in 2021/22 to further reduce demand for scoping capacity.
- Introduced screens in our endoscopy waiting and recovery areas to help increase capacity safely.
- Investigating the use of air filtration units to reduce downtime between each patient and therefore increase capacity.
- All priority one endoscopy patients were dated within 2 weeks.
- Faecal immunochemical tests continued in line with national programme guidelines.

(Health and Care Standards: Safe Care; Timely Care and Staff and Resources)

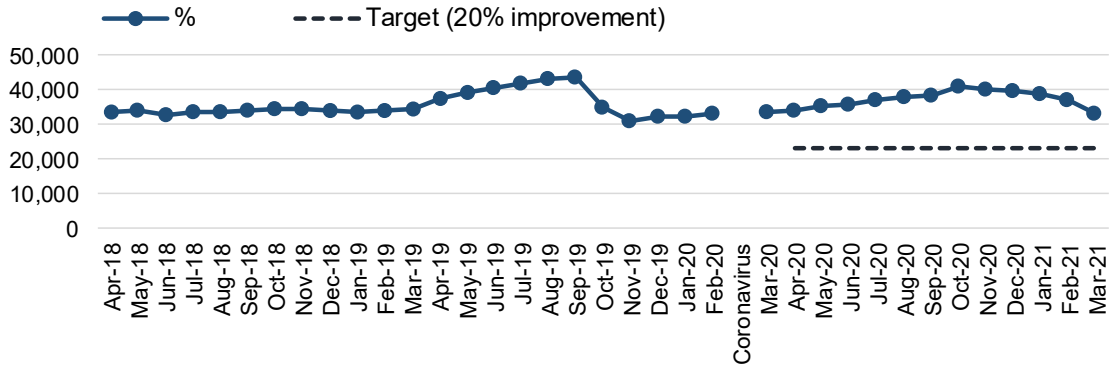
Outpatients

The national guidance for outpatient services during the COVID-19 pandemic requires us to:

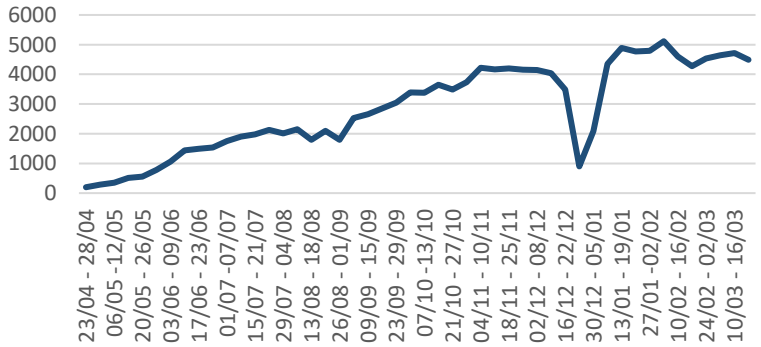
- Minimise the risks associated with COVID-19.
- Look for flexible solutions to safely maximise capacity.

Due to advances in digital technology, our performance for delayed outpatient appointments has not been greatly affected by the COVID-19 pandemic. In March 2021 there were 32,972 patients waiting longer than their target date for a follow up outpatient appointment, which is a reduction of 448 (1.3%).

Delayed follow up outpatient appointments (all specialties)



Remote consultations in secondary care (using AttendAnywhere)



Except for Christmas 2020 when there was a temporary reduction in remote consultations, the number of consultations being undertaken remotely per week increasing from around 300 in April 2020 to 4500 in March 2021.

Key issues and risks

The COVID-19 pandemic has resulted in reduced face-to-face capacity for outpatient appointments. This is primarily due to reduced staffing levels and infection control constraints.

Key actions taken to ensure continued delivery of essential outpatient services

- We have embraced and implemented new ways of working to increase outpatient capacity and reduce delays. These include virtual outpatient reviews and Consultant Connect.
- Face-to-face contact has continued where necessary for urgent patients.
- We have contacted all patients who have waited over 52 weeks for treatment. Building on the success of our COVID-19 Command Centre, we are also working to establish a single point of contact for patients to enable timely responses and advice.
- We are adding patients to the See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways in two ways, as part of validation and after a patient has had a follow up appointment. In March 2021 there were 920 patients added to an SOS / PIFU

pathway. In 2021/22 we will be actively monitoring how many patients call back for a consultation.

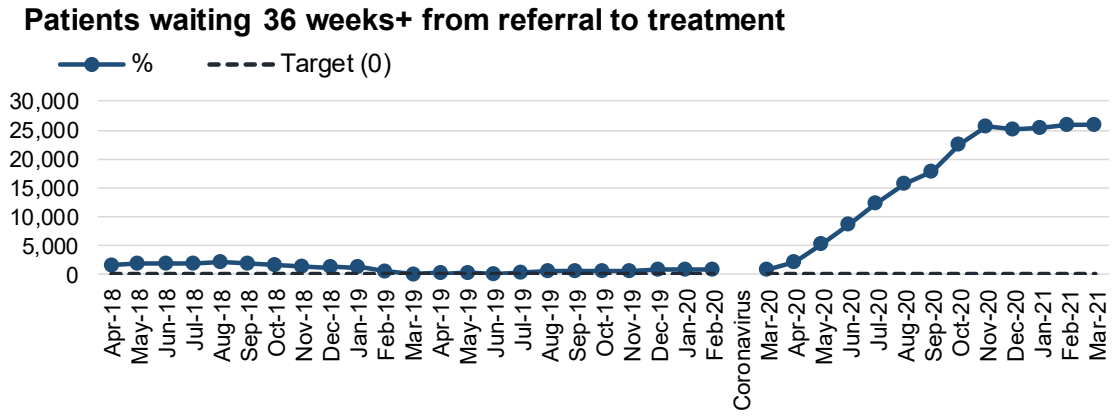
(Health and Care Standards: Staying Healthy; Timely Care and Staff and Resources)

Managing our waiting lists and identifying those at higher clinical risk or harm

During the COVID-19 pandemic, the national guidance for planned care services requires us to:

- Ensure patients have access to the necessary information to enable them to make an informed decision on whether to proceed with surgery.
- Look for local flexible solutions to safely maximise capacity.
- Minimise the risks associated with COVID-19.
- Risk assessment of patients and prioritise accordingly so those at higher clinical risk or risk of harm are treated first.

The pandemic and related government restrictions to keep us safe, have naturally had detrimental impacts to access to care. Whilst emergency and urgent cancer care has continued, we have had to stop or reduce planned care for significant periods of time during the last 18 months. This has included postponements of planned operations or procedures and as a result far more of you are waiting longer than we would like. As a result, the number of patients waiting 36 weeks or more for referral to treatment (all stages) increased from 722 in March 2020 to 25,868 in March 2021. The chart below shows how the number of breaches increased until November 2020 but then steadied for the remainder of the financial year.



Key issues and risks

As shown above, the COVID-19 pandemic has impacted heavily on our planned care performance.

- It will take a long time to treat the increased number of patients on our waiting list.
- Due to a sharp increase in COVID-19 cases, a temporary pause was put on planned operations from the 18 December 2020 until 20 January 2021.
- Lower numbers of patients are being treated compared to pre-pandemic; this is primarily due to social distancing and stringent infection control measures.
- The need to prevent patients having major surgery while they have COVID-19 except for life, limb or sight-saving procedures, as their outcomes are likely to be poor.
- Significant public concern about attending acute hospitals.

- There is a significant risk regarding ward staffing vacancies to ensure safe staffing levels to support planned operations.

In line with national guidelines, our clinical staff are working to risk assess every patient waiting for an inpatient or day case procedure. As at the 31 March 2021, we had risk assessed 73% of patients on the waiting list, of which 6% (842 patients) were assessed as needing their operation within 4 weeks due to clinical need or a risk of harm. The breakdown by specialty is included below.

Patients who have had their outpatient and/or diagnostic appointments and are now waiting for an inpatient or day case procedure as at 31 March 2021.

Specialty	1 Operation needed within 72 hours	2 Surgery can be delayed up to 4 weeks	3 Surgery can be delayed up to 3 months	4 Surgery can be delayed >3 months	Waiting to be risk assessed	**Total patients waiting**
Trauma & Orthopaedics		382	995	2,879	181	**4,437**
Ophthalmology		32	328	2,621	13	**2,994**
Urology		143	242	373	1,416	**2,174**
General Surgery		166	337	830	568	**1,901**
Gastroenterology			6		874	**880**
Gynaecology		43	183	237	269	**732**
Pain Management		3	69	252	71	**395**
ENT		28	89	234	15	**366**
Colorectal		40	58	71	168	**337**
Cardiology					114	**114**
Other specialties		5	6	5	286	**302**
All specialties		**842**	**2313**	**7502**	**3975**	**14,632**

Key actions taken to ensure continued delivery of essential planned care services

- Following the temporary pause, we recommenced planned operations for urgent patients at the end of January 2020.
- We are working to ensure those at highest clinical risk or risk of harm are identified so that they can be treated as a priority.
- We continue to plan to restart planned surgery for priority groups 2 and 3 as soon as it is safe and feasible to do so.
- We have developed a revised post-COVID-19 watchtower planned care monitoring programme.
- Patients are offered treatments in line with policy across our four acute sites, to enable equity of time and care delivery. Regular review of progress is undertaken at the weekly watchtower meeting.
- We have implemented pre-assessment and screening pathways, including social isolation pre and post operatively with COVID-19 screens 72 hours pre-operation.

- We have written to patients waiting for 52 weeks for treatment to check if they still need their operation. We intend to write to more patients in 2021/22. In the meantime, we have provided some supportive resources for people awaiting surgery. This information can be found on our website (https://hduhb.nhs.wales/ healthcare/covid-19-information/) by selecting 're-starting services' or 'preparing for treatment'.

(Health and Care Standards: Safe Care; Timely Care; Individual Care; and Staff and Resources)

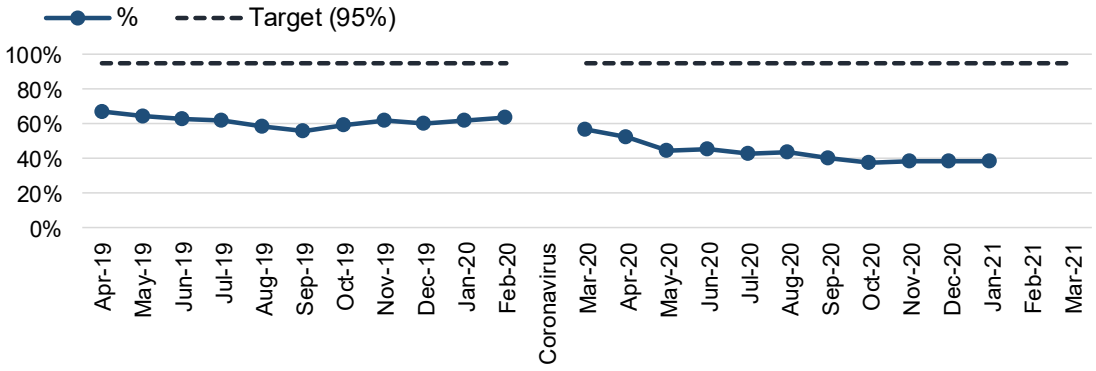
Eye care

The national guidance for eye care services during the COVID-19 pandemic requires us to:

- Ensure urgent patients are seen and reviewed as appropriate.
- Ensure strategies are implemented that mitigate the loss of hospital-based ophthalmology outpatient capacity.

During 2020/21, we consistently missed the target for seeing high risk eye care patients by their target date or within 25% excess of that date. Our performance deteriorated at the start of the year but steadied from November 2020 onwards.

R1 eye care patients seen by target date (or <25% excess)



Key issues and risks

The COVID-19 pandemic has impacted on our performance for the delivery of essential eye care services:

- Some patients have chosen not to attend hospital appointments due to COVID-19 concerns.
- Routine surgery and face-to-face outpatient activity have been postponed.
- Due to our eye care population demographics, most patients require hospital transport which has affected attendance.
- New patients experienced longer waits due to the combined impact of pandemic related restrictions and a shortage of consultant ophthalmologists.
- Glaucoma patients, on the follow up review, have not had regular diagnostic tests as these cannot be undertaken virtually.

Key actions taken to ensure continued delivery of essential eye care services

- Ophthalmology services reconfigured to meet essential urgent care where required.
- Increase in collaborative working with community optometric practices.

- The telephone triage of emergency eye casualties by a senior clinician reduced attendance by 50%, with patients being managed via other routes, including independent prescribers in optometric practices.
- We have started working on a business case to provide a sustainable age-related macular degeneration service with care closer to home.
- We have maintained treatments and reviews for imminently sight threatening or life-threatening conditions (prioritised those patients most at risk).
- Patients waiting over 100% of their target date have their notes reviewed by a doctor to determine the appropriate action.
- Clinicians triaged patients waiting beyond 25% of their target date.
- Urgent cataract procedures were undertaken on our behalf by Werndale Hospital.
- Patients waiting over 100% of their target date have their notes reviewed by a doctor to determine the appropriate action.
- Service provided 24 hours a day, via an on-call consultant rota for emergencies.
- Clinicians review and contact patients in advance of treatment, with patients requiring a negative COVID-19 result pre-operation.
- The intravitreal injection therapy service continued for all patients.
- We continue to work closely with Swansea Bay University Health Board to develop a regional response and solutions for the short/mid and long term.
- The age-related macular degeneration service has implemented a one-stop service which has increased the number of patients seen.
- Started developing phased plans to increase capacity in 2021/22, whilst adhering to national guidelines.

(Health and Care Standards: Safe Care; Effective Care; Timely Care and Staff and Resources)

Mental health services

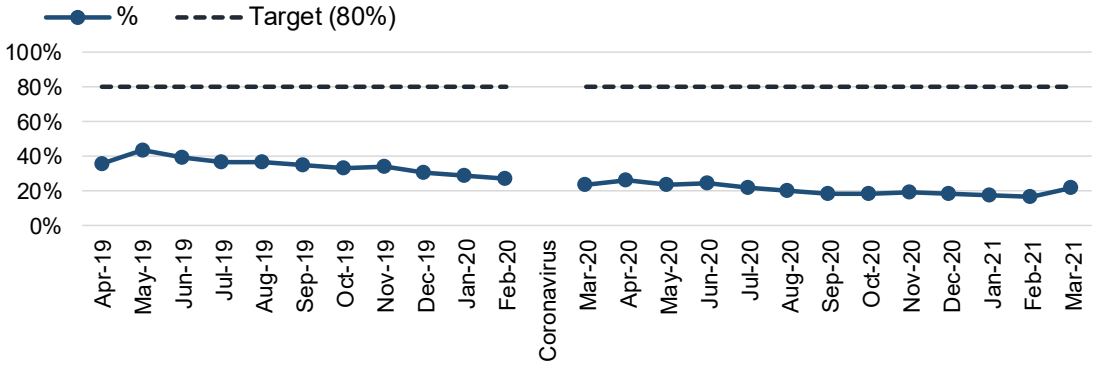
The national guidance for mental health services during the COVID-19 pandemic requires us to:

- Continue to provide Mental Health Act (the Act) assessments, both in and out of hospitals.
- Provide a range of mental health and learning disability inpatient care settings for both informal patients and patients detained under the Act. The care must include a range of medical, nursing and therapeutic interventions delivered by the multidisciplinary team in line with Matrics Cymru designed to promote recovery and ensure patient safety.
- Undertake mental health examination in emergency departments or other general hospital settings following self-harm or where mental health problems may be indicated.
- Provide the five functions of the Local Primary Mental Health Support Service assessment.
- Joint working across mental health and specialist eating disorders teams to deliver monitoring, support and treatment in community and home settings.

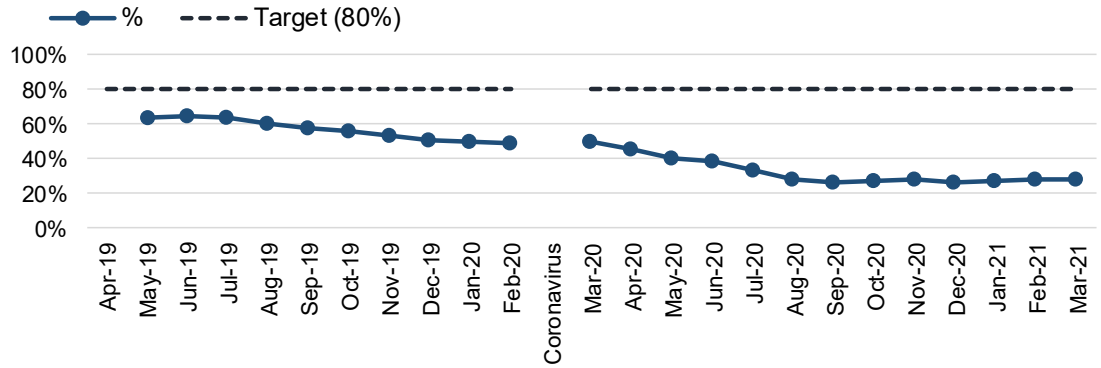
We failed to meet targets throughout 2020/21 for children and young people requiring a neurodevelopmental assessment and adults waiting for a psychological therapy.

Our Mental Health and Learning Disabilities services have been working with the local authority partners and the Third Sector to ensure that there is broad provision of services available at the point when they are required. This has meant that we have strengthened Tier 0 services so that our population can more readily get the help and support and safeguards the more specialist services so that they can also be available to people at the point of need. We have continued to invest in and strengthen our out of hours services and liaison services again to enable more timely mental health input. See sections below for a summary of the risks and issues which have impacted our performance and the actions we have taken and have planned to address.

Children/young adults waiting less than 26 weeks for a neurodevelopment assessment



Adults waiting less than 26 weeks to start a psychological therapy



Key issues and risks

The COVID-19 pandemic has impacted on our performance for the delivery of essential mental health services:

- After the first wave of the pandemic, we reported that, due to competing priorities, work to develop a Mental Health and Learning Disabilities Single Point of Contact had halted.
- We are expecting some of the social impacts of the pandemic to impact on people emotionally, presenting as anxiety or depression, or as practical unmet needs, rather than as mental health conditions which require diagnosis and treatment. We therefore expect that people will need more Tier 0 / Tier 1 type of support.
- We are working with the all-Wales network of COVID-19 Mental Health and Learning Disabilities Directors and Welsh Government leads to look at ways of strengthening the availability of Tier 0 services. There is a recognition that the pandemic will have a far-reaching impact on people's resilience and mental well-being both as a direct consequence of experiencing COVID-19 itself but also the knock-on impact of economic decline and associated austerity. We have also been working with local authority and third sector colleagues locally to strengthen Tier 0 provision. There is a recognition that these services must be robust so that secondary mental health services can be safeguarded to meet the potential increase in demand, due to the pandemic, in a way that allows those who require access to do so in a timely manner.
- Staff vacancies in our Specialist Child and Adolescent Mental Health Service.
- We continue to receive a large volume of Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals which require diagnostic assessments. The team numbers are small and require suitably trained staff; this means that service provision is highly sensitive to vacancies and absences.

Key actions taken to ensure continued delivery of essential mental health services

- A core principle of our vision was the development of 24/7 community services across the three counties. We began piloting the integration of Community Mental Health Teams to deliver a 24/7 drop-in service in Ceredigion, before the pandemic. During the pandemic, we built on this by co-locating and integrating our Crisis Resolution Home Treatment Teams and Community Mental Health Teams to provide 7-day mental health services. We also tested the development of a temporary Centralised 136 Assessment Unit.

- During the first wave of the pandemic, third sector-commissioned services adapted to offer telephone/online services on a three-county basis where possible. Throughout the pandemic work has continued to work closely with the third sector and referrals to those services are up by 20% during the pandemic. They also do a huge amount of work to continually update local directories of services.
- Work to develop the Single Point of Contact service recommenced and progressed at pace. We secured Welsh Government funding to pilot a Single Point of Contact for mental health services via 111. The pilot began in January 2021 and triages calls from people requiring mental health support at all levels of need, including calls from carers. The service also supports affected by the social impacts of the pandemic. Over time, we will build a multi-disciplinary team element to the 111 service, providing a 'one-stop shop' approach to people requiring mental health support. We are training primary care staff to take part in the pilot, so that locally staff will know how to signpost people to services.
- We worked with partners, including the third sector, to provide 'out of hours' sanctuaries and pilot hospitality bed provisions, providing places of safety for people in mental distress who are detained by the police under Section 136 of the Mental Health Act.
- The above developments have enabled an accelerated delivery of our strategy in line with the delivery of our Transforming Mental Health programme.
- Work is ongoing to scope options for filling our vacancies. We are exploring other types of roles to backfill areas of deficit – however, certain statutory duties may only be undertaken by medics, in line with the Mental Health Act and Mental Health Measure.
- To improve our ASD / ADHD assessment capacity we are undertaking a range of actions, such as:
  - working with the Delivery Unit on demand and capacity modelling.
  - developing a recruitment plan.
  - investigating the use of weekend clinics.

(Health and Care Standards: Staying Healthy; Timely Care and Staff and Resources)

Dignified care

Due to a reduction in non-urgent activity and lower than expected rates of hospital admissions due to COVID-19 in the first wave of the pandemic, we were able to maintain provision of dignified care to all our patients. During the busier second wave, which had a greater impact on our population and inpatient services, clinical areas ensured that dignified care and regular clinical review was maintained for patients. This included, where appropriate, end-of-life-care plans for COVID-19 patients.

Within primary care and community services, we also continued to treat patients with dignity and respect throughout the pandemic.

We continue to work in partnership, including with local authorities and third sector, to support those with sensory loss, in line with the All-Wales Standards for Accessible Communication and Information for People with Sensory Loss. We strive to ensure those patients who have sensory loss receive accessible services and information, with the provision of information in alternative formats and access to interpreters if needed. Staff have received training on sensory loss and are familiar with the ways in which they can support service users, including pre-arranging interpreters, using communication aids, and providing information in accessible formats.

We have a specialist resource in our Mental Capacity Team, which provides direct support to clinicians with implementing the Act. The team was suspended from visiting clinical areas during the first lockdown but maintained ‘virtual’ contact. A careful risk assessment has enabled their return to hospital wards to support the processes of assessing decision-making capacity and making best interest decisions, providing an important safeguard in respect of patient autonomy and patient-centred decision-making.

Like many health bodies in Wales, we are undertaking a review of hospital acquired COVID-19 infections to ensure that there is learning and improvements within the Health Board. The review methodology includes consideration of the findings of the mortality review undertaken, the clinical decisions made such as end of life care planning and the management of each outbreak. The learning will be presented on a thematic review basis by hospital site. We recognise that, given the numbers of cases, these individual and thematic reviews will take longer to complete and anticipates that the first thematic review report will be presented within six months from outbreak.
(Health and Care Standards: Dignified Care; and Staff and Resources)

Capacity constraints lessons learnt throughout the year

Putting Things Right

Our process for managing concerns is in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Detailed information about 'Putting Things Right: Raising your concerns about the NHS' is available here: http://www.wales.nhs.uk/sitesplus/862/page/40398

The aim of 'Putting Things Right' is to have a single and supportive process for people to raise concerns, and to provide an effective and timely response based on the principles of openness and honesty. Learning from concerns is an essential part of this process. Further information on what we have done in response to the feedback we have received and the outcomes of investigations into concerns is explained below.
(Health and Care Standards: All Standards)

Concerns (complaints)

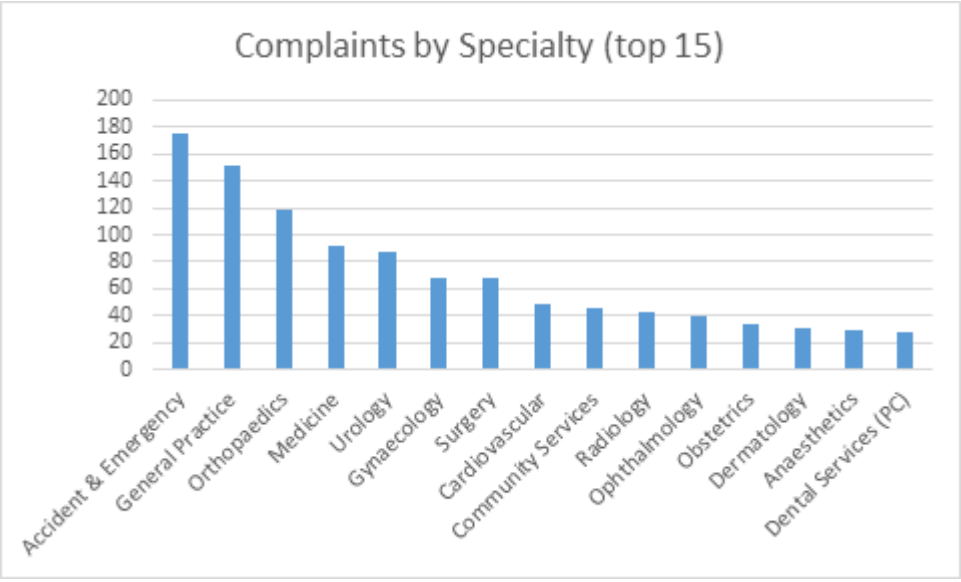
During the period 1 April 2020 to 31 March 2021, we received 2,318 concerns that were managed in accordance with the Putting Things Right process.

We are fully committed to resolving complaints within 30 working days.

When this is not possible (such as when complaints involve multiple agencies, or when a complaint is about a very serious event), our aim is to resolve complex matters within six months. Improving the timeliness and outcomes of the concerns process is a priority for us to ensure any remedial actions can be addressed as quickly as possible.

During the year, we responded to 65% of concerns received, within 30 working days and 89% within six months. Meanwhile, 23 of these concerns were referred to the NHS Redress Scheme.

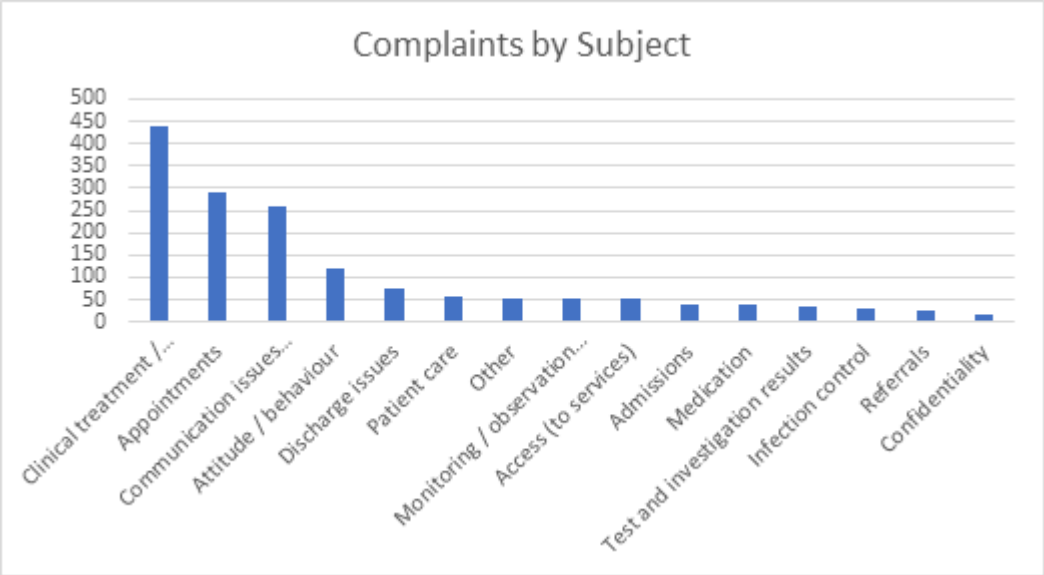
The number of complaints by specialty is set out below:



The specialties receiving the highest number of concerns, are our A&E departments, General Practice, and Orthopaedic services. These numbers must be taken in the context of the high volume of patient activity and contacts in these areas.

For General Practice, there are currently 48 practices (four of which are Health Board managed practices). The number above represents the total number of concerns received across general practice.

The reason for raising complaints, as shown in the table below, relates to waiting times, clinical treatment, communications, including concerns relating to the COVID-19 pandemic.



During the year, many non-urgent services have been suspended, for patient safety reasons in line with Welsh Government guidance relating to the COVID-19 pandemic. This has caused concern for many of our patients about waiting times and appointments. Communication was another cause for concern, particularly for families and loved ones who were unable to visit their relatives who were staying in our hospital wards. This was a challenging time for all concerned including our staff.

Public Services Ombudsman for Wales

There were 90 concerns raised with the Ombudsman during this year, which is a reduction in the number of complaints raised from the previous year. The number of concerns raised about complaints handling has also reduced. There has been a small increase in the numbers of investigation reports that have been upheld/partly upheld. We ensure that immediate action is taken to address any findings made by the Ombudsman. All reports are reviewed by our Listening and Learning Sub-Committee, who also assure the Board that action has been taken and within the agreed timeframes.

Patient experience and learning from concerns

We are highly committed to improving the patient experience and learning from both positive experiences of care, concerns, and complaints.

Electronic methods of providing feedback, such as our friends and family test, the online patient survey and 'The Big Thank You', as well as printed cards and ward surveys enable people to share their feedback, swiftly and easily, and provide us with valuable information to support continuous improvement. The range of ways in which feedback can be provided will be improved during this coming year when we look forward to implementing a new electronic patient experience system.

Our Board receives details of the feedback received from service users at each Board meeting and is informed of what is being done to improve patient experience. You can access the patient experience reports, which include patient stories about a range of experiences here.

This year, we approved our Improving Experience Charter which sets out what our service users can expect when using our services. It sets out a number of pledges that we call 'always experiences'. We will be working hard to implement the Charter during 2021 and will be reporting on progress through our Improving Experience Board report.

Learning from feedback is an essential element to the management of concerns. Without feedback from our service users and our staff, the Health Board will not be able to continually improve services for patient safety.

The summary below shows some of the important feedback received and what we have done to make changes:

You Said	**We did**
There was a lack of communication with staff on wards and some people could not receive timely updates on the well-being of their relatives and loved ones. There was also limited opportunity to speak to patients, which was distressing for all.	A new role was introduced onto wards and in some community facilities to undertake family liaison. The purpose of the role was to help proactive communication to support patients connecting with their loved ones; virtual visiting via iPads, telephone calls or e-mails; supporting the patient experience on the ward; and help of collection and return of clothing/laundry. This service was received very positively by patients, relatives and staff and we are looking at how this role can be extended as part of the future workforce.
You were concerned about delays in receiving your out-patient appointment.	To try and maintain appointments during the pandemic, we provided virtual appointments via video-calling or by telephone. Very positive feedback was received about the service, which reduced patient's travelling and waiting times at the hospital. We will continue to provide some appointments in this way, but also appreciate that face to face appointments are also important.
You were concerned about your waiting time for a hospital procedure.	Regrettably, the COVID-19 pandemic will have significant effects on the waiting times and waiting lists across many of our specialties. This is also a great concern for us, and we are considering ways in which we can address this. Maintaining communication with patients and is the most important priority with people who are waiting on a list for treatment. We set up a

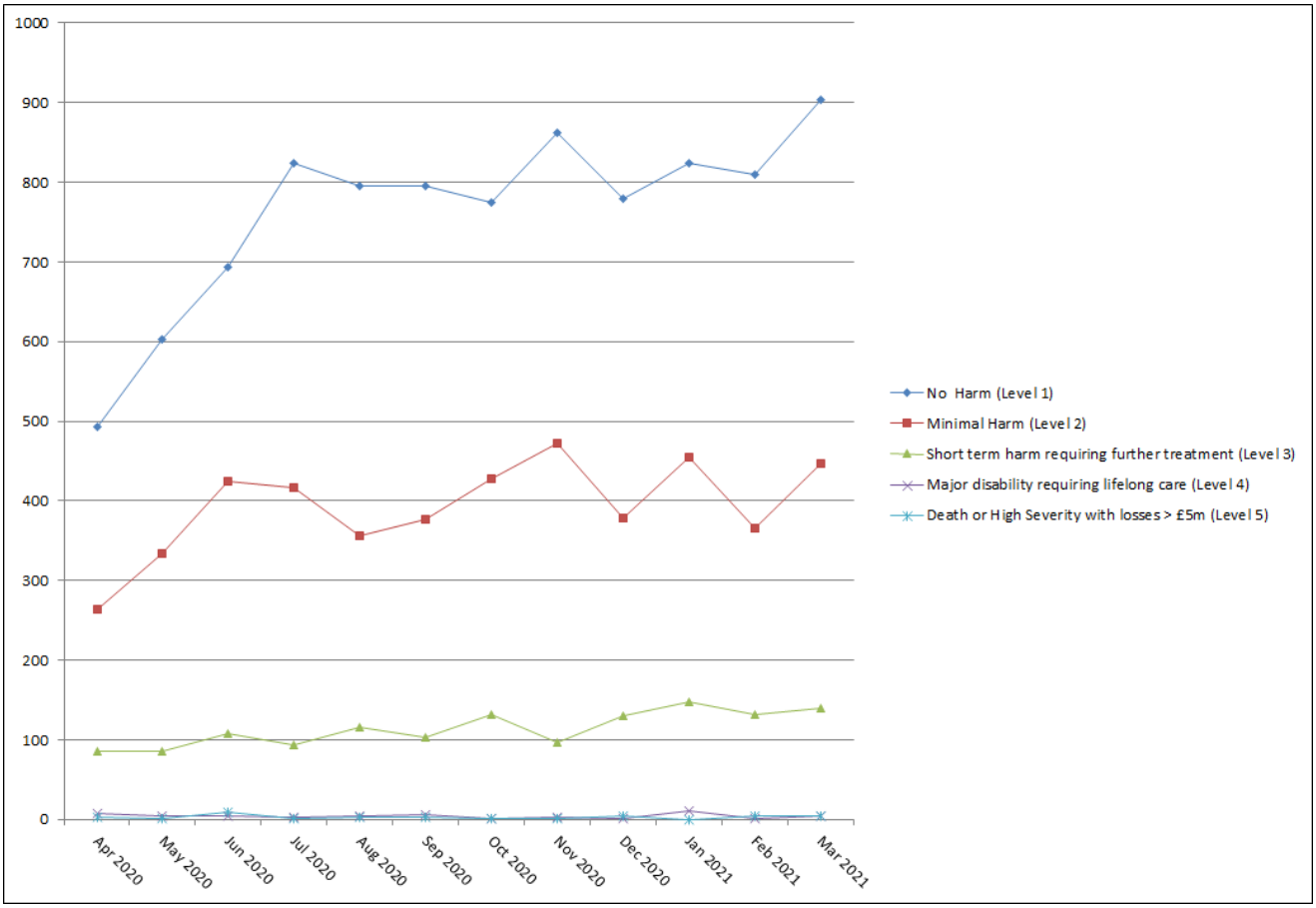
	single point of contact process during the year, starting with our orthopaedic patients. We will be extending this to other waiting lists as quickly as possible.
The wait for your medications in the discharge lounge was unacceptable for a modern service.	The pharmacy team has reviewed the process for this, ensuring that waiting times are minimised and there are no delays in accessing transport arrangements.
You experienced long waiting times at the A&E department, and there was poor communication about expected waiting times and access to food/drink.	We understand that at very busy periods in our emergency departments, that patients can wait longer than we would like and that when there is a lack of communication about expected wait times, this can cause additional distress and concern. There are vending machines available to ensure access to drinks and food. We have also been receiving support from organisations such as the Red Cross to provide additional support to patients during their time in the department. Other improvements we are currently working on include signage and announcements on waiting times, better support with food and drink arrangements and improved communication with family members. We will be ensuring that feedback from our patients is being reviewed regularly.

Incidents and investigations

In view of the pressures on the frontline teams, our Quality Assurance and Safety Team increased scrutiny on incidents reported, which were escalated / highlighted as required. All our reported incidents are now reviewed daily (Monday to Friday), whereas previously the focus had been on the more serious incidents. A weekly overview thematic report is also produced by the Quality Assurance and Safety Team for internal scrutiny and to inform our weekly Clinical Executives quality and safety meetings.

There were 15,333 incidents reported between 1 April 2020 and 31 March 2021, of which 13,134 were affecting patients. Of the 13,134 patient safety incidents, 5433 were deemed to have caused harm. The following severities were recorded:

No harm = 7,703
Low harm = 4,096
Moderate harm = 1,246
Severe harm = 52
Catastrophic harm = 37



The top 5 incidents reported for the year were:

- Pressure damage
- Patient accident/fall
- Medication error
- Behaviour
- Staff accidents/falls

During the year, we reported 72 serious incidents to Welsh Government and the NHS Wales Delivery Unit. During 2020/21, Welsh Government, in recognition of the impact of the COVID-19 pandemic, amended the guidance for reporting of serious incidents. Therefore, a comparison to previous years reporting cannot be made as to whether incident numbers have increased or decreased. Whilst there was a reduction in external reporting, the management of serious incidents within the Health Board did not change and all incidents have, or are undergoing, a proportionate investigation to identify any learning and improvement from the incident.

Patient safety

Despite the challenges posed by the COVID-19 pandemic, we have made substantial progress in work to improve consistency and standardised reporting for quality and safety. This includes the following development of processes and mechanisms to support directorates and county teams to ensure the delivery of safe, effective, and quality services, and to escalate and share learning:

- Review and analysis following a serious incident (or proportionate investigation where the impact is lower) for learning and improvement.
- Introduction of a Listening and Learning Sub-Committee to review and scrutinise serious incidents and investigation findings.
- Strengthened clinical leadership through the appointment of a Clinical Director for Clinical Effectiveness, Clinical Director for Clinical Audit and Clinical Leads for Quality Improvement.

While the requirement for the collection of clinical audit data has been suspended due to the pandemic, we have maintained as much participation as possible due to our commitment to the delivery of safe, effective, and quality services for patients (see the Annual Governance Statement for further information).

Many clinical audit projects continued and we have demonstrated some positive outcomes, including the National Hip Fracture Database (NHFD). The NHFD is a clinically led web-based audit of hip fracture care and secondary prevention in England, Wales, and Northern Ireland. The report published on 14 January 2021 uses a set of six NHFD key performance indicators (KPIs) to describe how the quality of patient care varies between hospitals and changes over time. These KPIs complement the range of data on assessment, operative care, rehabilitation, follow up and outcomes presented throughout the report. The recent report has reflected the improvements that have been embedded for patients admitted to hospital with hip and femoral fractures. Our hospital sites achieved 100% in several standards with Bronglais Hospital achieving fifth best (of 175 hospitals) in many categories. We delivered the best in Wales for patients returning to their original residence within 120 days, with Glangwili Hospital and Bronglais Hospital achieving top quartile results. Bronglais Hospital achieved the fifth lowest mortality for case mix, which has been identified as an incredible achievement as 30% of patients are American Society of Anaesthesiologists (ASA) grade 4/5, which is double the national average. This has received personal recognition from the National Audit Leads.

Throughout 2020/21, we have continued to work on ways to improve consistency and standardised reporting for quality and safety. Whilst some of this work has been challenging during the COVID-19 pandemic, there has been substantial progress.

We have developed processes and mechanism to support directorates and county teams to consider and ensure the delivery of safe, effective, and quality services and to escalate and share learning.

(Health and Care Standards: Safe Care; Effective Care and Timely Care)

Quality improvement

We embedded a Quality Improvement Framework within the organisation prior to COVID-19 pandemic. Staff in the quality and improvement team were re-deployed, bringing their expertise to support the frontline in the COVID-19 response both clinically and operationally. Whilst this paused some organisational-wide quality improvement work, it did not stop or pause all quality improvement.

For example, some team members were critical in the establishment of the Command Centre which has provided a fundamental part of our response and the improved ability for people to contact us and get the information they need.

Other team members were embedded in operational teams and have been able to support quality improvement during the pandemic and from within the teams themselves. For example, because of joint working on quality improvement, we now provide same day emergency care in our main hospitals. We call these SDEC or ambulatory emergency care units. They offer a way of providing care so certain patients who come to hospital can be quickly assessed, diagnosed, and treated without being admitted to a ward. They then go home the same day their care is provided. Currently around 115 people per week are seen through the units and 90% of people stay less than 4 hours. Plans are in place to increase the number of people being cared for in these units over the next few months. We are looking at how similar urgent care ways of working could help in our community based minor injury units and GP-out-of-hours service.

As we come out of the second phase of the pandemic we are now looking forward and working on a quality management system that will help us achieve our quality improvement goals by building our use of quality improvement in business strategy. This will help us to plan, know whether we are achieving our goals and outcomes, continuously improve and provide control and reassurance. We have also re-established our vehicle to support teams to progress quality improvement in their areas. The Enabling Quality Improvement in Practice scheme is now progressing through online, virtual support from specialists in QI and by providing a peer environment. New projects range from how we can avoid missed fractures to expansion of trials for withdrawing catheters for patients safely in hospital and potentially community environments.

(Health and Care Standards: All Standards)

Safeguarding

During the pandemic and the first lockdown, the corporate safeguarding team cancelled all safeguarding training, but quickly responded to the evolving situation and were the first service to innovate with the delivery of online training via Microsoft Teams. This has been highly successful in increasing compliance with adult safeguarding training particularly and feedback remains positive. This approach to training delivery enabled continuity of training during the second wave and will be continued in the future.

In December 2020, the Looked After Children Team recruited a Looked After Children Specialist Nurse specifically for our most vulnerable children in residential homes. This innovative new role was developed in line with the Provision for Local Authority and Private Residential Children's Home Guideline for Hywel Dda University Health Board (2017). The current team were unable to meet the recommendations in the guideline. The role is the first Looked After Children (LAC) post of its kind within Wales. The pandemic and lockdown brought challenges in how the nurse would engage with children and young people in residential care. Face-to-face contacts were halted to reduce the spread of infection and to protect the young people within residential care as well as the LAC Nurse. Despite this, contact was made with all the residential children's homes to establish new lines of communication with the children and young people through virtual (online) means.

It was recognised that the children and young people placed within the residential children's homes may require additional emotional support and a platform to discuss their thoughts and worries with the LAC nurse. Virtual clinics were set up and offered to all residential placements during lockdown. The clinics offered the children/young people in placement an opportunity to 'check in' and ask questions about their health or ask questions about their worries relating to coronavirus. Out of the 22 residential placements, four care homes indicated they wanted the virtual clinics for their young people, with seven children taking the opportunity to talk with the LAC nurse. Feedback from the managers in the residential homes following the virtual clinics was positive and children reported they enjoyed seeing 'a different face' and someone to talk to about their worries.

All Looked After Children Health assessments continue to be offered to children/young people via whichever remote platform they feel most comfortable with (Skype/Microsoft Teams/ telephone etc).

During the second wave of the pandemic members of the corporate safeguarding team were redeployed to clinical services to support the demand in operational services. The corporate safeguarding team business continuity plan was implemented, and the service maintained a single point of contact for partners and employees of the Health Board and continued to engage in multi-agency meetings.

We actively promoted making every contact count to identify people at risk of abuse and neglect during the pandemic and we progressed and led on the Regional Procedure for the Management of Injuries in Non-Mobile Children and the Procedure for Monitoring Vulnerable People who were not brought or did not attend appointments. We continue to participate in statutory multi-agency reviews to ensure that lessons continue to be learned to safeguard people at risk of abuse and neglect. This includes Child Practice Reviews, Adult Practice Reviews and Multi-Agency Practitioner Forums and Domestic Homicide Reviews.

(Health and Care Standards: Safe Care)

Nurse Staffing Levels

The Nurse Staffing Levels (Wales) Act (NSLWA) (Section 25B) currently requires that all adult medical and surgical wards calculate and take all reasonable steps to maintain nurse staffing levels that enable sensitive care to be provided to all patients.

Complying with these statutory requirements during the pandemic and, during the second wave, has been enormously challenging.

Calculated nurse staffing levels have needed to be reviewed on a frequent basis as wards have changed clinical specialty, patient acuity patterns, bed numbers and patient pathways as well as implementing new infection prevention measures as the Health Board responded to the pandemic.

Further challenges arose in keeping the agreed staffing levels with the pre-existing registered nurse vacancy position worsened by higher sickness levels and staff absence and supporting the staffing of added in-patient capacity.

In responding to our statutory responsibilities, systems were set up to regularly review and (re) calculate the nurse staffing levels required for each adult ward; and many steps, appropriate to each acute hospital site, were taken to ensure that all reasonable steps were taken to support nurse staffing levels.

Amongst many other steps, the deployment of registered nurses (and other clinical staff) from other services into these wards, the recruitment of more Health Care Support Workers and the availability of incentivised additional hours payments were key mitigation steps taken.

Despite these and the many other steps taken to maintain staffing levels, there were, nevertheless, periods when wards on each acute site worked at escalated nurse staffing positions during the winter months of 2021/22. Any patient safety risks that arose during these times were mitigated through intense and robust operational communications and hour by hour planning of the most effective deployment of staff on each acute hospital site.

In this way, the requirements within the Nurse Staffing Levels (Wales) Act can be shown to have been met, even in the most challenging of circumstances that have existed during 2021/22.

In addition to the specific requirements laid out in Section 25B of the Act, the Health Board also has a principal duty ‘to have regard to providing sufficient nurses to care for patients sensitively’ (in both its provided and commissioned services). The detailed evidence to show how this duty has been discharged across all the Board’s nursing services is laid out in the NSLWA Annual Assurance report presented to the Board in May 2021.

(Health and Care Standards: Staff and Resources)

Changes to visiting - impact and lessons learnt

The ‘NHS Wales Hospital Visiting during the Coronavirus Outbreak: Guidance and Supplementary Statement’ came into effect on 30 November 2020. It set out the baseline for visiting in Wales during the pandemic but acknowledges and recognises the need for health providers to depart from the guidance in certain incidences. This includes when there are rising levels of COVID-19 transmission in localities, such as levels which result in a national lockdown and/or evidence of nosocomial transmission in a particular setting. Conversely it also allows for health care providers to depart from guidance in the incidence of falling levels of transmission in their local area.

This has allowed us to make decision locally regarding hospital visiting, in collaboration with Public Health Wales, and enabled us to demonstrate compassion and allow for flexibility in visiting arrangements to respond to increasing or falling transmission.

We are constantly reviewing visiting arrangements to ensure that along with patient and staff safety we also promote patient's experience. Where face to face visiting cannot be facilitated, our nursing staff and family liaison officers have been able to support virtual (online) visits between patients and relatives.

(Health and Care Standards: Staying Healthy; and Safe Care)

Delivering in partnership

The role of the Stakeholder Reference Group (SRG)

The Stakeholder Reference Group (SRG) provides a forum for engagement and input amongst stakeholders from across the communities we serve. Its aim is to consider and reach a balanced stakeholder perspective to inform our decision making. The group has membership from a wide range of stakeholders who have an interest in, and whose own role and activities may be impacted by heath board decisions. Members include community partners, provide organisations, and special interest groups.

One meeting of Hywel Dda SRG took place during 2020/21, other meetings were deferred as part of the Health Board's response to dealing with the COVID-19 pandemic.

SRG members were provided with opportunities to discuss, comment, and make recommendations to the Health Board on the following listed areas of work. This has ensured active involvement and direction from stakeholders in these key areas of Health Board business.

- Transformation Programme
- Regional Winter Plans 2020/21
- Patient Experience Charter
- Strategic Discover Report – Applying the Initial Learning from our Pandemic Response to the Health and Care Strategy
- Stakeholder Management System and Engagement Tool
- Children and Young People Participation Standards

An example of SRG input in action involved an idea from the group when discussing the voice of children and young people around a children's rights charter, but from a regional perspective.

Following this, we have been exploring the idea with partners and whilst local authorities already have charters in place, we are now working with Dyfed Powys Police, the Office of Dyfed Powys Police Crime Commissioner and Mid and West Wales Fire and Rescue Service on a joint 'blue light' charter, supported by the Children's Commissioner.

SRG members also received presentations from the following groups and organisations for information and discussion:

- Strategic Partnerships, Diversity and Inclusion Team provided an overview of their work of working and supporting vulnerable groups and provided assurance that the Health Board are committed in developing an accessible and inclusive organisation, culture, and environment not only for patients but also for its employees.
- Welsh Ambulance Service Trust provided SRG Members with an overview of the pressures the service was experiencing. An update on WAST performance identified the significant amount of work undertaken on discharges and getting patients home safely, as well as preventing admission to hospital.

(Health and Care Standards: All Standards)

Supporting care homes, social care, and safe discharge

We have worked closely with social care and independent care home providers throughout the three counties during the last year. Our shared purpose has been to protect the health of residents and staff and to ensure people with COVID-19 are treated with dignity and respect and involved in decisions about their care.

A wide range of key workers from across the sector have worked together in exemplary ways. This has included hospital clinicians collaborating with GPs and community teams to care for residents in their home, or in hospital when needed.

Our Long-Term Care Team supported safe discharge from hospitals to care homes, representing 161 'discharge to assess' pathways between 18 March 2020 and 23 February 2021. The team also provided support in the prevention and management of out-breaks and with COVID-19 testing and results.

During the first wave (March 2020-September 2020), daily monitoring calls were made to nursing homes to find any concerns with PPE, staff or training, or end-of-life support. Since October 2020, this has been integrated into the weekly monitoring calls.

Regular statutory care reviews were kept throughout 2020/21, although these were via MS Teams as opposed to on-site.

Technology has also been used to keep contact between care homes and other healthcare professionals. A support group with senior leadership and guest speakers was formed for nursing home managers.

Throughout the pandemic we have continued to signpost care home staff to well-being and professional development / training resources.

The West Wales Care Partnership, under the direction of the statutory Regional Partnership Board, has ensured collaboration in support of our care homes through a regional care home action plan.

This was developed in the context of the rapid national report by Professor John Bolton. It addresses areas including infection prevention, sector stability and resilience, sustaining the workforce and pastoral or welfare support.

Learning from the first wave of the pandemic, which has been integrated into the action plan, included:

- The need for clear and consistent communication, which is now provided by regional partners to the sector.
- Formation of a Contingency Planning Group to ensure planning and systems and processes for possible provider failure.
- Development of a Regional Nursing and Residential Care Home Risk and Escalation Management Policy to mitigate risk of harm to residents, prevent avoidable deaths, ensure timely and appropriate support for recovery after an escalation, and minimise impact of potential care home failure on the wider health and social care system.

(Health and Care Standards: All Standards)

Safeguarding

Along with multi-agency partners of the Mid and West Wales Regional Safeguarding Board, we were concerned that children and adults at risk of abuse and neglect and victims of domestic abuse and sexual violence were not being seen during the pandemic and lockdowns. We have also witnessed an increase in self-harm in young people and an increase in Looked After Children during the pandemic.

As a member of the multi-agency Mid and West Wales Regional Safeguarding Board, we responded through COVID-19 response meetings, which took place fortnightly basis during the initial peak of the pandemic. The response group shared good practice and addressed the challenges faced in safeguarding people at risk of abuse and neglect.

The corporate safeguarding team took every opportunity to make staff aware that safeguarding remained a priority and to make very contact count and be alert to abuse and neglect.

We have seen an increase in child safeguarding reports known as Multi Agency Referral Forms (MARFs) to Local Authorities made by our own staff during the pandemic. During the latter three quarters of 2019-2020 the number of reports per quarter remained consistent. This trend continued during Quarter 1 2020-2021, however this period saw the commencement of the COVID-19 pandemic restrictions. Quarter 2 2020-2021 saw the review of the COVID-19 restrictions and subsequent removal of the lockdown, resulting in services returning and becoming accessible to children and families and the opportunities to disclose increasing. During this period, we saw a 58% increase in the number of MARFs submitted by Health Board employees. This provides assurance that our staff continued to discharge their statutory duty to report a child at risk of abuse or neglect.

Responding to a report about a child that is at risk of harm, abuse, or neglect, is the responsibility of social services at the relevant local authority, which gathers information to determine the action that should be followed. This may include working collaboratively with the police if the child is at immediate risk of significant harm and/or a criminal offence may have been committed.
(Health and Care Standards: Safe Care; and Staff and Resources)

Management of plans for excess deaths

The Local Resilience Forum (LRF) has supported the planning for an increase in deaths during the pandemic and has co-ordinated the development of additional facilities if they be needed to enhance the existing NHS facilities and Funeral Director/Crematoria sectors.

Additionally, the LRF has developed a COVID-19 Resources Sub-Group which facilitates requests for assistance from any of the partner agencies, be it additional staff, equipment, or premises.
(Health and Care Standards: Staff and Resources)

A Healthier Mid and West Wales: Our Future Generations Living Well

'A Healthier Mid and West Wales: Our Future Generations Living Well' is an ambitious programme of change. It is funded through the Welsh Government's Transformation Fund and delivered via the West Wales Care Partnership, under the direction of the Regional Partnership Board. Transitional funding of £6m has been awarded to support these programmes in 2021-22.

Three core programmes of work are funded, and their impact will inform decisions in the coming year on whether new models of care will be permanently established, through mainstream funding beyond March 2022.

CONNECT programme

The CONNECT programme is the first of its kind in Wales and is based on prevention and early intervention to support people to maintain their independence for longer. It uses personalised well-being assessments and plans to identify appropriate support for individuals to maintain physical and mental well-being, utilising pro-active well-being calls to help identify any potential health and well-being issues for people and any changes to their personal circumstances. Support packages offered through CONNECT include a range of technology enabled care (TEC), digital support to connect clients with their communities and families, and a 24/7 welfare response service for those clients who need it. Almost 2,500 people are already being supported by the scheme, which was particularly helpful during lockdown to people shielding. It is a key part of our work to reduce loneliness and isolation and improve digital inclusion.

Fast tracked, consistent integration

Fast access community teams are being established across our region to provide a range of different support to people in their own homes and prevent their condition or health from worsening, potentially resulting in admission to hospital. There is involvement from primary care colleagues across the three counties to agree delivery to meet specific local need. Common to all will be a re-focus on primary care to provide timely and effective emergency care. We intend to build on learning from the COVID-19 pandemic as we develop this programme.

Creating connections for all

This programme seeks to build community resilience and active citizenship across our area. There are several interconnected activities that have progressed this year:

- Time banking (through 'connect to' platforms) to match people who need specific help to those wanting to volunteer.
- Incentivising volunteering.
- Creating local action hubs in communities to stimulate voluntary activity.
- Promoting the 'connect to kindness' approach to celebrate acts of kindness in communities and encourage local people to reach out to each other and promote local action.
- A skills programme for paid staff and volunteers who support community development.

In addition, the Transformation Fund provides capacity for performance and evaluation and continuous engagement in support of the programme. It also supports the West Wales Research, Innovation, and Improvement Coordination Hub (RIICH). This is one of seven across Wales supporting the whole health and care sector in building an evidence-based approach to change and facilitating shared learning within and beyond the region.

(Health and Care Standards: All Standards)

Further details on 'A Healthier Mid and West Wales: Our Future Generations Living Well' can be found in the Annual Governance Statement.

Communications

A joint communication plan for COVID-19 response and recovery was established between the Health Board, and the three local authorities. Its aim was to support and deliver, as well as amplify or adapt at a local level, the Welsh Government Keep Wales Safe, and Test Trace Protect communication strategies.

A Regional Communications Group was set up between the agencies, and with representation from the police, and higher education providers, to enable a collaborative approach to informing and communicating with our communities in a consistent and engaging way.

This included targeted activities and communication about official guidance and advice, good hygiene measures, how to get a test, contact tracing and what it means, when to self-isolate, and information about local and national restrictions. In addition, this involved responding promptly to individual and multiple clusters, incidents, and outbreaks, in a co-ordinated and consistent way. We also planned for peak times in the year, such as the impact of tourism during the summer holidays and challenges such as the emergence of seasonal flu in the winter months.

The agencies continue to meet regularly in their joint response to this situation and working through the formal Dyfed Powys Local Resilience Forum (LRF). The LRF is a multi-agency partnership made up of representatives from public services including police, other emergency services, local authorities, the NHS, Natural Resources Wales, and others.

We responded swiftly to reports of scamming, liaising with our Local Resilience Forum members, particularly Dyfed Powys Police, and advising communities about misinformation and the need to seek information from official sources only.

(Health and Care Standards: Staying Healthy; Safe Care; Timely Care; and Staff and Resources)

Workforce management and well-being

Ensuring safe staffing levels

The pandemic demanded an urgent response from the Workforce and Organisation Development (WOD) function to mobilise our existing workforce and maximise new workforce availability. A mass recruitment campaign took place in March/April 2020 and in addition to this staff were deployed from non-essential services and departments to roles which were deemed to be vital for the Covid-19 response.

A Covid-19 Workforce Planning Group was established to regularly review capacity and demand modelling undertaken for COVID-19, non-COVID-19, and Planned Care requirements by our operational service teams. There were limiting factors - the 2-meter rule on social distancing; the need to maintain staffing levels within the Nurse Staffing Act (NSA) and the availability of additional Registered Nurses (RNs) to be able to safely staff surge areas.

Due to the nature of the imminent impact of the pandemic options were limited for increasing the registrant workforce, therefore, as an escalation measure “workforce stretch” was considered and an escalation plan was developed as last resort. This was alongside other measures including alternative support roles and a “team around the patient model” in acute and field hospital settings.

New ways of working and alternative workforce models were assessed for field hospitals, Test Trace Protect and latterly mass vaccination.

Actions focussed on additional mass recruitment campaigns during the summer and autumn to address predicted shortfalls in our workforce availability identified in our Quarter 3 and 4 service delivery plans. The availability of our temporary workforce capacity (additional hours, overtime, bank, and agency) was maximised via a range of proactive measures of engagement with staff, bank workers and agencies.

The extent of the recruitment exercises has been unprecedented in terms of numbers recruited; however, it positioned the Health Board well in terms of the support staff required to respond to the pandemic.

(Health and Care Standards: Staff and Resources)

Identifying and training staff to undertake new roles

Staff were deployed from non-essential services and departments to roles which were deemed to be vital for the Covid-19 response.

Initially a Deployment Centre was established. This enabled requests for additional staff and new roles to be processed. It also supported change whereby existing staff whose skill sets could support these requests, could be deployed to meet these priorities. This deployment process also enabled those staff who were shielding or who had other underlying health issues to be able to deliver care for our patients through different working arrangements.

A registered nurse redeployment programme was developed to support nurses to go back into clinical practice from corporate or non-clinical roles when there was a need. A 3.5-day condensed training programme was developed by specialist practitioners, supported with background reading and the opportunity to undertake further e-learning modules. Facilities staff were trained in 'dual roles' to work in the field hospitals. In addition to the clinical training, the introduction of the Family Liaison Office (FLO) role allowed our patients contact with their loved ones. A comprehensive two-day training programme was developed, centred around our values, patient experience and communication.

(Health and Care Standards: Staff and Resources)

Training and use of retired staff

A number of registrants who had previously retired or allowed their professional registration to lapse for other reasons and left the NHS in recent years were asked to re-register and help the health service to tackle the increase in demand associated with COVID-19. All those who were considered as potentially being able to support were contacted by the workforce team to discuss individual circumstances and areas where they may be able to help. A number of offers of employment were made with many returning to support the immunisation programme. All those offered employment completed mandatory training as well as training specific to the role being fulfilled.

(Health and Care Standards: Staff and Resources)

Well-being initiatives for staff

The *Well-being initiatives for staff Welsh Health Circular* set out the expectation for all NHS Health Boards and trusts in Wales to support the health and well-being of their workforce by facilitating access to the coherent and coordinated package of support which has been made available. This includes support to complete the COVID-19 Workforce Risk Assessment Tool, promoting access to the free multi-layered well-being support offer and ensuring access to the Covid-19 Life Assurance Scheme for eligible beneficiaries of frontline staff should they die in service because of being affected by COVID-19. We are confident that it meets the expectations set out in the circular.

The Staff Psychological Well-being service continues to deliver existing services addressing team well-being, supporting managers and staff, and providing one to one psychological support. Investment was made in our in-house counselling provision with an expansion of the team from October 2020 onwards. We also continued our Employee Assistance Programme, which is a 24/7 bilingual counselling service, delivered through Care First. We are contributing to the evidence base for well-being at work through participation in appropriate research studies in collaboration with neighbouring universities. Arrangements are in hand to continue to develop a responsive framework for building organisational and individual resilience including:

- A peer support and psychoeducational model for preventing and managing stress and psychological trauma.
- A programme for Psychological Flexibility (ACT in the Workplace) for individuals, teams, and input into leadership development.
- Nature-based well-being programme for staff at risk of burnout or on sick leave due to stress.
- Regular listening spaces for staff from various sites and professions to come together to share experiences and gain peer support.

Managers were routinely encouraged to ensure risk assessments were undertaken for all staff, including those shielding. Those staff members who were deemed to be high risk or who were immunocompromised were either encouraged to work from home or deployed to alternative roles.

During 2021, our Chair also set-up a group of experts, including the military and partners from the third sector, to advise on how best we support the rest and recovery of staff coming out of the pandemic. To rebuild stronger, we need a solid foundation, and this is achieved by supporting and ensuring the welfare of our staff who deliver or enable the care we provide.

This will be informed by a second 'discover' project to understand more about the experience of staff during the pandemic and how this can support their res, recovery, and recuperation in the years to come.

No COVID-19-related staff deaths were recorded.

(Health and Care Standards: Staying Healthy; and Staff and Resources)

Role of Employee/Professional Advisory Groups

A key commitment from the workforce and organisational development team was to continue to work in close partnership with staff-side partners (trade unions) during these challenging times. This has been built on existing relationships. During the pandemic, the Director of Workforce and Organisational Development has met twice weekly with the staff-side chairs from each county and with online meetings of the Partnership Forum. Frequently asked questions are regularly updated, and mechanisms are in pace to address staff concerns and deal with queries as they arise. This included the availability of workforce and organisational development specialty response to staff enquiries received through the Command Centre.

The specific risks faced by our Black, Asian and Minority Ethnic staff was raised by Welsh Government in early May 2019, following growing evidence of a potential for heightened vulnerability for this category of staff. Our preparation for COVID-19 included undertaking risk assessments in March 2019 for all staff defined as being potentially vulnerable based on health status and age which resulted in redeployment away from red areas and in some cases working from home/shielding. An additional risk assessment was introduced later to ensure our Black, Asian and Minority Ethnic staff deemed to be at extreme risk could be redeployed. The Chair of the Health Board also conducted a listening exercise with key members of these groups. A formal Black, Asian and Minority Ethnic Advisory Group to the Board has been formed as a result. Terms of reference for this group include advising the Health Board on mainstreaming equality, diversity, and inclusion and to provide a forum to discuss, influence and advise on issues affecting staff with key decision makers. The two Vice Chairs of the Black, Asian and Minority Ethnic Board Advisory Group also alternate attending at each Public Board meeting.

(Health and Care Standards: Staff and Resources)

Speak Up Safely

Through leadership from our Health Board Chair and the Director of Nursing and Quality Improvement, we have strengthened support for staff to raise concerns through introduction of Speak Up Safely, Champions, who are passionate about living our values and improving the culture of openness and are providing staff with a good listening to discuss their concerns. The Champion will either guide the member of staff as to the most appropriate route for resolution of the concern, such as where there is an overlap with a workforce policy; or escalate the concern to an ambassador. The Speak Up Safely Ambassadors are a group of senior staff who, like the Champions, believe that an open culture is important in the organisation and who believe that those members of staff raising concerns should not fear retribution for bringing an issue to the attention of the senior team. We currently have five Ambassadors, while 16 members of staff have confirmed that they would like to be Champions and will be receiving training for the role.

Each concern raised under within the Health Board under all Wales Raising (staff) Concerns Procedure is reviewed by the Speak Up Safely Ambassadors. An Ambassador is allocated to each concern and the Ambassador will link with the person raising the concern to ensure they are supported and are kept up to date with the action being taken to investigate the issue they have raised.

This is a new scheme to strengthen the organisational arrangements for implementation of the All-Wales Raising (staff) Concerns Procedure, and we look forward to reporting progress in the next annual report.
(Health and Care Standards: Safe Care; and Staff and Resources)

Decision making and governance

(Health and Care Standards: Governance, Leadership and Accountability)

Our Board and Committees

The Board is accountable for governance, risk management and internal control. 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 is comprised of individuals from a range of backgrounds, discipline, and areas of expertise, and provides leadership and direction ensuring that sound governance arrangements are in place.

The Board has an established committee structure with each statutory committee chaired by an Independent Member of the Board or Associate Member (Finance). 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 Health Board's functions and its roles and responsibilities.

The diagram below shows the main committees of our Board:

Hywel Dda University Health Board	Audit and Risk Assurance Committee
	Charitable Funds Committee
	Finance Committee
	Health and Safety Assurance Committee
	Mental Health Legislation Assurance Committee
	People, Planning and Performance Assurance Committee
	Quality, Safety and Experience Assurance Committee
	Renumeration and Terms of Service Committee

Further details can be found in the Annual Governance Statement, including our full committee structure, the arrangements in place during 2020/21 and some of the challenges and risks we have encountered.

Governance changes to mitigate the pandemic

In 2020/21, Hywel Dda University Health Board and the NHS in Wales faced unprecedented and increasing pressure in planning and providing services to meet the needs of those who are affected by COVID-19, whilst also planning to resume other activity where this has been impacted and to revise the way the governance and operational framework is discharged. In April 2020, we implemented revised governance arrangements to enable agile decision-making, and effective scrutiny and leadership throughout the pandemic.

Further details can be found in the Annual Governance Statement.

Civil Contingencies and Emergency Planning

The scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to prepare and respond to the likely impact on the organisation and population. This has involved working in partnership on a multi-agency response as a key member of the Local Resilience Forum (LRF) Strategic Co-ordination Group. Further details can be found in the Annual Governance Statement.

Audit and Assurance

The purpose of the Audit and Risk Assurance Committee (ARAC) is to advise and assure the Board on whether effective arrangements are in place to support them in their decision taking and achievement of our objectives. The committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

ARAC continued to operate as normal during 2020/21 and the details of items considered can be found here: https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/audit-and-risk-assurance-committee-arac/.

Further details can be found in the Annual Governance Statement.

The well-being of our future generations

The Well-being of Future Generations (Wales) Act 2015 is multi-layered and requires individual organisation actions, as well as collaborative working with Public Services Boards (PSBs) and wider partners. The Act also sets out where change needs to happen within seven corporate functions of an organisation: corporate planning; workforce planning; performance management; financial planning; risk; assets, and procurement. These are the parts of the organisation that should be seeking to do things differently as they affect the rest of the organisation's services.

We refreshed our well-being objectives in November 2019 and recognised that we need to increase the scale and pace of our work to support de-carbonisation and biodiversity. Our well-being objectives are not confined to a single national outcome, and all align to more than one of the national goals:

1. Plan and deliver services to increase our contribution to low carbon.
2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS.
3. Promote the natural environment and capacity to adapt to climate change.
4. Improve population health through prevention and early intervention, supporting people to live happy and healthy lives.
5. Offer a diverse range of employment opportunities which support people to fulfil their potential.
6. Contribute to global well-being through developing international networks and sharing of expertise.
7. Plan and deliver services to enable people to participate in social and green solutions for health. Encouraging community participation through the medium of Welsh.
8. Transform our communities through collaboration with people, communities and partners.

During 2020/21 we have been working closely with our Executive Directors, linking our well-being objectives to the organisation's planning and strategic objectives and specific portfolios of work, including environment and climate change and the foundation economy.

In our Annual Quality Statement for 2019/2020 we committed to delivering an Organisational Development Programme to progress the skills needed to deliver high quality services (Health and Care Standards: Staff and Resources). The Apprenticeship Academy scheme is one way in which we have achieved this. The scheme has been expanded to include non-clinical roles and is a key example of work we are doing to support A Prosperous Wales, investing in local wealth building and contributing to our own well-being objective to offer a diverse range of employment opportunities which support people to reach their full potential.

A Decarbonisation Task Force has been established and it identified that we had made both carbon and financial savings from active water management initiatives on our sites. For the 11-month period from 1 April 2020 to 28 February 2021 this equated to 7.9 tonnes per carbon dioxide equivalent (TC02e) and £47,600 savings. These are additional to multiple solar photo voltaic panel programmes which are on-going and our feasibility and engineering studies to inform optimum solutions for electric vehicle charging facilities.

The Health Board is partnering with Milford Haven Energy Kingdom on a project to explore smart decarbonised local energy including solar, onshore wind, future offshore wind and biomass for decarbonised gas transition. Linked to this programme will be the trialling of a hydrogen car for use by our Community Nursing Team in Milford Haven. All are important contributions to a prosperous Wales, a resilient Wales, and a healthier Wales.

During the pandemic, the Procurement Department has worked in partnership with one of our key contracted suppliers, Castell Howell Foods. This has made a shift to increase the purchasing of locally and Welsh produced food. This demonstrates our commitment to the principles of the Foundational Economy and helping our valued local supply chain and local businesses. The Health Board has also worked with the Centre for Economic Strategies and our Public Service Boards on developing a progressive procurement approach to develop a local supply chain.

There is a wealth of evidence of how health can be improved by increasing our access to green and blue spaces and improving the quality of our natural environment. This year a vegetable garden was developed adjacent to Morlais Ward at Glangwili Hospital, Carmarthen. This is used by patients for therapeutic gardening and the produce is used for cooking sessions, thus improving the patient experience by creating more opportunities for patients to contribute to their own care (Health and Care Standards: Effective Care and Individual Care). Increasing biodiversity and caring for natural ecosystems are vital as we face the climate emergency. Our “magnificent meadows” project at Withybush Hospital, Haverfordwest, benefits patients, staff, visitors and the natural living world. The “magnificent meadow” encourages patients, staff and visitors to stay healthy by providing an outdoor space where the focus can be on the natural living world (Health and Care Standards: Staying Healthy).

Another success of the past 12-months has been the growth in community-led initiatives and the overwhelming outpouring of support from volunteers. We are committed to supporting resilience in communities and having a clear, present and very palpable crisis through the COVID-19 pandemic has brought individuals, neighbours and communities together.

Seventeen Health Board volunteers were recruited and trained to support 28 families identified by the Paediatric Palliative Care Service who, due to shielding requirements needed help in obtaining basic daily necessities and thus ensure that arrangements were in place to provide support as locally as possible (Health and Care Standards: Effective Care). This led to increased links with local food banks and the development of information for staff to raise awareness of how to connect families to community support services.

In 2020/21 we also established international links on two major IT related projects that are focused on improving patient pathways:

- We are looking into adopting HealthPathways, which is an IT platform for the storage, management and distribution of clinical pathways for use in primary care. It provides access to internationally developed pathways which have been created from the latest clinical guidance, which can then be locally tailored. It will provide relevant guidance to general practitioners on the management of conditions in the community and referral to specialist hospital services for additional investigation and support. It has the potential to improve consistency of referral patterns, avoid unnecessary referrals where patients can be managed in primary care, emphasise the need for prevention and self-management and free up resource to increase access to specialist care for those patients who need it.

- We are working with the New Zealand-based company, Lightfoot, to convert our data into a flow-based system-wide view. This will help us to create integrated pathways focused on patient needs that minimise waste and delay.

These are just a few examples of the work which the Health Board has undertaken.

In addition to this report, we also publish a specific Well-being Objectives Annual Report each year to demonstrate in more detail our progress towards meeting our well-being objectives. We use the “Teulu Jones” family to help us think about the impact and difference our actions can make to improve well-being in our population. Teulu Jones is a fictious family but based on the make-up of real people living in our communities. With seven distinct family members, we use them to test what changes and proposals for our health and care system could mean for families living in our area.

Further information about our Well-being Objectives and Annual Reports can be found on our website here: http://www.wales.nhs.uk/sitesplus/862/page/85517

Welsh language

Hywel Dda University Health Board wants to be the first Health Board in Wales where both English and Welsh are treated with equal status (Health and Care Standards: Dignified Care). In this way, we will not only comply with the Welsh Language Standards but embrace the spirit.

The Welsh Language Standards, effective from 30 May 2019, are a set of statutory requirements which clearly identify our responsibilities to provide excellent bilingual services. These can be accessed via the Welsh Language Services section on our website here: https://hduhb.nhs.wales/healthcare/services-and-teams/welsh-language-services/.

Even though our organisation is passionate and ambitious to achieve and go beyond our statutory duties, we recognise that delivery is not always consistent across our sites and teams. Culture needs to evolve for us to deliver a seamless bilingual service to people who use the NHS and care services, and this is a long-term endeavour. The Welsh language is one of the treasures of Wales. It is part of what defines us as both people and as a nation. The Health Board aims to deliver a bilingual healthcare service to the public and facilitate staff to use the Welsh language naturally within the workplace. We aim to be an exemplar in this area, leading by example by promoting and facilitating increased use of Welsh by our own workforce. Whether a fluent speaker, a speaker lacking in confidence who wishes to improve their skills, or a new speaker, the workplace provides opportunities to use, practise and learn Welsh.

A huge milestone towards this goal was achieved this year when we approved a new Bilingual Skills Policy. The policy is aimed at ensuring our organisation delivers a bilingual healthcare service to the public and support staff to use Welsh naturally within the workplace. It details how we will improve the quantity and quality of data held on our workforce system, strengthen the Welsh language skills of our workforce and provide practical support for managers.

We will report progress on this, and other key actions to achieve our ambitions and statutory obligations for the Welsh language in our Annual Welsh Language Report, which will be published on our website (https://hduhb.nhs.wales).

Language skills of staff

The language skills of staff, in accordance with Standard 116 and 117, are captured and recorded on the electronic staff management system (ESR). As at 31 March 2021, 92.7% of staff have recorded their Welsh language skills as follows:

Welsh skill level	Number of Employees	%
0 - No Skills / Dim Sgiliau	3,555	33.2%
1 - Entry/ Mynediad	2,536	23.7%
2 - Foundation / Sylfaen	973	9.1%
3 - Intermediate / Canolradd	821	7.7%
4 - Higher / Uwch	866	8.1%
5 - Proficiency / Hyfedredd	1,190	11.1%
Not yet recorded on ESR	778	7.3%
Grand Total	**10,719**	**100%**

Whilst the number of individuals not recorded on ESR has increased slightly from 2019/20, the reason for this is due to the rapid COVID-19 mass recruitment.

The number of new and vacant posts that were advertised during the year, recorded as per those where Welsh language skills were essential or desirable and the number where Welsh needs to be learnt or where Welsh was not necessary are reported below:

Number of Welsh Essential Posts	Number of Welsh Desirable Posts	Number where Welsh needs to be learnt	Number where Welsh not necessary	Total Number of Posts
30	2,351	6	125	2,512

Welsh language related complaints

No Welsh language service complaints were received during 2021/21. It is believed the COVID-19 pandemic is the main contributory factor for this. We did however receive our first investigation by the Welsh Language Commissioner within the year.

Following a previous complaint by a member of the public during 2019/20 - the complainant received an English-only appointment letter and questionnaire. This was a clear breach of Standard 5 and Standard 36 of the Standards and therefore the commissioner carried out an investigation under section 71 of the Welsh Language Measure.

The commissioner's resulting report included the following three enforcement actions - Hywel Dda University Health Board must:

- Conduct a review to check that appointment letters sent from other departments comply with Standard 5 and act upon the results of the review.
- Conduct a review to check that forms provided to the public by other departments comply with Standard 36 and act upon the results of the review.
- Provide sufficient written evidence to satisfy the Welsh Language Commissioner that it has carried out enforcement actions 1-2.

As a result, we have reviewed all letters and forms in most directorates within the organisation. Not all directorates' reviews are complete yet due to operational pressures from the COVID-19 pandemic. We are grateful to the Welsh Language Commissioner in granting an extension to the usual response period. We will act upon the results of the review and provide sufficient written evidence to satisfy the Welsh Language Commissioner that we are compliant or have an agreed pathway and schedule for full compliance.
(Health and Care Standards: Dignified Care; Individual Care; and Staff and Resources)

Conclusion and forward look

Hywel Dda Health Hub and Waiting List service

You read about the establishment of our COVID-19 Command Centre on page 14. This co-ordinated function, which has been welcomed by those who have used it, has demonstrated both need and benefit of a co-ordinated approach to dealing with enquiries.

To date, patients and staff contacting the Health Board have had multiple pathways to services and teams through different switchboards, call centres or individual directories, with varying levels of call response dependent on the call handler and administrative support available.

In the short-term the Command Centre will continue to support our Test Trace Protect strategy and COVID-19 response. But we outline in our Annual Plan for 2021/22 a key planning objective to build on the success of the centre and develop it further for the long term. Our ambition is to develop one single telephone and email point of contact for enquiries – the 'Hywel Dda Health Hub'. This would incorporate existing switchboard, service-based call-handling and appointment booking into a single function, supporting specialist teams.

Another important planning objective for us recognises the need to maintain personalised contact with the far greater number of people that we have waiting for planned care because of the pandemic. We have prepared for a pilot waiting list service for a cohort of orthopaedic patients, which is due to begin early in 2021/22. This service will keep patients regularly informed about their current expected wait; offer a single point of contact should they need us; provide advice on self-management options whilst waiting, as well as advice on what to do if their symptoms deteriorate; use clinical and patient measures of harm to inform their prioritisation on the waiting list; and offer alternative treatments if appropriate.

Whilst we are starting this as a pilot with one group of patients, the intention is to roll-out to all specialties in the future.

Improving Together

Working together to be the best we can be and striving to deliver and develop excellent services are two of our new strategic objectives. A significant piece of work to deliver on these objectives is the Improving Together framework, which we began to develop in 2020/21.

The framework aims to align the work of all our teams and staff members to our strategy and to support them with key improvement measures and tools to achieve their continuous improvement goals. This will deliver a quality management system and support staff and teams with targets, training, and other peer support and tools to aid delivery.

The approach will try to align each member of our staff towards a single purpose – as we saw in the battle against COVID-19 – but towards our long-term vision. We will test the approach with a small number of teams from April-June 2021

Duty of Candour

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (Putting Things Right (PTR) regulations), place a duty on responsible bodies providing NHS care to be open when harm may have occurred.

We operate a culture of being open, this involves explaining and apologising to patients or their families or carers when harm has or may have been caused as a direct result of an unexpected or unintended clinical incident. The being open process also extends to being open with colleagues and employers and to co-operate in any reviews or investigations that take place.

The following procedures are in place within the Health Board to support staff and managers to meet the duties, as set out above and are subject to regular review:

- Being Open/Duty of Candour Guidelines.
- Concerns management processes – for incidents/complaints and the NHS redress.
- Raising concerns (speaking up) policy for staff and the implementation of the Speaking up Safely process.
- Safeguarding procedures.

In July 2019, the Health and Social Care (Quality and Engagement) Wales Bill was introduced by Welsh Government. The Bill introduces significant changes to the function and duties of health bodies in Wales, placing quality at the heart of all that we do, and will also introduce a legal Duty of Candour. In preparation for the implementation of the Bill in 2023, we have been working to reinforce our culture of openness and address any barriers that may prevent disclosure. Other ways we have been working towards implementation include:

- Improving the Incident Reporting Culture to ensure that all incidents and near misses are reported by all professions; and that reporting is seen to be the norm rather than the exception, including near misses; and low-level harm incidents are seen to be as important for reporting and learning.
- Support for Staff – The support (both peer and managerial) process should allow the staff to come to terms with what has happened; allow them to feel safe in disclosing the process and facilitate their involvement in the investigation; Multi-Disciplinary Team (MDT) reviews and reflection will be encouraged to facilitate a team approach to learning and to avoid any potential feelings of ‘scapegoating’.
- Establishment of a ‘speaking up safely process’ to enable staff to discuss any concerns they have in a confidential environment and be supported in doing so.
- Support for staff involved in a complaint or investigation is recognised as a priority for the Health Board and the ‘Assist Me’ model is being introduced as part of the revised arrangements for the investigation of concerns and the duty of candour process.
- A revised training and education programme will support the process, particularly in induction, leadership and development programmes.
- Improved learning from events process, which will be strengthened by the establishment of the Listening and Learning from Events Group which will review all areas of significant learning, arising from all claims and complaints, clinical incidents, health and safety incidents, patient and staff experience, whistleblowing, and internal/external reviews involving quality of care and patient safety.

Listening to our communities

We will continue to ‘check in’ with our communities and open a conversation about the pandemic and what it has meant for you and your experience and access to health and care. We want to consider any new information you have that we need to consider when planning your health services for the future. We are particularly looking forward to talking to our communities and using their input to plan for our new hospital in the south of Hywel Dda area, as well as for the continued enhancement of community-based care and support.

In closing

The COVID-19 pandemic has had a major impact on all areas of our service, but as this report outlines, we have responded quickly and adapted. We have changed many aspects of how we work, including how we liaise with you our partners, such as local authorities, to keep people safe. Coronavirus is likely to remain with us during 2021/22, however we are confident that we have the processes and personnel in place to rise to any future challenges.

Hywel Dda University Health Board is committed to re-starting services for a post-pandemic world. This includes further building and developing the innovative ways of working to improve healthcare quality and the safety of patients and staff across the whole patient pathway; to help evidence the duties of quality and candour set out in the Health and Social Care (Quality and Engagement) (Wales) Act; and to deliver safe, sustainable, accessible and kind health and care as described in more details in our long-term health and care strategy, A Healthier Mid and West Wales: Our Future Generations Living Well

Looking ahead over the next year, we intend to commission detailed modelling work that will help us better predict the medium- and longer-term impact of the pandemic on our services. This will support our ability to plan for when and where staff will be deployed over the coming months and years. It will also help us prepare for the recovery of our services, particularly the planned care service.

Chapter 2

Accountability Report

CONTENTS

INTRODUCTION TO THE ACCOUNTABILITY REPORT

The Accountability Report is one of the 3 reports which form Hywel Dda University Health Board's (the Health Board) Annual Report and Accounts. The accountability section of the Annual Report is to meet key accountability requirements to the Welsh Government (WG). 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 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.

As not all requirements of the Companies Act apply to NHS bodies, the structure adopted is as described in the HM Treasury's Government Financial Reporting Manual (FReM) and set out in the 2020/21 Manual for Accounts for NHS Wales, issued by the WG.

The Accountability Report consists of 3 main parts. These are:

- The Corporate Governance Report**:** This report explains the composition and organisation of the Health Board and governance structures and how they support the achievement of the Health Board's objectives. The Corporate Governance Report itself is in three main parts; the Directors' Report, the Statement of Accounting Officer's Responsibilities and the Annual Governance Statement.

- The Remuneration and Staff Report**:** The Remuneration and Staff Report contains information about senior managers' remuneration. It will detail salaries and other payments, the Health Board's policy on senior managers' remuneration, and whether there were any exit payments or other significant awards to current or former senior managers. In addition, the Remuneration and Staff Report sets out the membership of the Health Board's Remuneration Committee, and staff information with regards to numbers, composition and sickness absence, together with expenditure on consultancy and off payroll expenditure.

- Parliamentary Accountability and Audit Report**:** The Parliamentary Accountability and Audit Report provides information on such matters as regularity of expenditure, fees and charges, and the audit certificate and report.

Hywel Dda University Health Board

PART A:

CORPORATE GOVERNANCE REPORT 2020/21

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Introduction

The Corporate Governance Report provides an overview of the governance arrangements and structures that were in place across Hywel Dda University Health Board during 2020/21. It includes:

- The Directors' Report**:** This provides details of the Board and Executive Team who have authority or responsibility for directing and controlling the major activities of the Health Board during the year. Some of the information which would normally be shown here is provided in other parts of the Annual Report and Accounts and this is highlighted where applicable.

- The Statement of Accounting Officer's Responsibilities and Statement of Directors' Responsibilities**:** This requires the Accountable Officer, Chairman and Executive Director of Finance to confirm their responsibilities in preparing the financial statements and that the Annual Report and Accounts, as a whole, is fair, balanced and understandable.

- The Annual Governance Statement**:** This is the main document in the Corporate Governance Report. It explains the governance arrangements and structures within the Health Board and brings together how the organisation manages governance, risk and control.

Directors' Report

The Composition of the Board and Membership

Hywel Dda University Health Board (the Health Board) has 11 Independent Members (including Chair and Vice-Chair) who are appointed by the Minister for Health and Social Services, and 9 Executive Directors. All Independent Members and Executive Director Members have full voting rights. In addition, there are 4 Associate Members who have been appointed by the Health Board in accordance with Standing Orders and approved by the Minister for Health and Social Services. Associate Members have no voting rights. There is also 1 Director and the Board Secretary who form part of the Executive Team who have no voting rights.

Before an individual may be appointed as a Member or Associate Member they must meet the relevant eligibility requirements, set out in Schedule 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulation 2009, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the following link: https://law.gov.wales/publicservices/health-services/health-service-bodies/lhbs/?lang=en.

Further details in relation to the composition of the Board can be found in the Annual Governance Statement. This will include Board and Committee membership, including the Audit and Risk Assurance Committee, for 2020/21, the meetings attended during the year and the champion roles fulfilled by Board Members. In addition, short biographies of all Board Members can be found on the Health Board's website at: https://hduhb.nhs.wales/about-us/your-health-board/board-members/.

Register of Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis. A Register of Interests is available on the Health Board's website at: https://hduhb.nhs.wales/about-us/governance-arrangements/register-of-interests-gifts-sponsorship-and-hospitality/register-of-igsh-documents/register-of-members-interests-up-to-8-april-2021/, or a hard copy can be obtained from the Board Secretary on request.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed in the Annual Governance Statement.

Environmental, Social and Community Issues

These are outlined in the Annual Governance Statement.

Statement for Public Sector Information Holders

This is contained in the Parliamentary Accountability and Audit Report.

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 of 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.

I can confirm that:

- To the best of my knowledge and belief, 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.

- Hywel Dda University Health Board's 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 it 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.

Signed by: **Date: 10 June 2021**

Steve Moore
Chief Executive Officer

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 HM 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 HM Treasury;
- Make judgements and estimates which are responsible and prudent; and
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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 by:

On behalf of Chair:	…… Maria Battle	Date:	10th June 2021
Chief Executive:	…… Steve Moore	Date:	10th June 2021
Executive Director of Finance:	…… Huw Thomas	Date:	10th June 2021

Annual Governance Statement

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.

The Annual Report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services during a global pandemic. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided. Where necessary additional information is provided in the Annual Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Annual Governance Statement (AGS).

This AGS explains where the Health Board has deviated from normal operating procedures, and details the arrangements to manage and control the Health Board's resources in place during 2020/21 to discharge my responsibilities as the Chief Executive Officer. It will also detail the extent to which the organisation complies with its own governance arrangements, in place to ensure that it fulfils its overall purpose, which is that it is operating effectively and delivering quality and safe care to patients, through sound leadership, strong stewardship, clear accountability, robust scrutiny and challenge, ethical behaviours and adherence to the Health Board's values and behaviours. It will set out some of the challenges and risks the Health Board encountered and those it will continue to face going forward.

It has been just over a year since the first national lockdown in response to the COVID-19 pandemic. As a Health Board, we have faced unprecedented and increasing pressure to plan and deliver healthcare to its local communities, to meet the needs of those affected by COVID-19 and those requiring access to non-COVID related services. To do this, we have had to work very differently, both internally and with our staff, partners and stakeholders, and it has been necessary to revise the way the governance and operational framework is discharged. In recognition of this, Dr Andrew Goodall, Director General Health and Social Services/NHS Wales Chief Executive wrote to all NHS Chief Executives in Wales on 30 March 2020, with regard to "COVID19 Decision Making and Financial Guidance". The letter recognised that organisations would be likely to make potentially difficult decisions at pace and without a firm evidence base or the support of key individuals which under normal operating circumstances would be available.

Despite operating within a global pandemic, as public bodies, the Health Board must still demonstrate that its decision-making has been quality focussed, efficient, and able to stand the test of scrutiny with respect to compliance with Managing Welsh

Public Money, and be able to demonstrate Value for Money after the COVID-19 crisis has abated and the organisation returns to more normal operating conditions.

Whilst the pandemic has been extremely challenging, it has provided us with the opportunity to learn and become more agile and responsive in its decision-making and governance arrangements. Audit Wales (AW) recognised in their Structured Assessment 2020 how the Board has matured in how it adapted its governance arrangements to ensure public transparency, agile decision-making and effective scrutiny and leadership throughout the pandemic. Internal Audit (IA) also acknowledged that the Health Board's governance arrangements operated effectively during the peak of the pandemic and complied with the guidance and principles issued by WG.

Shorter, quarterly planning cycles in-year has enabled the organisation to be more fluid and responsive to incoming data and anticipated peaks in demand for critical care and bed capacity as a result of COVID-19 activity, whilst trying to maintain essential services, and understanding the impacts of scaled back services on delivery, quality and safety, finances and performance.

Targeted Intervention

The Health Board is held to account for its performance by the WG, who have established arrangements for escalation and intervention to support NHS bodies to address issues effectively and deliver the required improvement.

During 2020/21, in recognition of the our continued good performance prior to the pandemic and the professional and considered way in which the we responded to the extraordinary circumstances of the pandemic, WG reduced our escalation status from 'targeted intervention' to 'enhanced monitoring'. In order for us to move into 'routine monitoring', the Health Board needs to focus on future financial plans, which will be dependent on delivering the Health and Care Strategy and the capability and capacity of the organisation in terms of planning. The Health Board welcomed the reduction in escalation status which recognised the developing maturity of the organisation and reflected the efforts of the whole organisation both prior and during the pandemic.

The Governance Framework

The Model Standing Orders, Reservation and Delegation of Powers are issued by Welsh Ministers for the regulation of the Health Board's proceedings and business. These are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These were reviewed by the Board in January 2021.

These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of our

Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

As part of the response to the pandemic, in April 2020, we set out our approach to maintaining the appropriate level of Board oversight and scrutiny to discharge our responsibilities effectively, whilst recognising the reality of Executive focus and time constraints, in its 'Maintaining Good Governance COVID-19' report, which can be accessed via https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/board-agenda-bundle-16th-april-2020/#page=34. The Board reinforced that in a fast moving pandemic, governance arrangements must be strengthened, in order to receive assurance on key issues such as:

- service preparedness and the response to the pandemic;
- clinical leadership;
- engagement and ownership of developing plans;
- health and wellbeing of staff;
- proactive, meaningful and effective communication with staff at all levels; and
- health and care system preparedness.

The Board considered and agreed new ways of working which were continually reviewed and adapted during the pandemic, and approved a temporary variation from its Standing Orders and Reservation and Delegation of Powers. These are explained further in the Board Activity section.

As Accountable Officer, I ensured that these arrangements remained under constant review with the Chair and the support of the Board Secretary during the year, with reports on 'Maintaining Good Governance during COVID-19' presented to every Board Meeting in Public. These reports can be accessed in the Board papers via the following link: https://hduhb.nhs.wales/about-us/your-health-board/.

Part of these arrangements required the Board to approve temporary variations from the legal framework to which the Board operates within. The variations agreed by Board were as follows:

Variations to Standing Orders approved by Board on 16 April 2020		
Reference	**Heading/Sub Heading**	**Proposed Change**
Xxxii	Variation and amendment to Standing Orders	Changes to the standing orders will be agreed at Board first and communicated to Audit Committee (not the other way round)
2.1	Chair's action on urgent matters	In principle, the current Board scheme of delegation and specifically the matters the Board reserves for its own decision (Schedule 1 of the Standing Orders) will remain. In the event of a critical or urgent decision(s) needing to be made, we will use Chair's action. • Where possible the full Board will retain decision making;

		• If the full Board is not available or cannot be convened at speed, we will operate with a quorum as set out in our standing orders • Chair's Action will be used when an urgent decision is required and will be recorded and ratified by the Board.
3.3	Committees of the Board	1. Audit and Risk Assurance Committee continue to operate in a remote format with an agenda focussed on ensuring compliance, in particular with the Annual Accounts, Governance Statements and Annual Report 2. Quality, Safety and Experience Assurance Committee continue to operate in a remote format with an agenda focussed on ensuring compliance in particular with the Annual Quality Statement, patient experience and Putting Things Right. The Committee will also have an assurance role linked to COVID-19. The Committee will meet on a monthly basis. 3. People, Planning and Performance Assurance Committee suspended for the foreseeable future – performance information will be considered by the Board with the people elements reviewed in QSEAC. 4. Health and Safety Assurance Committee will continue to meet with a reduced remit and agenda. 5. Finance Committee will continue to meet with a reduced remit and agenda 6. The Mental Health Legislation Assurance Committee - guidance is being provided from WG in relation to this committee; 7. The Remuneration and Terms of Service Committee is suspended for the foreseeable future 8. Variation to People/HR Policy – Any variation of HR policy to be approved by the Executive Director, with oversight in place from CEO. Adaptions to be recorded and reported to Board for assurance. 9. Where appropriate, some HR/people decisions will come to full Board.
6.1	Putting citizens first	Variation – The Board is unlikely to meet in person for foreseeable future and so will meet through electronic/telephony means. As a

		result of this, members of the public will be unable to attend or observe. To facilitate as much transparency and openness as possible at this extraordinary time, the Health Board will undertake to: • Publish agendas as far in advance as possible – ideally 7 days *(See Board Activity Section)* • Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. The opportunity to increase the use of verbal reporting which will be captured in the meeting minutes • Draft Board minutes to be available within 1 week as well as an action log, a pending log will be kept of actions that will not be progressed during the pandemic • A clear link to our website pages and social media accounts signposting to further information will be published. • The website (which constitutes our official notice of Board meetings) and explain why the Board is not meeting in public will be amended.
6.2	Annual plan of Board business	Suspended for the foreseeable future
6.2.5 – 6.2.7	Annual General Meeting (AGM)	WG have confirmed that AGMs are required to be held by end of November 2020.
6.4.3	Notifying and equipping Board members	• Every attempt will be made to publish agendas 7 days in advance. • Every attempt will be made to publish papers at the same time • Provision will also be made for increased greater use of verbal reporting which will be captured in the meeting minutes.
6.5	Conducting Board meetings – Admission of the public, the press and other observers	Variation – The Board is unlikely to meet in person for foreseeable future and will therefore meet through electronic/telephony means (See Board Activity Section). As a result of this, members of the public will be unable to attend or observe. To facilitate as much transparency and openness as possible at this extraordinary time, the Health Board will undertake to:

		• Publish agendas as far in advance as possible – ideally 7 days • Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. There may be the need to increase our use of oral updates to reports based on more concise papers. Draft Board minutes to be available, within 1 week as well as an action log, a pending log will be kept of actions that will not be progressed during the crisis • A clear link to the website pages and social media accounts signposting to further information. • The website (which constitutes our official notice of Board meetings) and explain why the Board is not meeting in public will be amended.
6.5.8	Chairing Board meetings	In the absence of the Chair and Vice Chair, approve the Chair of the Planning, Performance and People Committee as the 3rd chair and the Chair of the Quality, Safety and Experience Assurance Committee as the 4th Chair.
6.5.11	Executive nominated deputies	The standing orders allow for a nominated deputy to represent an Executive Director, but not to have voting rights. The organisation currently has 9 substantive Executives with voting rights; in the event that none are available the Board would need to determine if the nominated deputies should have voting rights. We propose to make recommendations on this if the need occurs. In the absence of the CEO and Deputy CEO approve that the Executive Director of Workforce and OD act in either the CEO or Deputy CEO role dependent upon circumstance.

Variations to Standing Orders approved by Board on 30 July 2021		
Reference	**Heading/Sub Heading**	**Proposed Change (in italics)**
1.3.1	Tenure of Board Members	Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years*, with the exception of those appointed or re-appointed in accordance with Regulation 2 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or reappointment*. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.
1.3.2	Tenure of Board Members	Any Associate Member appointed by the Board will be for a period of up to one year. An Associate Member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than 4 years*, with the exception of those appointed or re-appointed in accordance with Regulation 2 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

The foregoing amendments will cease to have effect on 31 March 2021 or, where an appointment(s) has been made under the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020 or, to the tenure of a Chair or Vice-Chair of the Stakeholder Reference Group or Health Professionals' Forum, at the end of that term, whichever is the later.		
7.2.5	Annual General Meeting (AGM)	The LHB must hold an AGM in public no later than *30 November 2020* (replacing the previous 31 July each year).
Whilst the foregoing amendment will cease to have effect on 31 March 2021, the Health Board decided to retain its AGM date of 30th July 2020 as previously planned.		
1.4.6	Appointment and terms of office [Stakeholder Reference Group (SRG)]	The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional *term(s)*. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.
1.4.8	Appointment and terms of office [Stakeholder Reference Group (SRG)]	The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for additional *term(s)*, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.
1.5.3	Appointment and terms of office [Healthcare Professionals Forum (HPF)]	The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional *term(s)*. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.
1.5.5	Appointment and terms of office [Healthcare Professionals Forum (HPF)]	The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for additional *term(s)*, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.
The foregoing amendments (where reference to the additional term being limited to one year has been removed) will cease to have effect on 31 March 2021 or where an appointment(s) has been made in accordance with the amendment, at the end of that term, whichever is the later.		

The Board

The Board has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board provides leadership and direction to the organisation and is responsible for governance, scrutiny and public accountability, ensuring that its work is open and transparent. The Board functions as a corporate decision-making body.

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 is comprised of individuals from a range of backgrounds, discipline and areas of expertise, and provides leadership and direction ensuring that sound governance arrangements are in place.

The Board consists of 20 voting members (9 Executive Directors, 11 Independent Members). There are also 4 Associate Members that take part in Board Meetings in Public, however they do not hold any voting rights. The Board is supported by the Board Secretary, and the Director of Primary Care, Community and Long Term Care and, up to 4 September 2020, the Director of Partnerships and Corporate Services who also attend its meetings but do not have voting rights.

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. These posts were introduced to Local Health Boards and NHS Trusts in 2003 and are a mix of statutory and non-statutory roles, to be held at independent member, executive director level or both. During 2020, the WG undertook a detailed assessment of all the Champion roles in order to assess which areas should continue and issued WHC 2021/002 which sets out the Board Champion roles that need to be maintained. Appendix 3 of the Chair's Report to the March Board outlined the new list of Board Champions to be in place from 1 April 2021. The report can be accessed through the link - https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-march-2021/25th-march-2021-documents/item-2-3-report-of-the-chair/.

The table below sets out the composition of the Board in 2020/21 outlining the positions held, the area or expertise/ representation role, the Board and Committee membership and attendance, and the Champion roles.

Name	Position & Area of Representation Role	Board Committee Membership/ Attendance (see page 102 for more information on the role of the Committees)	Attendance at Meetings	Champion Role
Maria Battle	Chair	• Board (Chair) • RTSC (Chair)	8/8 6/6	• Unscheduled Care • Public & Patient Involvement
Judith Hardisty	Vice Chair (Mental Health Primary Care & Community Services)	• Board (Vice Chair) • ARAC • FC • HSAC (Chair) • MHLAC (Chair) • QSEAC	8/8 8/8 11/12 5/5 2/2 8/11	• Carers
Anna Lewis	Independent Member (Community)	• Board • CFC • PPPAC • QSEAC (Chair)	7/8 2/3 5/5 11/11	
Prof John Gammon	Independent Member (University)	• Board • PPPAC (Chair) • QSEAC • RTSC	8/8 5/5 10/11 6/6	
Owen Burt	Independent Member (Third Sector)	• Board • ARAC • CFC • HSAC • PPPAC (Vice-Chair) • SPF	8/8 8/8 3/3 5/5 5/5 1/1	• Design
Maynard Davies	Independent Member (Information Technology)	• Board • ARAC • FC • MHLAC • PPPAC	8/8 8/8 12/12 2/2 5/5	
Simon Hancock	Independent Member (Local Government)	• Board • ARAC • CFC (Chair) • HSAC • PPPAC	8/8 7/8 3/3 5/5 5/5	• Older People • Equalities & Diversity • Flu • Emergency Planning • Armed Forces & Veterans
Ann Murphy	Independent Member (Trade Union)	• Board • CFC • HSAC (Vice-Chair) • PPPAC • QSEAC	7/8 3/3 4/5 4/5 10/10**	

Delyth Raynsford	Independent Member (Community)	• Board • CFC (Vice-Chair) • HSAC • MHLAC (Vice-Chair) • QSEAC (Vice-Chair)	8/8 3/3 4/5 2/2 10/10**	• Welsh Language • Cleaning, Hygiene and Infection Management • Children, Young People & Maternity Services • Nutrition & Hydration • Putting things right
Mike Lewis	Independent Member (Finance)	• Board • ARAC (Vice-Chair) • CFC • HSAC • FC (Vice-Chair) • MHLAC	8/8 8/8 3/3 4/5 12/12 1/2	
Paul Newman	Independent Member (Community)	• Board • ARAC (Chair) • FC • MHLAC • QSEAC • RTSC	8/8 8/8 12/12 2/2 9/11 6/6	
Jonathan Griffiths	Associate Member	• Board	4/7	
Michael Hearty	Associate Member	• Board • FC (Chair)	8/8 12/12	
Hazel Lloyd-Lubran*	Associate Member from 10 October 2020	• Board • SRG (Chair)	3/3 1/1	
Mo Nazemi*	Associate Member from 1 April 2020	• Board • HPF (Chair)	2/4 5/5	
Steve Moore	Chief Executive Officer	• Board • RTSC	8/8 6/6	• Time to Change Wales Mental Health
Karen Miles	Executive Director of Planning, Performance & Commissioning to 11 October 2020	• Board • PPPAC	2/5 1/2	
Huw Thomas	Executive Director of Finance	• Board • ARAC • CFC	8/8 8/8 3/3	

		• FC • PPPAC	12/12 5/5	
Mandy Rayani	Executive Director of Nursing, Quality & Patient Experience	• Board • CFC • HSAC • QSEAC	8/8 3/3 5/5 11/11	• Violence & Aggression • Children's Act 2004 • Children & Young People's Services
Alison Shakeshaft	Executive Director of Therapies and Health Science	• Board • QSEAC	7/8 10/11	
Lisa Gostling	Executive Director of Workforce & Organisational Development	• Board • PPPAC • RTSC	8/8 5/5 6/6	
Ros Jervis	Executive Director of Public Health	• Board • PPPAC • QSEAC	7/8 3/5 10/11	• Emergency Planning
Phil Kloer	Executive Medical Director & Director of Clinical Strategy/ (Deputy Chief Executive)	• Board • QSEAC • HPF	8/8 11/11 4/5	• Patient Information • Caldicott Guardian
Andrew Carruthers	Executive Director of Operations	• Board • HSAC • MHLAC • PPPAC • QSEAC	7/8 4/5 2/2 4/5 9/10**	• Delayed Transfers of Care • Sustainable Development • Security Management • Fire Safety
Joanne Wilson	Board Secretary	• Board • ARAC • HSAC • PPPAC • QSEAC • RTSC	8/8 8/8 5/5 5/5 11/11 5/6	• Counter Fraud
Jill Paterson	Director of Primary Care, Community & Long Term Care	• Board • QSEAC	8/8 6/10**	

Sarah Jennings	Director of Partnerships & Corporate Services to 4 September 2020	• Board	4/4	• Public Patient Involvement

**Deputising arrangements were in place whilst the Health Board was awaiting Ministerial approval for the new Chairs for the Stakeholder Reference Group and Chair of Health Professionals Forum.*
***QSEAC had a reduced membership in April 2020 due to comply with social distancing requirements.*

Biographies, providing further information on Board Members, are published on the Health Board's website at https://hduhb.nhs.wales/about-us/your-health-board/board-members/.

On 23 March 2020, the WG suspended all Ministerial Public Appointment campaigns with immediate effect. At the time of this suspension, the Health Board was due to commence recruitment campaigns for the Independent Member (Local Authority and Finance) positions on the Board as the incumbent Members' tenures were due to end, however working with the Public Appointments Unit in WG, a request was made to the Minister for Health and Social Services to approve extensions to aforementioned tenures until the end of March 2021. The Board recommenced recruitment campaigns in September 2020 for these positions and commenced campaigns for the Independent Member (Community and Third Sector) positions, with all posts appointed to by 1 April 2021, with commencement in posts by 1 April 2021 and 1 May 2021 respectively.

There have also been changes to the composition of the Executive Team where membership has reduced from 12 to 11. In October 2020, the Executive Director of Planning, Performance and Commissioning, left the organisation, which led to a review of the position and portfolio. The Executive Director of Finance managed the portfolio in the interim and it was confirmed by the Remuneration and Terms of Service Committee (RTSC) that performance, commissioning and digital services would remain under the Executive Director of Finance on a permanent basis, with a new Executive Director of Strategic Development and Operational Planning post created. This post was taken up on 26 April 2021. The Director of Partnerships and Corporate Services, also left the Health Board in 2020, which led to the disestablishment of the post, with the portfolio being shared between the Executive Team.

Board and its Committees

In line with Section 2 of the Health Board's Standing Orders which provides that "The Board may and, where directed by the WG, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions", the Board has an established Committee structure with each Statutory Committee chaired by an Independent Member, with other Committees chaired by an Independent or Associate Member (Finance). 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 Health Board's functions and its roles and responsibilities.

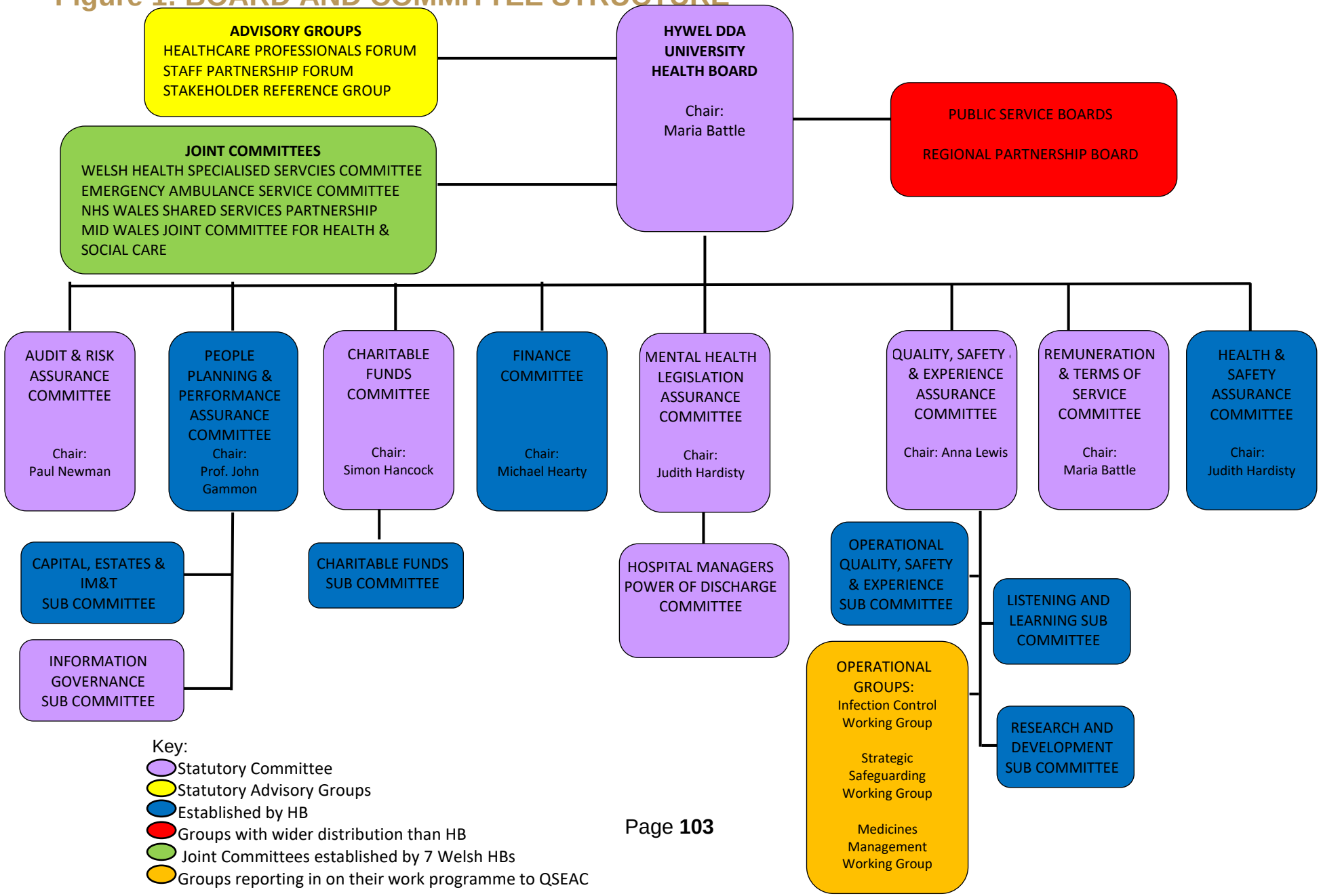
Prior to the pandemic, the Board agreed a new Board and Committee Structure which was to be implemented from April 2020, which reduced the number of Committees and core membership to make governance within the Health Board more enabling. This new streamlined governance structure, in Figure 1 (next page), was phased in during early 2020/21 and enabled us to be much more focused in our governance during the pandemic. In light of the learning through the pandemic, we will be reviewing and realigning our governance arrangements in May 2021, including building on the Command and Control Structure, and redesigning the role of the Executive Team to support to the implementation of the Annual Recovery Plan, and better alignment to the planning objectives to the Committees.

The Chair of each Committee reports to the Board on the Committees' activities outlining key risks and highlighting areas which need to be brought to the Board's attention in order 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. Further, in line with Standing Orders, each Committee has undertaken a self-assessment and produced an annual report, for 2020/21, setting out a helpful summary of its work. The Committee self-assessment was enhanced to ensure richer data was provided which will enable more meaningful development plans can be developed to strengthen Committees, and also facilitated themes to be identified across the Committees.

All Committees have undertaken a review of their Terms of Reference in 2020/21. Copies of Committee papers and minutes, a summary of each Committee's responsibilities and Terms of Reference are available on the Health Board's website: https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/. Each Committee will maintain a Table of Actions that is monitored at meetings.

Each of the main Committees of the Board is supported by an underpinning sub-committee structure reflecting the remit of its roles and responsibilities.

Figure 1: BOARD AND COMMITTEE STRUCTURE



The following table outlines dates of Board and Committee meetings held during 2020/21, with all meetings being quorate:

Committee	Board	Audit and& Risk Assurance Committee	Charitable Funds Committee	Finance Committee	Health & Safety Assurance Committee	Mental Health Legislation Assurance Committee	People, Planning & Performance Assurance Committee	Quality, Safety & Experience Assurance Committee	Remuneration & Terms of Service Committee
Month									
April 2020	16.04.20	21.04.20		28.04.20		06.04.20 (stood down*)	30.04.20 (stood down*)	07.04.20	07.04.20
May 2020	28.05.20	05.05.20 27.05.20		26.05.20	14.05.20			07.05.20 (Extraor dinary)	28.05.20
June 2020	23.06.20	23.06.20	16.06.20 (stood down*)	25.06.20	22.06.20	02.06.20 (stood down*)	30.06.20	09.06.20	
July 2020	30.07.20			24.07.20				07.07.20 (Extraor dinary)	
August 2020		25.08.20		26.08.20			27.08.20	13.08.20	
September 2020	24.09.20		15.09.20	29.09.20	07.09.20	01.09.20			18.09.20
October 2020		20.10.20		22.10.20			29.10.20	06.10.20	09.10.20
November 2020	26.11.20		30.11.20	30.11.20	02.11.20			13.11.20 (Extraor dinary)	24.11.20
December 2020		15.12.20		22.12.20		02.12.20 (stood down*)	17.12.20	01.12.20	
January 2021	28.01.21			26.01.21				14.01.21 (Extraor dinary)	
February 2021		23.02.21		25.02.21	17.02.21		25.02.21	02.02.21	04.02.21
March 2021	25.03.21		09.03.21	23.03.21		02.03.21		16.03.21 (Extraor dinary)	

**Agreed by Board to stand meeting down.*

Board Activity

It is acknowledged that in these unprecedented times, there are limitations on Boards and Committees being able to physically meet where this is not necessary and can be achieved by other means. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings and has not therefore been possible to allow the public to attend meetings of the board and committees from 20 March 2020. To ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:-

- Publish agendas as far in advance as possible – ideally 7 days (the Board acknowledge that this is a breach of Model Standing Orders which stipulates agendas should be published 10 days prior to meetings);
- Oral reporting which will be captured in the meeting minutes;
- Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. As detailed above there may be the need to increase the use of oral updates to reports based on more concise papers;
- Draft public Board minutes to be available within 1 week of the meeting;
- Provision for written questions to be taken from Board Members who are unable to attend at board meeting and response provided immediately following the meeting;
- A clear link to the Health Board's website pages and social media accounts signposting to further information will be published; and
- Amend the website (which constitutes the official notice of Board meetings) and explain why the Board is not meeting in public.

As the Board in April 2020 was not able to be held in public due to emergency measures for social distancing, a short recording was prepared, however the full May 2020 Board meeting was recorded and was made available the day following the meeting. The Board resumed live broadcasting of its Board Meetings in Public from 23 June 2020. The Board recognises that this is a variation to Standing Orders however in light of the public not being able to physically attend Board meetings due to social distancing, it has taken every step to ensure it remains as open and transparent as possible. Operating in a virtual environment has enabled all Board Members to fulfil their accountabilities. The public are also unable to physically or virtually attend its Committee meetings, which is a breach of its Standing Orders. This has been risk assessed, taking into account that all decisions are made by the Board, and Committee papers and minutes are made available on the Health Board website under the Statutory Committee section - https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/.

The Health Board also stood down Public Forums, where questions were submitted to the Chair by the public in advance of the Board Meeting.

There remains a clear patient and staff centred focus by the Board at the meetings, demonstrated by the presentation of patient and staff stories at each meeting through the Patient Experience Report.

Attendance is formally recorded within the minutes, detailing where apologies have been received and deputies have been nominated. The dates, agendas and minutes of all public meetings can be found on the Health Board's website: https://hduhb.nhs.wales/about-us/your-health-board/.

During 2020/21, the Board held:

- 8 meetings in public (all were quorate);
- 1 Annual General Meeting; and
- 4 seminar sessions (2 of these were used for Board Meetings in Public)

In response to the pandemic, the Board agreed in April 2020, minimum agenda items for Board meetings during the pandemic. These included the following:

- COVID-19 report – urgent issues;
- Advice, requirements and guidance from WG;
- Risks;
- COVID-19 - Planning for the next phase;
- Financial report;
- Performance report against revised WG guidance;
- Business as usual items requiring Board approval;
- Minutes of the previous meeting; and
- Post-meeting communications.

The Board has a programme of work which was adapted during the course of the year to respond to emerging events and circumstances. Regular items throughout the year to the Board included those listed above, as well as the following:

- Reports on 'Maintaining Good Governance during COVID-19';
- Reports on the financial performance and the related risks for discussion;
- Reports on improving patient experience, providing feedback and activity, for assurance;
- Corporate risk reports providing assurance on the management of risks, and any variances to agreed tolerance levels;
- Reports from the Chair and Chief Executive (including the Register of Sealings for endorsement and status reports on consultations) for discussion; and
- Assurance reports and endorsement of any matters arising from the In-Committee Board, Committees, Joint Committees, Advisory Groups and Statutory Partnerships of the Board.

The Board discussed and considered the following items during 2020/21:

ITEMS	Decision	Discussion	Assurance	Information
Delivering the here and now				
Health and Care Standards Fundamentals of Care Audit 2019				✓
Care Home Preparedness – COVID-19				✓
Financial Governance and Value for Money Considerations – COVID-19	✓			
The Nurse Staffing Levels (Wales) Act Annual Report 2019/20			✓	
Calculating and Maintaining the Nurse Staffing Levels during the COVID-19 Pandemic			✓	
Transformation Steering Group – The Strategic Discover Report – Applying the initial learning from our pandemic response to the Health and Care Strategy	✓			
Influenza Vaccination Plan 2020/21	✓			
Funded Nursing Care: Methodology to apply for 2021/22	✓			
Health Board's Well-being Objectives Annual Report 2019/20	✓			
Nurse Staffing Levels (Wales) Act: Annual Presentation of Nurse Staffing Levels			✓	
Pooled Funds for Adult Care Home Placements	✓			
Joint Committee on Vaccination and Immunisation/Chief Medical Officer Announcement to Defer Second Dose Pfizer Vaccine to up to 12 weeks	✓			
Children and Young People Health Services across Hywel Dda University Health Board			✓	
Procurement of Haematology and Coagulation Managed Service Agreement		✓		
Single Point of Contact Update			✓	
Draft Annual Recovery Plan 2021/22	✓			
Enhancement of Cleaning Standards within Hywel Dda University Health Board to meet recommended Standards and Principles as described by WG for all NHS Wales Organisations	✓			
Hywel Dda University Health Board Pharmaceutical Needs Assessment	✓			
Governance				
Management of Outstanding Recommendations from Auditors, Inspectorates and Regulators	✓			

Management of Operational and Corporate Risks during the COVID-19 Pandemic	✓			
Governance, Leadership and Accountability Standard	✓			
The Terms of Reference for: ○ Audit & Risk Assurance Committee ○ Charitable Funds Committee ○ Finance Committee ○ Health & Safety Assurance Committee ○ Mental Health Legislation Assurance Committee ○ People, Planning & Performance Assurance ○ Committee ○ Quality, Safety & Experience Assurance Committee	✓			
Establishment of a Black, Asian and Minority Ethnic (BAME) Board Advisory Group	✓			
Establishment of a Transformation Steering Group	✓			
Auditor General for Wales – Annual Audit Report 2020 and Structured Assessment 2020 report			✓	
Hywel Dda University Health Board's Escalation and Intervention Arrangements from Targeted Intervention to Enhanced Monitoring			✓	
Delivering our Strategy				
Developing the 3 Year Plan for the Period 2021/22 – 2023/24 – Strategic and Planning Objectives	✓			
Major Infrastructure - Programme Business Case (PBC)	✓			
Programme Business Case – Implementing the Healthier Mid and West Wales Strategy		✓		
Transformation Steering Group – The Strategic Discover Report – Applying the initial learning from our pandemic response to the Health and Care Strategy	✓			
Update from Transformation Steering Group			✓	
Assurance				
Committee Annual Reports	✓			
The Annual Quality Statement, Accountability Report, Annual Governance Statement, Annual Accounts, Letter of Representation and AW ISA 260 for submission to WG	✓			
Hywel Dda University Health Board Annual Report for 2019/20	✓			
Strategic Equality Plan Annual Report 2019/20	✓			
Annual review of Standing Orders and Standing Financial Instructions	✓			

NHS Blood and Transplant Organ Donation: Review of Actual and Potential Deceased Organ Donation 01/04/2019 – 29/02/2020		✓		
For information				
Healthcare Inspectorate Wales (HIW) Annual Report 2019/20 Presentation				✓
Hywel Dda Community Health Council (CHC) Annual Report 2019/20				✓
Ethics - National Principles				✓
Head of Internal Audit Annual Report and Opinion 2019/20				✓

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; and
- Being responsive to changing demands, including the prediction and management of risk.

Formal Board Development sessions were suspended during 2020/21 to allow the Board to focus on its response to the pandemic. These sessions were used for extraordinary Board Meetings in Public or for Board Seminars.

With the introduction of 4 Independent Members in the first quarter of 2021/22, the Health Board has restarted both its Board Development sessions and Executive Team Seminars from April 2021, and this has begun with the relaunch of the reverse mentoring programme.

Board Effectiveness

The Board is required to undertake an annual self-assessment of its effectiveness and was presented with the following sources of internal and external assurance and assessments to help it to evaluate its annual effectiveness:

- WG de-escalation of the our status from 'targeted intervention' to 'enhanced monitoring' (see Targeted Intervention section of the report);
- AW Structured Assessment (more information on this can be found in the AW Structured Assessment section of the report);
- Self-assessment against the Corporate Governance Code (see Corporate Governance Code of the report);
- Annual Self-assessment against the Governance, Leadership and Accountability (GLA) Standard (see GLA Standard section of the report);

- Feedback from the Board Committee self-assessment programme;
- Head of Internal Audit Opinion is provided 'Reasonable' assurance for 2020/21;
- IA Review of Governance Arrangements during the Covid-19 Pandemic;
- IA Report on the Health and Care Standards. More information on this can be found in the Health and Care Standards section of the report;
- Internal Audit of Quality Governance Arrangements;
- Internal Audit of Standards of Behaviour;
- Work to address the Health and Safety Executive Improvement Notices; and
- Work to address the Fire Enforcement Notices and the IA Report on the Management of Fire Enforcement Notices.

As we is in unprecedented times due to the current pandemic, the Chair and Chief Executive have agreed to make an assessment on the Board's maturity, using the evidence above, on the Board's behalf. This was shared with Board Members for information and reported to the Audit and Risk Assurance Committee (ARAC) in May 2021.

The following maturity level has been proposed, with suggested areas of improvement that will be taken forward when the Health Board begins to exit the pandemic:

> *Level 4 - The Health Board has well developed plans and processes and can demonstrate sustainable improvement throughout the service.*

The Health Board recognises that it has only just moved into level 4 and therefore work is needed to maintain this level and to progress towards a level 5.

Committee Activity

Throughout the year, the Board continually reviewed and approved a number of changes to Board Committees arrangements in response to operational pressures. Committee agendas were dominated by COVID-19 however continued to consider and scrutinise a range of reports and issues relevant to the matters delegated to them by the Board. Reports considered by the committees included a range of IA reports, AW reports and reports from other review and regulatory bodies, such as HIW. These reports provided information on the effectiveness of the framework of internal controls and risk management.

The Committees also considered and advised on areas of local and national strategic developments and new policy areas. Further information on the Health Board Committees is provided below, with the Committee papers, including minutes and table of actions, a summary of each Committee's responsibilities and Terms of Reference available on the Health Board's website: https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/.

Audit and Risk Assurance Committee (ARAC)

The purpose of the ARAC is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

A number of outcomes from the work of the Committee during the year have resulted in escalation of certain matters to the Board, and in these cases, the Committee has made recommendations and undertaken further actions in order to seek and provide assurance to Board that issues of concern have been addressed where possible, thus supporting the Health Board's governance and assurance systems. These have included:

- The Head of Internal Audit Annual Report and Opinion for the previous financial year 2019/20 provided a reasonable assurance rating. A detailed discussion was held on the capital and estates management domain, noting due to the number of limited assurance audits within this domain this could have received a limited domain rating. The Committee remained concerned regarding the number of limited assurance audits within this domain, noting this would be an area of focus within the 2020/21 plan. It is therefore pleasing to note the improvement in this area with 6 reports receiving a substantial or reasonable rating, and only 1 limited assurance rated report in 2020/21;
- The impact of COVID-19 on clinical audit and potential consequences in terms of quality and safety and patient safety. This has been continuously monitored by the Committee throughout the year with assurances provided at the 20 April 2021 meeting that clinical audit will be become more outcome focused moving forward;
- Findings of the IA report into control of contractors resulted in limited assurance in 2019/20 and highlighted in particular an over-reliance on the knowledge and experience of individual estates officers and the lack of a single unified system across the Health Board. This IA report was followed up as part of the Estates Assurance - Follow Up reported to ARAC in February 2021 and received a substantial assurance rating;
- Issues regarding the findings of the IA report into contracting led to limited assurance in 2019/20, particularly in respect of the need to strengthen various processes. The follow-up audit to ARAC in February 2021 provided an improved reasonable assurance rating, with the contract register now in place;
- Concerns around the assurance offered by the review of Personal Appraisal Development Review (PADR) process follow-up IA report which gained reasonable assurance, in view of the limited sample size of PADRs reviewed. It was agreed that the follow-up report and the original report would be shared with the Chair of People, Planning and Performance Assurance Committee (PPPAC), and that a discussion between the Chairs of ARAC and PPPAC

would be facilitated. PADR compliance is now a standard item on the Workforce and Organisational Development (OD) update report provided to every PPPAC meeting;

- Concerns around the findings of the Glangwili Hospital, Women and Children's Development Phase 2 IA report despite its reasonable assurance rating, with agreement that the matter referred to PPPAC for detailed discussion. This was followed up later in the year however delays in the scheme and escalating costs resulted in a limited assurance rating. A follow up IA report is scheduled to be presented to the Committee in May 2021 which will highlight any outstanding issues/concerns;
- A lack of assurance/progress on radiology issues raised in a previous IA report, with actions and timescales revisited and updates provided on shift pattern impact on posts for radiology students. The pace of delivery against the AW Radiology Review continued to be monitored during 2020/21, with a further update provided in February 2021 where ARAC noted that, despite extended timeframes, significant progress had been made to addressing the outstanding recommendations;
- A lack of assurance was reported on variable pay in pathology. Greater clarity was provided regarding the revised management response and ARAC was advised that the Executive Team agreed to pathology being included onto the new e-roster system 'Allocate'. The overall roll-out plan for Allocate runs over a 2 year period from April 2021, with nursing services already having been prioritised. In the interim of this future development, pathology internal manual processes related to contracted hours, pay enhancements and on-call and overtime payments have been bolstered;
- The delays in the resolution of Post Payment Verification (PPV) visit issues, the scheduling of revisits and escalation processes. It was agreed that the Executive Director of Finance would enter into discussions with NWSSP, and that the Director of Primary Care, Community and Long Term Care should attend ARAC for future PPV discussions. Further reports were provided in February 2021 by NWSSP and the Director of Primary Care, Community and Long Term Care providing a detailed assurance report on the process;
- The limited assurance rating was issued by IA in respect of the partnership governance arrangements and assurance framework of the Regional Partnership Board (RPB) however addressing the findings in the report requires commitment from other partners. It was agreed that the IA report would be presented to the Integrated Executive Group (IEG) to agree how the issues in the report can be taken forward. The Health Board is working jointly with the Head of Regional Collaboration, West Wales Care Partnership, to strengthen the governance arrangements, with the Head of Corporate and Partnership Governance leading on this work on behalf of the Health Board;
- Delays in improving medical record keeping, and the progress to improve medical record keeping, has been affected by the pandemic. Systems and processes have been strengthened however this will require time to embed. A further report presented at the October 2020 ARAC meeting provided increased confidence that the right mechanisms, leadership and reporting arrangements were in place to continue to address the issues raised. Medical record keeping will be reviewed as part of the 2021/22 Internal Audit Plan;

- The limited assurance rating issued by IA highlighted a lack of progress with respect to records management. Whilst work had commenced by the Health Records Modernisation Programme, the pandemic had impacted its implementation. This is a large scale, complex programme of work that cuts across the Health Board to address the current issues and modernise the processes and systems within the Health Board. Records management will be included on the 2021/22 Internal Audit Plan and will be developed into a planning objective within the Annual Recovery Plan 2021/22;
- Concerns were raised during discussion of the IA review of backlog maintenance. Whilst the IA report received a reasonable assurance rating, this reflected the manner in which the Health Board is managing the backlog, rather than the level or seriousness of the backlog. The report demonstrated the importance of the Major Infrastructure Programme Business Case (PBC) submitted to WG, the need for a strategic approach at scale, and emphasised the pace to address backlog maintenance issues. Ongoing scrutiny of plans will be monitored via PPPAC; and
- Continued concerns following consideration of the KPMG Review of Transformation Fund report regarding partnership governance arrangements. The Health Board is working jointly with the Head of Regional Collaboration (West Wales Care Partnership) to strengthen the governance arrangements, with the Head of Corporate & Partnership Governance leading on this work on behalf of the Health Board.

Other items identified by the Committee as requiring Board attention included:

- Support for the establishment of the Listening and Learning from Events Sub-Committee to ensure a greater focus on learning from these events, to avoid repetition and future claims. This Sub Committee is now in place and reports to the Quality, Safety & Experience Assurance Committee (QSEAC);
- The review of the adequacy of the Declaring, Registering and Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship arrangements currently in place and the proposed actions for 2020/21 to promote and improve the adequacy of these arrangements, which include follow up discussions with targeted staff members, increased staff communications to raise awareness and exploring ESR Project Support. The next annual review will be reported to the Committee in June 2021;
- The approval of all documentation relating to year end by the Board at its meeting on 23 June 2020;
- Closure of the 4 outstanding recommendations from the AW Structured Assessment 2018 and 2019, and closure of both reports, recognising that these areas would be looked at in future AW Structured Assessment reviews;
- The approval of the revised Health Board's Standing Orders (SOs) and Standing Financial Instructions (SFIs) at the Board meeting on 28 January 2021;
- The ratification of the Committee's Terms of Reference; and
- The recognition of the positive findings and the work undertaken as highlighted in the following reports;
    - Governance Arrangements during the COVID-19 (advisory/no rating);
    - IA Quality and Safety Governance report (reasonable assurance);

- Effectiveness of IT Deployment in Relation to COVID-19 report (substantial assurance);
- Agility to Flex Workforce to COVID Planning (substantial assurance);
- Mass Vaccination Programme (advisory/no rating); and
- Quality and Safety Governance (reasonable assurance).

An overview of the other Board Committees is provided below, with the key areas of focus in 2020/21 of these Committees provided in their Annual Reports which will be presented to the June 2021 Board meeting.

Charitable Funds Committee (CFC)

The CFC is charged with providing assurance to the Board in its role as corporate trustees of the charitable funds held and administered by the Health Board. 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. One meeting (June 2020) during 2020/21 was stood down.

Finance Committee (FC)

The FC provides scrutiny and oversight of the financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability), reviews (and reports to the Board) financial performance and any areas of financial concern, and conducts 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. It regularly reviews contracts with key delivery partners, and provides assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, provides early warning on potential performance issues and makes 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.

Whilst the FC continued to meet monthly during 2020/21, albeit with a more focused agenda and with 'In Attendance' membership reflecting only those required to attend to present the items identified on the agenda. From November 2020, a set agenda for the committee was agreed which included the following:

- In-Year Financial Performance –ongoing scrutiny and challenge of the financial position for 2019-20;
- In year Assurance on COVID-19 expenditure (including field hospitals);
- Financial Plan to March 2021; and
- Financial Strategy to 2027-28.

Fortnightly meetings also continue to take place between the Chair of the FC and the Executive Director of Finance, with Members requested to channel all assurance questions relating to the finance agenda through the Chair of the FC.

Health and Safety Assurance Committee (HSAC)

The HSAC was constituted from 1 April 2020 by the Board to provide assurance around the 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. It provides advice on compliance with all aspects of health and safety legislation, as well as advises and assures the Board on whether effective arrangements are in place to ensure organisational wide compliance of the Health Board's health and safety policy, approves and monitors delivery against the Health and Safety Priority Improvement Plan and ensures compliance with the relevant Standards for Health Services in Wales. Where appropriate, the HSAC advises the Board on where and how its health and safety management may be strengthened and developed further.

With regard to its role in providing advice to the Board, the HSAC comments specifically upon the adequacy of assurance arrangements and processes for the provision of an effective Health and Safety function.

The HSAC held its inaugural meeting on 14 May 2020, and has continued to meet bi-monthly during the year, with the exception of the December meeting which was stood down due to the progress made, and due to pressures resulting from a second wave of the pandemic. In March 2021, the Board recognised the improvements that have been in terms of health and safety compliance.

Mental Health Legislation Assurance Committee (MHLAC)

The MHLAC assures the Board that those functions of the Mental Health Act 1983, as amended, which have been delegated to officers and staff are being carried out correctly; and that the wider operation of the 1983 Act in relation to the Health Board's area is operating properly, the provisions of the Mental Health (Wales) Measure 2010 are implemented and exercised reasonably, fairly and lawfully, the Health Board's responsibilities as Hospital Managers is being discharged effectively and lawfully, and that the Health Board is compliant with the Mental Health Act Code of Practice for Wales. The MHLAC also advises the Board of any areas of concern in relation to compliance with mental health legislation and agrees issues to be escalated to the Board with recommendations for action.

During 2020/21, MHLAC met twice (in September 2020 and March 2021) with scheduled meetings for April and December 2020 stood down in response to the first and second waves of the pandemic, with the provision for any urgent mental health legislation issues to be considered by the Board.

Quality, Safety and Experience Assurance Committee (QSEAC)

The QSEAC 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 Health Board. It provides assurance to the Board in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people and improving the quality and safety of health care to meet the requirement and standards determined for the NHS in Wales.

The QSEAC continued to meet bi-monthly, however with a shorter agenda, reduced membership and tried to be paper light to consider COVID and non-COVID issues. A COVID-19 QSEAC was held in the alternate month to the normal bi-monthly meeting. The QSEAC had a critical role during the pandemic ensuring that the decisions and actions taken by the Health Board were quality and risk assessed, and in the best interest of the public and staff. Whilst PPPAC was stood down, assurance on the workforce element was incorporated into the work programme of QSEAC.

This was supplemented by a fortnightly meeting held between the Chair of QSEAC and the Executive Director of Nursing, Quality and Patient Experience, with Members requested to channel all assurance questions relating to this agenda through the Chair of the QSEAC with these being discussed in the meeting, followed by communications to all Board Members.

People Planning and Performance Assurance Committee (PPPAC)

The PPPAC was constituted from 1 April 2020 by the Board to provide assurance on compliance with legislation, guidance and best practice around the workforce and OD agenda, including the implementation of the Health Board's Workforce & OD strategy and enabling plan. Their role is also to ensure that the planning cycle is being taken forward and implemented in accordance with Health Board and WG requirements, guidance and timescales. PPPAC also ensures 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, and that wherever possible, Health Board plans are aligned with partnership plans developed with Local Authorities, Universities, Collaboratives, Alliances and other key partners.

In respect of its performance role, PPPAC supports the Board in its role of scrutinising performance and assurance on overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required, focuses in detail on specific issues where performance is showing deterioration or there are issues of concern. PPPAC also provides 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, reporting any areas of significant concern and recommending

acceptance of risks that cannot be brought within the Health Board's risk appetite/tolerance to the Board.

As PPPAC is not a statutory Committee, the Board agreed in April 2020 to temporarily stand the Committee down, to enable the organisation to focus on its response to the pandemic, with the following caveats:

- People – Workforce and Organisational Development performance scrutinised monthly through Board, COVID and non-related COVID workforce issues considered by Board, and quality and safety workforce issues appropriately considered by QSEAC monthly;
- Planning – COVID and non-COVID strategic planning scrutinised by Board; and
- Performance – scrutinised monthly by Board, with quality and safety issues delegated to QSEAC.

This was supplemented by a fortnightly meeting between the Chair of PPPAC and the Executive Director of Workforce and OD and the Executive Director of Planning until it held its first meeting on 30 June 2020, with Members requested to channel all assurance questions relating to the PPPAC agenda through the Chair of the Committee.

Advisory Groups

The Health Board has a statutory duty to "take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals". This is achieved in part by three Advisory Groups to the Board which are:

- The Stakeholder Reference Group (SRG);
- The Staff Partnership Forum (SPF); and
- The Healthcare Professionals' Forum (HPF)

In recognition of the disproportionate affect that COVID-19 has on the Black, Asian and minority ethnic (BAME) staff, the Chair established a BAME Advisory Group to advise the Health Board on how improvements can be made in areas, such as communication, recruitment and selection, welcoming and mentoring, prevention of bullying, a stronger voice, and a Charter.

Matters from the Advisory Groups that have been brought to the attention and dealt with by the Board have been outlined in Appendix 1.

Stakeholder Reference Group (SRG)

The SRG is formed from a range of partner organisations from across the Health Board's area and engages with and has involvement in the strategic direction, advises on service improvement proposals and provides feedback to the Board on the impact of its operations on the communities it serves. The SRG only met once during 2020/21. At its meeting in October 2020, SRG agreed its new Chair. Further information on the role of SRG can be found in the Delivering in Partnership section of the Performance Report.

The Staff Partnership Forum (SPF)

The SPF engages with staff organisations on key issues facing the Health Board. It provides the formal mechanism through which the Health Board 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. During 2020/21, the SPF have continued to meet bi-monthly, with any issues included in the workforce section of the COVID-19 report to Board. In addition, the Director of Workforce and Organisational Development and Trade Union representatives met weekly.

The Healthcare Professionals' Forum (HPF)

The HPF comprises of representatives from a range of clinical and healthcare professions within the Health Board 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 Health Board delivers its services. During 2020/21, the HPF continued to meet bi-monthly with the exception of May 2020.

Black, Asian and Minority Ethnic (BAME) Advisory Group

The BAME Advisory Group was established in July 2020 to advise the Health Board on mainstreaming equality, diversity and inclusion and provide a forum to empower and enable BAME staff to achieve their potential through creating positive change. The BAME Advisory Group two Vice-Chairs also alternate attending the Board.

Rest and Recovery Reference Group (RRRG)

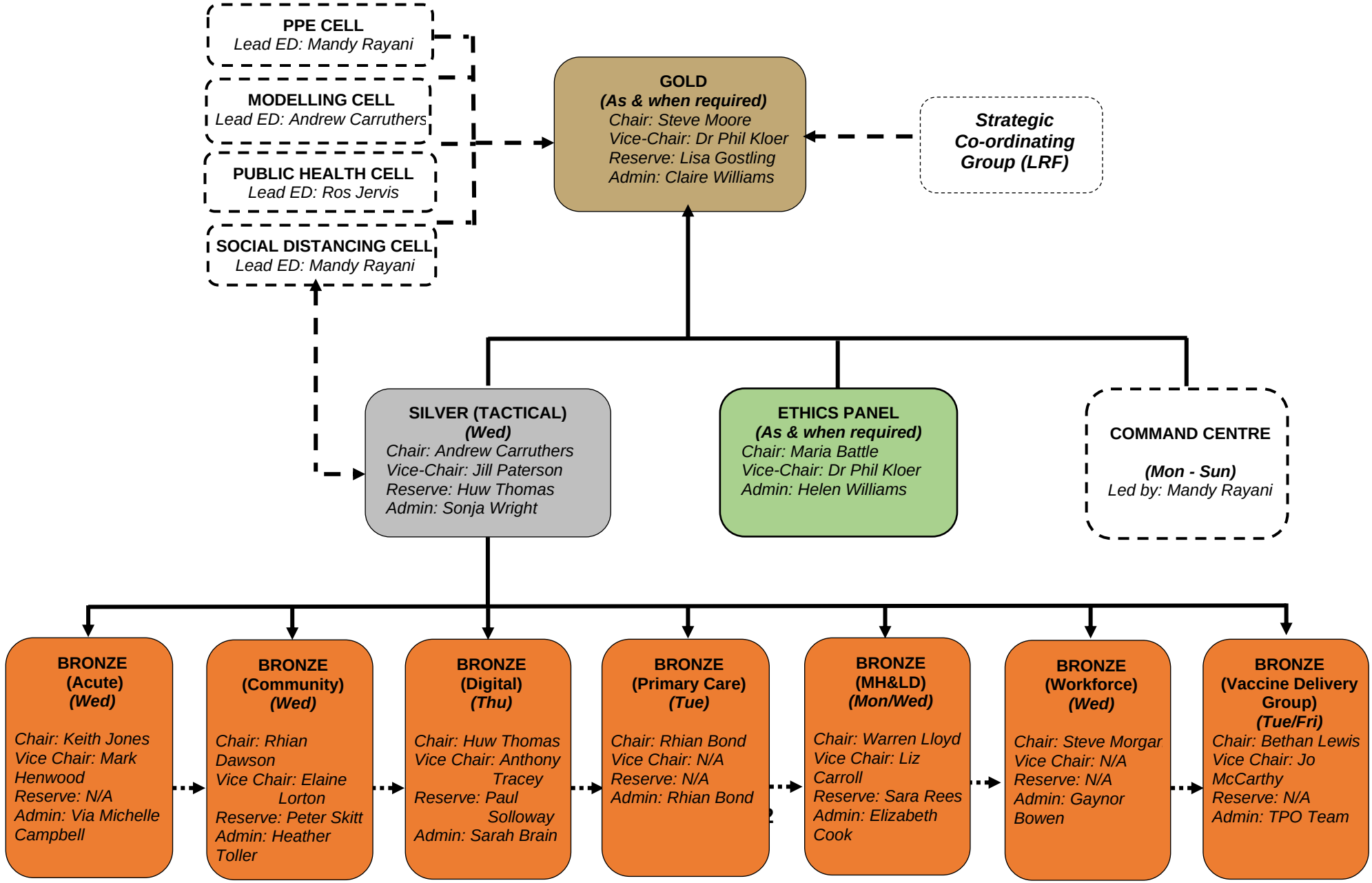
Following the second wave of the pandemic, in early 2021, the Chair established a RRRG with internal and external experts, including the military, and leads from the tourist industry, to advise on how the Health Board can best provide support to staff as it exits the pandemic, including ensuring that the right pathway referrals are in place should they need to access psychological therapies. This built on the staff wellbeing work which was supported by the Chair throughout the pandemic.

Command and Control Structure

To enable the Health Board to respond promptly to the developing pandemic, a Command and Control structure was established in March 2020. This enabled decisions on the clinical model to be made rapidly and worked within the Board approved Standing Orders and Standing Financial Instructions, with appropriate decisions referred to the Board for approval and/or ratification. The Command and Control structure evolved throughout 2020/21 in response to the pandemic. The latest version can be found in Figure 2, with previous versions available in the 'Maintaining Good Governance' reports presented to the Board throughout 2020/21. These are available by accessing individual agendas for each Board meeting, all of which are available via the following link https://hduhb.nhs.wales/about-us/your-health-board/.

With the current environment remaining uncertain in respect of the pandemic, the Command and Control Structure has continued through quarter 1 of 2021/22, however at its seminar in April 2021, the Board considered strengthening its governance arrangements to support the delivery of its strategic and planning objectives, which is likely to lead to a wholesale review of its governance structure during Quarter 2.

Figure 2: COMMAND AND CONTROL STRUCTURE



Gold (What)

The Gold Group is made up of some members of the Executive Team and takes overall responsibility for the Health Board's response to the pandemic, and establishes a framework of policy within which tactical managers work by determining and reviewing a clear strategic aim and objectives. The Gold Group has overall control of the resources of the Health Board and ensures that sufficient resources are made available to achieve the strategic objectives set, whilst taking into consideration the longer term resourcing implications and any specialist skills that may be required. This level of management also formulates media handling and public communications strategies, in consultation with any partner organisations involved. The Gold Group also ensures the Health Board's image and reputation is safeguarded.

The Gold Group delegates actions to the Silver Group for them to implement a tactical plan to achieve the strategic aims. All strategic actions are documented on a decision log to provide a clear audit trail and these are ratified by the Board.

There have also been weekly Formal COVID-19 Executive Team meetings to review the work of the Silver Tactical Group and the Gold level cells, which enable it to have clear oversight of the Health Board response and management to the pandemic.

Silver (How)

The Silver Group reports to the Gold Group and is responsible for the development and implementation of the Tactical plan to achieve the strategic direction set by the Gold Group, and works within the framework of policy outlined at the strategic level. This ensures a consistent and co-ordinated response to COVID-19 within an ethical framework. The Group also provides the pivotal link between Gold and Bronze levels. Silver oversees, but is not directly involved in, providing any operational response at the Bronze level. A decision log and minutes are maintained.

Bronze (Do it)

The Bronze level groups responds to events at an operational level as they unfold. The term Bronze refers to operational teams who manage the physical response to achieve the tactical plan defined by Silver, controlling the management of resources within their given area of responsibility. Several Bronze groups were established during the year, based on either a functional or geographic area of responsibility. These included Bronze Groups for acute, community, digital, estates and capital, mental health and learning disabilities, primary care, workforce and more latterly, vaccine delivery. A Bronze Chairs' Coordination Group has also been established to ensure a cohesive response at operational level. Each Bronze Group has minutes and a decision log.

Clinical Ethics Panel

The Clinical Ethics Panel (CEP) provides ethics input into Health Board policy and guidelines, supports health professionals and external partners with ethical issues arising within patient care, and facilitates ethics education for health professionals and other Health Board staff. Members include clinicians, lawyers and ethicists from within and outside the organisation. Ethical questions could be referred from within the Health Board and by partners.

The CEP does not provide legal advice, advise on research ethics, or advise on specific issues of resource allocation. CEP advice is consultative rather than prescriptive.

Command Centre

The Health Board's COVID-19 Command Centre was established to co-ordinate all inquiries and provide advice in relation to COVID-19. For further information on the role of the Command Centre, please see the Command Centre section in the Performance Report.

Gold Level Cells

These cells were established to support decision-making in respect of the pandemic:

- Modelling Cell – the cell provides regular forecasts of the progress of the pandemic at local level. Its role was to build and maintain a model to monitor COVID-19 outbreaks, and model the timing and extent of demand surges capable of giving maximum possible notice of critical care surges (working with the WG modelling group). The cell provides advice to the Bronze groups and other cell leads on reasonable planning assumptions regarding the timing and size of peaks based on the latest transmission model and actual experience;
- PPE Cell – the cell was established to address concerns and availability of Personal Protective Equipment (PPE). Its role was to establish an efficient and sustainable plan to predict, source, organise and distribute PPE to health and care services (including domiciliary care, care homes and residential homes);
- Public Health Cell – the cell provides an effective Test, Trace & Protect (TTP) service for the population of Hywel Dda. Its aim was also to prepare for winter pressures to support local health and care services with co-circulation of influenza and COVID-19 by ensuring a robust 2020/21 influenza vaccination plan is in place. Furthermore, the cell was responsible for developing mass vaccination plans, ensuring there is a specific focus on improving uptake of childhood and adult immunisation and vaccination programmes, which were paused due to COVID-19. The cell also co-ordinates effective communications for public health protection services including the testing, contact tracing and immunisation programmes; and
- Social Distancing – the cell is responsible for ensuring social distancing measures are in place across the Health Board in all operational, office and other Health Board premises.

Other Committees of the Board

Matters that have been brought to the attention of the Board for the Committees below can be found on our website within the Board papers section via the following link: https://hduhb.nhs.wales/about-us/your-health-board/.

Welsh Health Specialised Services Committee (WHSSC) & Emergency Ambulance Services Committee (EASC)

The WHSSC and the EASC are statutory joint committees of the seven local health boards. They were established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) and 2014 (2014/9 (w.9)) (the WHSSC Directions) and the Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.8)) (the EASC Directions). The WHSSC was established in April 2010 and is responsible for the joint planning and commissioning of specialised and tertiary health care services on an all Wales basis. The EASC was established in April 2014 and is responsible for the joint planning and commissioning of emergency

ambulance services, including Emergency Medical Retrieval & Transfer Service (EMRTS) on an all Wales basis and commissioning Non-Emergency Patient Transport Services (NEPTS).

The Chief Executive represents the Health Board at both these Committees and a summary of key matters and decisions is reported to the Board following each meeting.

NHS Wales Shared Services Partnership Committee

The NWSSPC has been established under Velindre NHS Trust which is responsible for exercising shared services functions including the management and provision of Shared Services to the NHS in Wales.

The Executive Director of Finance represents the Health Board at this Committee and a summary of key matters and decisions is reported to the Board following each meeting.

More information on the governance and hosting arrangements of the WHSCC, EASC and NWSSPC can be found in the Health Board's Standing Orders in the Statutory Committees section of its website: https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/.

NHS Wales Collaborative Leadership Forum (CLF)

The CLF was constituted in December 2016. As the responsible governance group for the NHS Wales Health Collaborative it has been established to agree areas of service delivery where cross-boundary planning and joint solutions are likely to generate system improvement.

The forum also considers the best way to take forward any work directly commissioned by WG from Health Boards and Trusts as a collective; and provides a vehicle for oversight and assurance back to WG as required. Assurance is given to individual Boards by providing full scrutiny of proposals. The meeting on 14 April was cancelled due to the pandemic, however the forum met on 28 July 2020 and 1 December 2020.

Mid Wales Joint Committee for Health and Social Care (MWJC)

The MWJC role is to have a strengthened approach to planning and delivery of health and care services across Mid Wales and support organisations in embedding collaborative working within their planning and implementation arrangements. The meeting on 23 March 2020 was cancelled due to the pandemic, however the Committee met on 28 September 2020.

Hywel Dda Public Service Board

The Health Board is a statutory member of Public Services Boards (PSBs) in Carmarthenshire, Ceredigion and Pembrokeshire. PSBs were established under the Well-being of Future Generations (Wales) Act 2015 (the Act), and their purpose is to improve the economic, social, environmental and cultural well-being in its area by

strengthening joint working across all public services in Wales. The effective working of PSBs is subject to overview and scrutiny by the Well-being of Future Generations Commissioner, AW as well as designated local authority overview and scrutiny committees.

PSB Funding from Welsh Government

The Minister for Housing and Local Government wrote to all PSBs to say that due to the need to review funding priorities that Welsh Government were unable to continue to fund PSBs going forward. This has yet to be discussed at the local PSBs but will have an impact on the resourcing of the running of the PSBs and local and regional co-ordination and activity. Papers for each PSB can be accessed via the following links:

- Carmarthenshire PSB - https://www.thecarmarthenshirewewant.wales/meetings/
- Ceredigion PSB - https://www.ceredigion.gov.uk/your-council/partnerships/ceredigion-public-services-board/public-services-board-meetings/
- Pembrokeshire PSB - https://www.pembrokeshire.gov.uk/public-services-board/psb-agendas-and-minutes

Each PSB has published its well-being assessment and has a well-being plan that can be accessed through the following links:

- Carmarthenshire Well-Being Plan - https://www.thecarmarthenshirewewant.wales/media/8331/carmarthenshire-well-being-plan-final-may-2018.pdf
- Ceredigion Well-Being Plan - https://www.ceredigion.gov.uk/media/3956/local-well-being-plan-2018-2023.pdf
- Pembrokeshire Well-Being Plan - https://www.pembrokeshire.gov.uk/public-services-board/well-being-plan

West Wales Regional Partnership Board

Regional Partnership Boards (RPB), are based on Local Health Board footprints, became a legislative requirement under Part 9 of the Social Services and Wellbeing (Wales) Act 2014 (SSWBWA). Their core remit is to promote and drive the transformation and integration of health and social care within their areas.

In the light of the COVID-19 outbreak, on 20 March 2020 WG advised RPBs of a series of relaxations in relation to reporting and monitoring of Transformation Fund (TF) and Integrated Care Fund (ICF) programmes. It also signalled flexibility in relation to deployment of existing funding to support the response to the pandemic.

WG confirmed the suspension of external evaluation of TF programmes and advised of a requirement to capture innovation/new ways of working in response to COVID-19 and share with WG as appropriate.

Temporary regional governance arrangements were put in place from 23 March 2020 to ensure timely decision-making during the pandemic whilst retaining openness and transparency. These included:

- Weekly meetings of Health and Social Care Leaders. This comprises of the Chief Executives of the partner organisations, Chair of the Health Board and Leaders of each Council:
- The formation of a Health and Social Care COVID-19 Planning Group (HSCCPG), which temporarily superseded the Integrated Executive Group (IEG), who met on a weekly basis until June 2020. This Group comprised all members of the Health Board Executive Team, Directors of Social Services and the Chief Executive of Ceredigion Association of Voluntary Organisations for the third sector. Its purpose was to coordinate a joined-up approach to the crisis, facilitate a whole system approach and take decisions on deployment of new funding and redirection of existing resources to support the COVID-19 response. The Group shared intelligence on key activities such as Test, Trace, and Protect, and approved key regional frameworks such as the Nursing and Residential Care Homes Risk and Escalation Management Policy. Decisions were also taken regarding deployment in West Wales of the £1.4m allocation to the region to support local arrangements to implement WG's COVID-19 Hospital Discharge Requirements: and
- Virtual meetings of the RPB to receive updates from partners and to ratify decisions taken by the HSCCPG.

IEG was reinstated with effect from 6 July 2020 and continued to meet weekly. The COVID-19 response was a key area of focus for the IEG over the remainder of 2020/21 providing a conduit for agreeing joint approaches to the significant challenges and pressures across the system. The Group also worked with the RPB to review the partnership's priorities in light of the pandemic, reflect on how business has been conducted over the pandemic period and apply lessons for enhanced joint working moving forward. The IEG also monitored the delivery of the West Wales Integrated Winter Plan which aligned to the Health Board's Q3 and Q4 Operating Plans.

In October 2020, the Health Board's Vice-Chair, Judith Hardisty, replaced Councillor Jane Tremlett as Chair, with Hazel Lloyd-Lubran, Chief Executive of Ceredigion Association of Voluntary Organisations appointed as Vice Chair.

In November 2020, the RPB approved a report for submission to WG which provided details of interim governance arrangements adopted by the RPB in response to COVID-19, and highlighted significant changes in anticipated need for care and support as a result of the pandemic, in comparison with that predicted in Population Assessment published in 2017.

In response to the facilitated self-assessment exercise undertaken by the RPB and IEG in late 2020, further support is being provided by the Institute of Public Care to review regional governance arrangements, strengthen joint working with PSBs and develop a high level 'manifesto' setting out the Board's key priorities and deliverables over the coming period. As part of this, there is a commitment to establish a new Programme Board to oversee delivery of the three Healthier West Wales programmes in the 2021/22 transitional funding year, ensuring that core objectives are met and impact assessed so that decisions can be made regarding continuation beyond the funding period. Further work will be undertaken in 2021/22 to strengthen the governance arrangements of the RPB.

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 2021 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. 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. 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 103 of this statement.

The Health Board 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 has been even more important during the pandemic, and Board and its Committees have continued to meet. Whilst some Committee and Sub-Committee meetings were temporarily stood down during the first and second waves (see Board and Committee section for further information), the impacts of doing so were considered and managed appropriately.

There were also changes to audit, inspectorate and regulatory regimes during the year as these organisations recognised the significant operational pressures on the NHS as a whole as it responded to increased activity during the first and second waves of the pandemic. There was a change from on-site audits and inspection activity to reviews being undertaken remotely. Healthcare inspections focused on COVID-19 specific work and audit plans were also adapted to include how effectively the Health Board was responding to the pandemic. Through the Board Secretary and Executive Director of Nursing, Quality and Patient Experience, regular contact has been maintained with its auditors, regulators and inspectorates to keep them updated on the Health Board's response to the pandemic and ensure activity continued as much as possible.

The responsibility for maintaining internal control and risk management systems continued to rest with management. The Board reinforced this in April 2020 when it agreed its approach to risk management and the management of recommendations from auditors, inspectors and regulators. These papers (items 2.3 and 2.4) can be accessed on the following link: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/board-agenda-bundle-16th-april-2020/#page=110

The ‘Maintaining Good Governance’ reports presented to Board throughout the year have detailed the Health Board’s approach to ensuring the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst recognising the reality of Executive focus and time constraints during the COVID-19 pandemic. These reports can be found in the ‘Your Health Board’ section of the Health Board’s website - https://hduhb.nhs.wales/about-us/your-health-board/.

CAPACITY TO HANDLE RISK

The Board is responsible for the effective management of the organisation’s risks in pursuance of its aims and objectives. The Board collectively has responsibility and accountability for setting the organisation’s objectives, defining strategies to achieve those objectives, and establishing governance structures and processes to best manage the risks in accomplishing those objectives. The Chief Executive, as Accountable Officer, has overall responsibility for ensuring that the Health Board has an effective risk management framework and system of internal control, however Executive Directors have responsibility for the ownership and management of principal risks and operational risks within their portfolios.

The Health Board’s lead for risk is the Board Secretary, who has responsibility for leading on the design, development and implementation of the Board Assurance Framework (BAF) and Risk Management Framework. AW have consistently reported through the Structured Assessment process that the Health Board has a well-developed BAF, and in 2020 reported that the Health Board adapted its risk management system during the pandemic.

In April 2020, the Board agreed its approach to the management of operational and corporate risks during the COVID-19 pandemic. This is detailed in item 2.4 in the following papers: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/board-agenda-bundle-16th-april-2020/#page=110

Risk Management Framework

The Health Board’s Risk Management Framework aims to facilitate better decision making and improved efficiency, risk management can also provide greater assurance to stakeholders. It is important that it adds value to ensure the Health Board reduces uncertainty, informs decision-making and priorities, and achieves the best possible outcomes.

Our Risk Management Framework clearly sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in the organisation. It clarifies roles and responsibilities, communication and reporting lines whilst also outlining the other components, such as the risk strategy and the risk protocols.

It is based on the “Three Lines of Defence” model which 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 Health Board's wider governance framework; however all three lines need to work interdependently to be effective.

There are procedures, guidance, systems and tools to assist management to identify, assess and manage risks on a day to day basis. This is supported with training, support and advice from the Health Board's Assurance and Risk team, whose role it is to embed the risk management framework and process, and to facilitate a risk aware culture across the organisation through a business partnering arrangement.

Now there are new strategic objectives, we will be reviewing its Risk Management Framework and Strategy to ensure they support the achievement of those objectives. This will be informed by an assessment of its risk maturity to enable the Health Board to continue to strengthen its risk management arrangements, culture and attitude.

Risk Management Process

The Health Board's Risk Management Framework supports the risk management process. This is a continuous process that should methodically address all the significant risks associated with all the activities of the Health Board. During the pandemic, risk assessments have been used to support key decision-making, and to understand the balance of risk.

Risks are identified in a bottom-up and top-down approach throughout the Health Board. Each corporate and clinical directorate is responsible for ensuring risks to achieving their objectives, delivering a safe and effective service and compliance with legislation and standards, are identified, assessed and managed to an acceptable level, i.e. within the Board's agreed risk tolerance.

It is the responsibility of Executive Directors to put forward significant operational risks from their directorate to be collectively agreed by the Executive Team for entry onto the CRR. Through 2020/21, the CRR was dominated by COVID-19 and reflected risks to its response to the pandemic and the delivery of its quarterly operational plans against the NHS Wales Quarterly Operating Framework.

In normal circumstances, it is also the responsibility of Executive Directors to identify principal risks associated with the delivery of the Health Board's objectives for inclusion onto the BAF. Throughout 2020/21, the BAF was stood down to allow the organisation to focus on delivering its quarterly operational plans against the NHS Quarterly Operating Framework. Although the Board approved its new strategic objectives in September 2020, work to develop its principal risks was paused to allow the organisation to respond to the second wave. Now that the Health Board's Draft Annual Recovery Plan 2021/22 has been developed, a series of workshops with the Executive Directors have been arranged for April/May 2021 to identify the principal risks to achieving its objectives. These will be included on the BAF to support the implementation of the Health Board's strategy and provide the Board with on-going assurance on the achievement of its objectives.

All risks are assessed in terms of likelihood and impact using the Health Board's risk scoring matrix which helps to facilitate a level of consistency and understanding of the scoring and ranking of risks throughout the organisation.

Oversight and Reporting of Risk

In following the three lines of defence model (above), the Health Board 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.

Risks are also aligned to the Health Board's assurance committee and Command and Control Structures, whose role it is to provide assurance to the Board that risks are being managed appropriately. The Executive Team hold a monthly risk session to review and consider the CRR.

The Board has received the CRR three times during 2020/21, 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 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.

Risk Appetite

The Risk Appetite Statement provides staff with guidance as to the boundaries on risk that are acceptable, and provides clarification on the level of risk the Health Board 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. The Risk Appetite was kept under review but was not changed during the pandemic.

The Board agreed its Risk Appetite Statement 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 Health Board 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 Health Board'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."

In addition, 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

Risk tolerance levels have been added to the Health Board's risk management system and risks above tolerance are reported and challenged through the assurance Committee structure.

The Health Board's risk appetite will be reviewed in 2021/22, to ensure it remains aligned to the Health Board's new strategic objectives and its capacity to manage risk, particularly whilst we continue to manage the pandemic and moves into recovery.

Risk Profile

Delivering healthcare through the current clinical model in a large, rural geographical area presents significant financial, service, workforce and quality challenges to the Health Board. Prior to the COVID-19 pandemic, the majority of our risks related to fragile services, poor patient flows, poor environments and aging equipment mainly as a result of staffing and funding (capital and revenue) challenges. The Health Board's new strategic objectives set out how it will address some of these issues going forward whilst considering the learning, developments and changes of practice implemented during the pandemic.

As the pandemic began to emerge, the following risks were initially identified on the CRR:

Risk 853 - Risk that Hywel Dda's response to COVID-19 will be insufficient to address peaks in demand terms of bed space, workforce and equipment and consumables	Moderate (5)

Whilst this had a risk score of 15 when it was entered on the CRR, it was reduced to 5 (within Health Board tolerance) in April 2021 based on estimated COVID demand and the planning undertaken to respond to COVID-19.

Risk 854 - The Health Board's response proves to be larger than needed for actual demand	Low (3)

This risk has a current risk score of 3 which is significant reduction from the initial risk score of 12. The likelihood recognises that limits to the Health Board's ability to grow its bed base reduces the risk of over-capacity and the modelling is informing the scale of gap. It also reflects revised planning assumptions from WG for winter COVID-19 demand which will be close to available field hospital capacity. The WG funding process for COVID-19 has been clarified and the current forecast out turn is in line with pre-COVID plans at £25m. The likelihood further reduced in light of the growing certainty of achieving the year-end financial target.

Risk 855 - The Health Board will be unable to address the issues that arise in non-COVID related services and support functions	High (8)

The level of this risk fluctuated throughout 2020/21 reflecting the changes in the levels of activity within hospitals. The risk score increased throughout the winter reflecting the pressures on services from the second wave (as it did in the first wave), when all but essential services were suspended with staff redeployed and only the most urgent surgery undertaken on a case by case basis. Clinicians continue to review patients on a case by case basis to ensure those at greatest clinical risk or risk of harm are seen first. The Health Board is using all available capacity at Werndale Hospital to support cancer and urgent surgery.

Risk 856 - The funding costs to address the Health Board response to COVID-19 may exceed the available funding	High (8)

This risk was de-escalated in March 2021 as the risk had been reduced to within tolerance as the Health Board was forecast to deliver a planned deficit of £25m.

These risks have remained on the CRR during 2020/21 and the changes in the level of risk through the year can be seen on the CRR presented to the Board in March 2021 - https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-march-2021/25th-march-2021-documents/item-3-6-corporate-risk-register/.

During the pandemic, the Health Board's key objective was to deliver its quarterly plans developed in response the NHS Wales Quarterly Operating Framework to minimise the 4 quadrants of harm:

- Harm from COVID itself;
- Harm from overwhelmed NHS and Social Services;
- Harm from reduction in Non-COVID activity; and
- Harm for wider societal actions/lockdowns.

As these quarterly plans were developed, significant risks to delivery were reflected on the CRR and were reported through the Command and Control Structure, with oversight by the Board and its Assurance Committees. These included the following risks:

Risk 1018 - Insufficient workforce to support delivery of essential services	Extreme (16)

Being able to respond effectively and swiftly to the changes in the workforce demand was identified as a risk early on in the pandemic to the delivery essential services, managing surge capacity, delivering the mass vaccination programme and staffing field hospitals. The pandemic Command and Control Structure is monitoring and managing this risk. Whilst there has been a significant recruitment during COVID-19, there is remains a nursing, medical and therapies staffing deficit position which will need to be addressed as part of the Health Board's long term strategy.

Risk 1027 - Delivery of integrated community and acute unscheduled care services	Extreme (16)

This risk was identified in November 2020 to reflect the risk of disruption to the delivery of essential services due to the fragility of the unscheduled care system across Hywel Dda, the impact of COVID-19 on available beds and staffing levels, and the delays in discharges beyond the remit of the Health Board. As such, a wide range of processes and controls are in place to mitigate e.g. daily virtual meetings for all sites, review of patients admitted to surge areas to ensure their acuity and dependency is monitored and controlled, discharge lounge for patients about to be discharged, joint workplan with the Wales Ambulance Service Trust. Due to the uncertainty surrounding any data modelling and the implications of restrictions lifting on future COVID and non-COVID demand, the situation remains fluid and changeable.

Risk 1032 - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Extreme (16)

This risk reflects the increasing length of time mental health and learning disabilities clients (specifically ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis. This was caused by new environmental (due to social distancing measures) constraints to undertake

required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID-19, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. Management of the risk is dependent on securing recurring funding Integrated Autism Service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments.

Risk 1048 - Risk to the delivery of planned care services set out in the Q3/4 Operating Plan and those proposed for Q1 and Q2 of 2021/22	Extreme (16)

This risk is caused by the legacy of the impact of the second wave on available capacity and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. The pressures the Health Board experienced necessitated it applying the WG Local Options Framework of actions to prioritise resources for COVID and other essential emergency pathways. Surgery for emergency and urgent cases recommenced in January 2021 and the Health Board is planning to restart other surgery as soon as it is safe and practical to do so. The plans in place reflect the maximum capacity the Health Board can achieve within the footprint of its existing hospital sites, particularly during the first half of 2021.

Risk 1016 - Increased COVID-19 infections from poor adherence to Social Distancing	High (10)

Social Distancing risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'key controls' measures in place such as social distancing guidance and signs for staff, patients and visitors, safety screens have been installed in hospital, ward and clinic reception areas. Hand sanitiser stations are available across all sites. The risk has been reduced from 15 to 10 to reflect the staff and public's positive response to social distancing measures as well as the Health and Safety Executive (HSE) informal feedback and lack of enforcement from visit on 20 January 2021.

Risk 1017 - TTP Programme being able to quickly identify and contain local outbreaks	High (10)

This was initially identified when there were issues with the public being able to access timely tests through the TTP programme. Whilst these issues have been resolved, there is still a risk to maintaining adequate Health Board staffing levels to support the TTP programme with regular requests for seconded staff to be pulled back to their substantive posts.

Risk 1030 - Reputational risk if the Health Board is perceived to not deliver the mass vaccination programme	High (8)

Whilst the Board have approved the Mass Vaccination Delivery Plan which is progressing at pace, there are a number of external factors that could cause delays. The risk at present is within the Health Board's tolerance level however remains on the CRR as the vaccination programme is a key objective of the Health Board.

In addition to the risks emerging through the pandemic, there are other risks facing the organisation that have been exacerbated. These are detailed below:

Risk 684 - Lack of agreed replacement programme for radiology equipment across the Health Board	Extreme (20)

This risk has been on the CRR since January 2019 and reflects the increased risk around the Health Board's stock of imaging equipment which requires significant periods of urgent and planned maintenance, creating downtime in use which puts pressure on all diagnostics, significantly impacting on the Health Board's ability to meet its performance targets and the impact to patients can include delays in diagnosis and treatment. Presently, equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity decreased due to COVID-19, the scanning of COVID-19 patients requires more time than non-COVID patients, which is an issue as requests for diagnostics for non-COVID patients increase as essential services resume. Commissioning of agreed equipment has also been delayed as a result of COVID-19 and this remains dependent external factors. Radiology has been asked to increase its service provision to other clinical directorates which it is currently unable to provide due to limitations on current equipment, however the new demountable CT-scanner will provide much needed resilience at Glangwili Hospital. WG have agreed funding for one new CT scanner and one new MRI scanner in 2021/22 (out of 5 scanners required). In the meantime, controls and processes are in place to mitigate the risk e.g. service maintenance contracts, daily quality assurance checks, disaster recovery plan in place.

Risk 624 - Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	Extreme (16)

This risk was added to the CRR in September 2018 and reflects the risk that there is insufficient capital funding from the All Wales Capital Programme and Discretionary Capital allocation to maintain and address the backlog maintenance. This was exacerbated during COVID-19 as capital funding to support COVID-19 capital expenditure was not confirmed. However based on knowledge of WG capital fund for imaging priorities, the Welsh Targeted Improvement Programme for Estates Infrastructure, capital receipts during 2021 and the Fire and Major Infrastructure business cases, this risk recently reduced from 20 to 16. The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

Risk 646 - Ability to achieve financial sustainability over medium term	Extreme (16)

The Health Board has not developed a full long term financial base-case model, which can then be used to assess the impact of ‘A Healthier Mid and West Wales’ and other medium term changes. The Health Board's underlying deficit also requires further work to fully explore and understand the opportunities for improvement which can be realised over the medium term. The forecast financial impact of COVID-19 on the underlying position is currently informed by modelling intelligence, due to the fluid nature of the pandemic and the multitude of unknown

variables inherent in such a situation. Furthermore, the funding from WG in response to the pandemic in 2020/21 has been confirmed on a non-recurrent basis; the recurrent funding position remains uncertain.

Risk 633 - Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	High (12)

This risk has been on the CRR since September 2018 and reflects the impact of COVID-19 on delivery of cancer services in 2020/21. Due to the COVID-19 situation, only urgent cancer elective surgery was carried out from the 21 December 2020 for a period of 4-6 weeks due to staffing levels. To help mitigate this risk, the Health Board has used Werndale Hospital for surgery. There is a COVID-19 escalation plan in place. The Health Board is working jointly with regional partners to offer patients on a tertiary pathway surgery within Hywel Dda.

As of 31 March 2021, there were 22 corporate risks, 19 of which were above the Health Board's risk tolerance. The heat map below presents the Health Board's principal risks (by their internal reference number) in respect of their likelihood and impact as at the end of March 2021:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5	853	117 634 1016 1017	813		
MAJOR 4		1030	291 628 633 451	624 646 750 855 1018 1027 1032 1048	684
MODERATE 3	854			129	
MINOR 2					
NEGLIGIBLE 1					

Further information on the highest scoring principal risks in 2020/21 (those that have risk score of 15 or over) can be found in the March 2021 Board papers: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-march-2021/25th-march-2021-documents/item-3-6-corporate-risk-register/

During 2020/21, 22 principal risks were closed or de-escalated from the CRR. These can be found at Appendix 2.

Emergency Preparedness/Civil Contingencies

The Health Board 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 Emergency Planning Unit. This plan, together with other associated emergency plans, details the response to a variety of situations and how the Health Board meets the statutory duties and compliance with the Civil Contingencies Act 2004.

Within the Act, the Health Board 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 (PHW), the Health Board is the first line of response in any emergency affecting its population. In order to prepare for such events, local risks are assessed and used to inform emergency planning.

We continue to ensure that Executive Directors are appropriately skilled to lead the strategic level response to any major incident via Gold Command training, with additional senior managers/nurses trained in tactical and operational major incident response. During the last year, the majority of training has moved to being delivered on virtual platforms to ensure COVID-19 safety.

Our response to the pandemic since the end of January 2020 has been based on well-established Command and Control structures (see Command and Control section for further information) developed through the on-going delivery of the requirements of the Civil Contingencies Act 2004.

As previously highlighted, the need to plan and respond to the COVID-19 pandemic presented a number of challenges to the organisation. A number of new and emerging risks were identified. Whilst we did have major incident and business continuity plans in place, as required by the Civil Contingencies Act 2004, the scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to prepare and respond to the likely impact on the organisation and population. This has also involved working in partnership on the multi-agency response as a key member of the Local Resilience Forum (LRF) Strategic Co-ordination Group. There does remain a level of uncertainty about the overall impact this will have on the immediate and longer term delivery of services by the Health Board, although there is confidence that all appropriate action is being taken.

We continue to work closely with a wide range of partners, including the WG as it continues with its response, and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust risk management arrangements and the ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve their strategic objectives.

Local Resilience Forum

The Health Board is a core member of the multi-agency Dyfed Powys Local Resilience Forum, (LRF) which sits at the apex of Dyfed Powys's local civil protection arrangements. Its overall purpose is to ensure that there is an appropriate level of preparedness to enable an effective multi-agency response to emergencies which may have a significant impact on the communities of Dyfed Powys. The LRF has been operating its Command and Control (incident management) structures throughout the pandemic, which have provided multi-agency strategic and tactical co-ordination involving the wider partner agencies and WG. A number of working groups have supported the main strategic and tactical co-ordinating groups in meeting the needs of the partners during the last year.

For example, the LRF has supported the planning for an increase in deaths during the pandemic and has co-ordinated the development of additional facilities in the event that they be needed to enhance the existing NHS facilities and Funeral Director/Crematoria sectors

Additionally, the LRF has developed a COVID-19 Resources Sub-Group which facilitates requests for assistance from any of the partner agencies, be it additional staff, equipment or premises.

The LRF also holds a Community Risk Register which informs the public about the potential risks the Health Board faces such as transport and industrial incidents and flooding/severe weather events and encourages them to be better prepared. As part of the LRF, the Health Board also works as a core partner to train and exercise staff to ensure preparedness for emergency situations.

Brexit

We continued to prepare for a no-deal Brexit situation with the UK and WG, the LRFs and other health and social care organisations across Wales, to ensure that patients and services would not be affected, or minimise any potential impact on NHS services. Focus intensified from the summer as the end of the transition period approached and confirmation of a deal was still awaited. Areas of main concern remained medicines management, procurement and workforce. Minor limited impact has so far been identified on any Health Board services which can be directly attributed to Brexit.

Tuberculosis (TB)

During 2020/21, we have continued to work with specialist health protection teams within PHW to maintain an overview of the TB Outbreak. Respiratory services have continued to deliver a range of TB clinics in accordance with COVID-19 restrictions to support those effected individuals and their local communities.

Penally Army Training Camp

In 2020, despite the Health Board raising concerns regarding the unsuitability of the accommodation, lack of consultation with local services, and the COVID-19 pandemic, the Home Office advanced plans for the Penally Army Training Camp Ministry of Defence (MOD) site near Tenby to be used to house asylum seekers from

elsewhere across Wales and England. As many as 179 asylum seekers, all of whom were adult males mostly from Eritrea, Iran, Iraq, Syria and Palestine, have resided at the camp at any given time. We have been central to the multi-agency integrated response to supporting the men at the camp. The delivery of safe and appropriate primary care services to the men seeking asylum who were placed in the Penally Camp has been complex and exacting, and challenging on many levels. The camp was formally closed by the Home Office on 21 March 2021. The Health Board ensured robust governance arrangements were in place to ensure it responded appropriately to the issues raised with Penally Army Training Camp.

PLANNING ARRANGEMENTS

Strategy

Improved health and wellbeing is a cornerstone of the our strategy *A Healthier Mid and West Wales*, signalling a move away from a reactive care system that responds to illness and toward a pro-active population health system that promotes staying well. Accordingly, the strategy sets out our 20-year vision for the future, a co-created vision developed from the three PSBs wellbeing plans, as follows:

> "Our shared vision is a mid and west Wales where individuals, communities and the environments they live, play and work in are adaptive, connected and mutually supportive. This means people are resilient and resourceful and enabled to live joyful, healthy and purposeful lives with a strong sense of belonging."

Although the Health Board was responding to the COVID-19 pandemic in 2020/21, we were conscious that at some point it would end and that we needed to be in the strongest possible position to accelerate the delivery of the strategy and bring the organisational values fully to life. Over the summer period, we took stock of where we were as an organisation, the lessons we learnt in the initial phase of the pandemic, the decisions we made and the progress achieved so far towards the strategic vision over the last 3 years. From this work, we have developed a new set of 6 strategic objectives which set out the aims of the organisation - the horizon it is driving towards over the long term.

Whilst these 6 strategic objectives provide a new clarity of purpose, the overall aim remains unchanged; the Health Board will deliver on the ambitions of its strategy as well as the requirements of WG, regulators and others, whilst building the organisation firmly around its values which is sustainable in the longer term. This revised approach will help us to more clearly plan, identify gaps and opportunities and track progress as a Board towards meeting these strategic objectives.

1. Putting people at the heart of everything w do	**4.** The best health and wellbeing for o communities
2. Working together to be the best we car be	**5.** Safe, sustainable, accessible, and ki care
3. Striving to deliver and develop excellen services	**6.** Sustainable use of resources

The organisational values form the first 3 strategic objectives - they have resonance with staff, many of whom contributed to their development. They place humanity at the centre of what the Health Board wish to be as an organisation. The 3 service aims bring together the ambitions to focus on population health and wellbeing in its widest sense, the need to deliver now, and for the future, the key aims that guided the *Health and Care Strategy* and the need to manage all resources in a sustainable manner.

Taken together these 6 strategic objectives encapsulate the quadruple aim as set out in *A Healthier Wales* whilst maintaining local resonance. A set of approximately 65 planning objectives, aligned to the members of the Executive Team, sit underneath these strategic objectives. A number of the planning objectives are also underpinned by specific requirements, including those of WG and regulators, which are to be addressed in their delivery.

In developing the planning objectives, all outstanding decisions and commitments by the Board were reviewed and a clear audit trail established to demonstrate how outstanding commitments are reflected in the new objectives. This detailed audit trail was presented to the PPPAC for scrutiny in October 2020.

The organisational objectives and commitments were then reviewed and themed, and the final planning objectives agreed by the Executive Team. Some of the planning objectives are very ambitious. We learnt during our response to the pandemic that we can often achieve things that may not have seemed possible previously. A process has also been put in place to allow staff members across the system, partners, stakeholders, thought leaders and ultimately the local population to propose new planning objectives in support of the strategic vision, for consideration and possible adoption by the Board. This is managed by the Transformation Steering Group (TSG) established by the Board in June 2020 (see below).

There are also a number of enabling functions that will need come together to deliver transformation across the Health Board. These include:

- Digital;
- Workforce;
- Quality Improvement;
- Governance;
- Finance;
- Estates;
- Decarbonisation, Green Health and the Foundation Economy; and
- Research, Development and Innovation.

A work plan to develop these enablers is in place and a Strategic Enabling Group (SEG) was established by the Board in June 2020 to oversee this and seek new ways to enable the organisation to achieve more from the delivery of its Planning Objectives.

Following Board ratification, Executive Directors and their teams have been developing their detailed delivery plans for each of the planning objectives. The Planning Team continues to engage with operational teams about their detailed plans, as part of the Health Board's new approach towards planning. In this new approach, the

development and implementation of planning objectives is a continuous process, informing the Health Board's planning cycle.

As we exit the pandemic, the role of the TSG and SEG will evolve. Work has already started to refocus the work programme of both TSG and SEG.

Transformation Steering Group (TSG)

In 2020/21, the existing strategy delivery arrangements were reviewed, and a need to change was recognised. The TSG was established, with membership consisting of the Chair, Independent members, Executive Directors (or deputies) and external advisors, to ensure that the Health Board:

- Learns from the pandemic and its response to it;
- Translates that learning into practical applications; and
- Enables the Board to continue transforming its services today and over the lifetime of the health and care strategy.

The learning resulting from the pandemic provided an opportunity to review this, reflecting on the flexible way of operating during these times which allowed us to deliver the required change and innovation needed to continue delivering healthcare services in a time of great flux. A new transformation governance system was established in July 2020 with the establishment of the TSG, led by the Chief Executive Officer (CEO) and supported by a set of strategic enabling groups to determine the timescales for delivery.

The initial piece of work undertaken by the TSG was to produce a Strategic Discovery Report, applying the initial learning from our pandemic response to the delivery of our health and care strategy. The report aimed to bring together the learning and innovation across the local health and care system to ensure that we can learn collectively from the pandemic and its response to it. The report enabled the Board to celebrate and authorise the changes and practical application of the learning that was achieved together, and to confirm the commitment to continue to transform services now and over the lifetime of the Health and Care Strategy, ensuring that the impact of all learning is maximised. The areas set out in the report to celebrate, authorise and decide can be found in the report to the July Board via the following link: http://www.wales.nhs.uk/sitesplus/documents/862/Item%203.3%20Strategic%20Discover%20Report.pdf. This was important learning to support the Health Board to recover services, to build on what worked well, and work towards a 'new normal'.

The Board has commissioned a second phase of its 'Discovery' work, which will focus on staff rather than services. This second 'Discovery' phase has in part already begun and will accelerate and continue through Quarter 1 of 2021/22. Its outputs will inform the 'Thank you offering' to staff and the Health Board's approach to support their rest, recovery and recuperation due to COVID-19. Other surveys around Health and Wellbeing, Stress and Burnout, and the National Staff survey conducted in November 2020 will also be used to inform this 'Discovery' work, along with the launch of the Medical Engagement Scale (due in early 2021/22). We also have a growing body of evidence from staff stories and quotes, shared through Workforce and Organisational Development colleagues; staff side, Chair and Executive visits; Clinical leads; Heads of Nursing; new COVID recruits and coaching experiences.

Feedback from engagement with the local population via the planned “Public facing Discovery” engagement exercise is also planned for 2021/22.

Planning and Delivery

In March 2020, the WG took the unprecedented decision to pause the Integrated Medium Term Plan (IMTP) and annual plan process to enable NHS Wales organisations to focus its attention on the immediate planning and preparations to deal with the COVID-19 pandemic, advising that the planning process would be restarted at a more appropriate time.

Nonetheless, in March 2020, the Health Board agreed to submit a Three Year Plan for 2020/23, which incorporated the Annual Plan 2020/21 to WG. The Annual Plan 2020/21 was developed following several planning meeting discussions with WG, as we would not be in a position to submit an IMTP as required by the National Health Service Finance (Wales) Act 2014, for 2020/23 given the current financial position and three year forecast.

Quarterly planning arrangements were introduced during 2020/21 in response to the pandemic in order to maintain essential services and retain flexibility and adaptability to changes in the community transmission rates of COVID-19. Quarterly plans were required from all organisations, aligned to the priorities in each quarter’s frameworks which were issued throughout the year. These were developed and approved through the Command and Control Structure, with ratification from the Board.

The Health Board recognises the seismic shift that COVID-19 has had on planning, deployment and implementation of systems, structures and services. The impact has been both significant and dynamic and cannot be underestimated. It has changed and advanced the way we approach our planning, meaning that many changes previously identified for the longer-term have had to be implemented sooner than envisaged, with digital enablement being a prime example of this. This means that planning and assumptions were re-thought, along with their timelines, as the Health Board moved into a transformational period. Despite the challenges and fundamental changes encountered during 2020/21, there have been unexpected opportunities presented to re-set, accelerate and expedite, where appropriate, to transform services.

Given the issues relating to, and the consequence of the current pandemic, WG requested an Annual Plan for 2021/22, rather than an IMTP. In recognition of the continued dynamic environment that Health Boards are currently operating in, the WG wrote to all Health Boards on 17 March 2021 with regards to the submission of their Annual Plans, reflecting that plans taken to Boards will only be draft plans as final funding packages have not been completed yet, and consequently draft plans will need to be reviewed in conjunction with WG colleagues to assess the levels of assumed spending.

In March 2021, the Board approved its Draft Annual Recovery Plan 2021/22 which sets out to the organisation and WG the priorities for 2021/22, for submission to WG. The full plan is expected to go to June 2021 Board for final approval. The strategic objectives and planning objectives, approved by Board in September 2020, form the foundations of the plan with the focus, first and foremost, on how the Health Board

continues to address, and recover from the COVID-19 pandemic: how it will support staff to recover after the challenges of the past year, and how it will lay the foundations to recover its system/services and support communities to thrive.

The draft Annual Recovery Plan recognises a planned deficit in the 2021/22 financial year, and that this does not recover the cumulative deficit incurred to date (which was reset to 1 April 2020). As a result of this, the Health Board has approved a draft budget which will breach its statutory financial duty for the three-year period, however we will continue to look at every opportunity to reduce expenditure and close the financial gap, wherever possible.

The Health Board was unable to meet its financial duty to not exceed the aggregate funding allocated to it over a period of 3 years. The Health Board had a deficit position of £35.4 million in 2018/19, £34.9m in 2019/20 and £24.9m in 2020/21. We are cognisant that financial planning and the delivery of our strategy is needed for long-term financial stability and sustainability.

Working with partners

In the past year the communication and the strength of the Health Board's partnerships with its 3 local authorities and other public bodies in West Wales has been key to the success of the collective response to the pandemic, particularly with providing personal protective equipment across health and social care, the Test, Trace and Protect programme, provision of field hospitals, roll out of the biggest mass vaccination programme in the history of the NHS and supporting care homes.

Improving health outcomes in mid and west Wales and creating a sustainable healthcare system for the future requires strong and effective partnerships. We are committed to developing strong partnerships with patients, public, stakeholders and partner organisations from the statutory, voluntary and independent sector.

The strategic partnership focus is on facilitating and supporting collaboration and integration of services, both internally and externally, by:

- Nurturing relationships with key strategic partnerships to drive needs-led, outcome focussed planning, activity and participation;
- Ensuring alignment between well-being plans and strategies between the health board and partners;
- Leading corporate planning and commissioning of information, advice and assistance for unpaid carers to meet their needs in an equitable way across the area;
- Leading and supporting and contributing to a range of multi-agency projects for vulnerable groups in order to create a pace of change and support service improvement;
- Delivering publication of the Health Board's Well-being Objectives and Annual Report; and
- Providing a range of awareness raising opportunities and targeted training to increase staff knowledge, understanding and competency in key legislative responsibilities and how to provide equitable services and inclusive working environment.

The Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 provide complimentary legal frameworks that include arrangements to support partnership working. The West Wales RPB is driving the integration of health and social services to plan and ensure the delivery of integrated, innovative services to best meet the needs of people with needs for care and support. The 3 PSBs sitting at local authority area level involve a broader range of partners working strategically at the wider economic, social, environmental and cultural well-being of the area.

On behalf of the RPB, the IEG (which consists of a number of directors across health and social care) monitors delivery of key programmes, including:

- The Healthier West Wales programme – funded through the WG's TF and comprising 3 ambitious programmes aimed at helping people to stay active, well and independent within their communities whilst providing targeted support where necessary. Transitional funding of £6m has been awarded to support these programmes in 2021/22, building on nearly £12m investment over the past two years.
- The TF also supports the West Wales Research, Innovation and Improvement Coordination Hub (RIICH), hosted by the Health Board and charged with working across all partner agencies to (1) promote the use of research, knowledge and information to understand what works; (2) support shared learning; (3) and use innovation and improvement to develop and evaluate better tools and ways of working.
- The ICF – bringing £12m revenue and £5m Capital transitional funding to the region in 2021/22 and supporting a wide range of programmes which bring services together, support independence and aim to significantly reduce the need for long term care. ICF investment spans all population groups, with focused allocations for older people, people with dementia, children and families, learning disabilities, unpaid carers and autism.

The Board's commitment to using a 'Well-being Lens' is supporting it to embed the sustainable development principles of the Well-being of Future Generations (Wales) Act 2015 into our everyday business. These plans have been developed through the lens of:

- Balancing the delivery of current services whilst planning for the longer-term delivery of sustainable health and care services for future populations;
- Preventing problems from occurring or getting worse, with actions focused on primary, secondary and tertiary prevention;
- Integrating services with others, both public sector partners as well as third sector organisations, to deliver seamless care;
- Collaborating with others to take action to address the wider determinants of health and improve patient experience and outcomes;
- On-going commitment to the continuous involvement of people who represent the diversity of the Health Board area to ensure that the patient, staff and stakeholder voice shapes the development of services.

As a health organisation, we are aware that other partners have a significant contribution to make in improving health outcomes as there are many wider determinants of health and well-being.

As we continue to work increasingly in partnership to deliver our strategic aims, objectives and priorities, it is essential that arrangements continue to be underpinned by robust governance arrangements, including appropriate reporting mechanisms, in order that the Board has a clear approach to its partnership work. 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 the most vulnerable patient groups, and where there needs to be both a trust and confidence in the arrangements in place.

Triennial Review of University Status

The WG awards 'University Status' to Health Boards able to evidence strong partnerships with Higher Education Institutions in relation to learning and teaching, research and development, and innovation. The status is reviewed every three years, although the WG has signalled an intention to align this to the medium term planning cycle from 2021/22. We retained our 'University Status' following a recent review by an assessment panel involving WG, Health and Care Research Wales, and Health Education and Improvement Wales on 16 April 2021.

The Health Board was awarded its university status in 2013. Its status was subsequently reviewed in 2016 and validated. Over the past two months, documentary evidence has been collated from key staff across the organisation and university partners. This has included speaking to partners at length about their perceptions of where the relationship with the Health Board in the 3 domains of partnership are particularly strong.

Bilateral executive level meetings have been held with each of the Health Board's university partners to determine progress and set future priorities in the domains of research and development, innovation, and education and workforce. The meetings have resulted in work plans, which will now be reviewed on 6 monthly basis. The summation of this evidence illustrates a positive picture of university partnership between 2016 and 2020, particularly with the our 3 main partners of Aberystwyth University, the University of Wales Trinity Saint David, and Swansea University, while recognising the strong links we have with other Higher Education Institutions in Wales and beyond.

The achievements include significant partnership activity in support of our University status:

- Workforce strategy, in areas including the 'grow your own – train, work, live' initiative, developing skills and education (e.g. new role creation, degree apprenticeships, and widening access to courses), supporting high quality placements, and continuing professional development;
- Research strategy, including jointly supported portfolio studies, research time awards, honorary and jointly funded posts, securing grants from significant

research funding bodies and commercial organisations, and maturing formal associations including the West Wales Academic Health Collaborative; and

- Innovation approach, both demand and supply side, including several joint projects supported through the efficiency through technology fund, meaningful partnerships with the Life Science Hub Wales (e.g. the Accelerate initiative), and significant engagement with the Bevan Commission's programmes, evidenced by the number of Exemplar projects supported.

THE CONTROL FRAMEWORK

Quality Governance Arrangements

The Health Board has a structure in place for quality governance lead by the Executive Director of Nursing, Quality and Patient Experience. In line with Standing Orders, the Board has established a Committee to cover the quality and safety business of the Board. This Committee holds Executive Directors to account and seeks assurance, on behalf of the Board, that it is meeting its responsibilities in respect of the quality and safety of healthcare services.

Throughout 2020/21, the Health Board has continued to work on standardising reporting to improve consistency through the quality and safety governance structure. Whilst some of this work has been hampered by the COVID-19 pandemic, there has been good progress. An IA review of Quality and Safety Governance arrangements was undertaken in line with the audit plan for 2020/21. IA awarded a 'reasonable' assurance rating and the audit concluded that the Health Board has made progress in embedding governance arrangements to review and progress quality and safety issues within the sampled directorates. Further work is underway to further strengthen the quality and safety governance arrangements with the introduction in early 2021 of County level meetings.

Organisational Quality Arrangements

The Executive Director of Therapies and Health Science, Executive Medical Director and Executive Director of Nursing, Quality and Patient Experience are all jointly accountable for quality and safety, and jointly provide this assurance through QSEAC and directly to Board. The Quality and Safety, Experience and Improvement teams are line managed by the Executive Director of Nursing, Quality and Patient Experience; however the deployment of this resource supports the organisation multi-professionally in matters relating to quality and safety.

The job descriptions of senior clinical leadership positions all include responsibility for quality and safety, and it is therefore made clear that this is a core part of their role.

In year, the Health Board has strengthened the quality and safety arrangements with the appointment of a Clinical Director for Clinical Effectiveness, a Clinical Director for Clinical Audit and Clinical Leads for Quality Improvement.

Each directorate/locality has a Triumvirate Team with joint responsibility for quality and patient safety. The Head of Nursing and Clinical Director work closely to ensure

that the quality and patient safety agenda is considered at the directorate level. To support the Triumvirate Teams the Quality Assurance and Safety Team (formerly the Assurance, Safety and Improvement Team) have introduced a business partner model. Quality governance will be further strengthened in 2021/22, when the Health Board continues to address the findings of the 2019 AW Quality Goverance Arrangements in Hywel Dda.

Listening and Learning Sub Committee

In 2020/21, the Health Board established a Listening and Learning Sub-Committee which reports to QSEAC. The Sub-Committee provides clinical teams across the organisation with a forum to share and scrutinise learning, and to share innovation and good practice. The learning may arise from a complaint, an incident, a claim, a patient story or experience feedback, external inspection and peer reviews.

Annual Quality Statement (AQS)

The requirement to publish a separate AQS was changed for 2020/21. To replace the AQS in line with WG guidance, the Health Board has ensured that the Annual Report has a focus throughout on quality.

Health and Care Standards (HCS)

The HCS set out the WG's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. The HCS set out what the people of Wales can expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. The HCS set out the expectations for services and organisations, whether they provide or commission services for their local citizens.

The HCS came into force from 1 April 2015 and incorporate a revision of the 'Doing Well, Doing Better: Standards for Health Services in Wales (2010)' and the 'Fundamentals of Care Standards (2003)'. The HCS have 7 themes and have been designed in order that they can be implemented in all health care services, settings and locations. The 7 themes are explained in more detail in the Introduction section of the Performance Report. They establish a basis for improving the quality and safety of healthcare services by providing a framework. Key objectives from each service should be considered in relation to HCS.

The HCS are intrinsic in the day to day business of the Health Board. The HCS are firmly embedded within the organisation and can be demonstrated in a number of ways:

- All Board and Committee reports are linked to HCS;
- Integrated Performance Assurance Report (IPAR) reported on alternative month to either Board or PPPAC under HCS domains; and
- Fundamental of Care Audits.

A review of the Health and Care Standards was completed by IA in February 2021 in line with the IA Plan 2020/21 to establish whether the Health Board had adequate procedures in place to ensure, and monitor, effective utilisation of the standards to improve clinical quality and patient experience. IA awarded a 'substantial' assurance

rating and confirmed that the maturity of the embedded Health and Care Standards within the organisation's governance framework has resulted in information for each standard being reported through to the Board and fully adopted into day-to-day practices.

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. The outcomes of any such reviews and any emanating improvement plans are discussed with any lessons learnt shared throughout the Health Board.

As a result of the unfolding COVID-19 situation, HIW paused all inspection activity during the period April to August 2020 and piloted a new way of working during August to October 2020, which has continued throughout the remainder of the financial year. This enables them to deploy their resources in a more agile way, responding to specific risks and issues arising from COVID-19, whilst taking into account the revised operating models during the pandemic. The new approach uses a three tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as their primary method of gaining assurance. The tiered model for undertaking 'quality checks' is as follows:

- Tier 1 - activity is conducted entirely offsite via the use of Microsoft Teams to interview key staff and used for a number of purposes. All supporting documentation for the quality checks are submitted electronically in advance of interviewing staff;
- Tier 2 - a combination of offsite and limited onsite activity; and
- Tier 3 - traditional onsite inspection.

All HIW reports, including the improvement plans, are reported 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). The Committee is also informed of any immediate assurance letters received by the Health Board. In the absence of quarterly Executive Performance Management meetings, the Assurance and Risk Team have put in place a rolling programme to obtain progress from individual services on a bi-monthly basis. This means that services are providing updates on progress on a more frequent basis which has enabled subsequent formal approval of closure of reports from Executive Directors. This also includes an escalation process to the relevant Executive Director where no response is received from the service.

As a result of increasing community transmission and hospital admissions within NHS Wales, HIW paused routine 'quality checks' from 24 December 2020 to the end of January 2021, with inspections recommencing in February 2021.

During the year, HIW have undertaken 10 'quality checks' across acute sites, mental health sites and community services including those created in response to the COVID-19 pandemic, such as mass vaccination centres within the Health Board.

HIW have also published the results of the first phase of their National Review of Maternity Services, which the Health Board was invited to provide responses to in March 2021.

The quality checks undertaken by HIW focus on key areas including governance, infection prevention and control, and the environment. The key messages emanating from the quality checks were that, overall, the Health Board has responded well to the emerging pressures of the pandemic and is maintaining a good quality of care towards patients. The work also highlighted some issues requiring further action, and where areas of improvement had been identified, the Health Board has generally responded soundly, with improvement plans being completed and submitted in a timely manner, and updates provided to HIW within three months of the completed 'quality check' on progress made against recommendations raised. Further information on HIW activity including areas visited can be found Appendix 3.

Clinical Audit

On 19 March 2020, the Deputy Chief Medical Officer contacted Health Boards to advise that all clinical audit data collection would be suspended. WG arrived at this decision in consultation with the Healthcare Quality Improvement Partnership (HQIP) who run the national programme. The programme continues to be suspended at this time.

Although there was no mandated expectation to do so, the Health Board has tried to maintain as much participation as possible during this unprecedented time. The list below includes the projects being maintained (in varying ways) include:

- Major Trauma Audit;
- National Joint Registry;
- National Diabetes Foot Care audit;
- National Asthma and COPD audit programme;
- National Early Inflammatory Arthritis;
- National Audit of Inpatient Falls;
- National Hip Fracture database;
- National Heart Failure;
- Myocardial Infarction National Audit Project (MINAP);
- National Paediatric Diabetes; and
- National Cancer audits would still routinely collect data as part of a normal working pattern and this is likely to be true for other audits e.g. Stroke

Further work is currently being carried out to evaluate more accurately the participation levels over the last 12 months. This will be reported through the Annual Clinical Audit Report later this year.

Local clinical audit activity also fell sharply once preparations for COVID-19 began. Clinical Audit staff were preparing to finalise the 2019/20 programme and in the process of developing the 2020/21 programme, however these processes have not been completed due to the clinical teams slowing down or not undertaking audit activity due to the resulting pressures of COVID-19. The decision was made not to continue with preparations for the 2020/21 programme so as not to over burden

clinical services during this crisis. This decision was made in conjunction with the decision from WG to suspend audit activity.

Clearly the reduction in clinical audit activity will have an impact both for the Health Board, and on a national level. A significant number of audits have understandably not been undertaken during this time. The impact of this will be somewhat mitigated by the reduction in the number of patients and consequently insufficient patient samples for effective data collection. This will certainly apply to all elective admission based audits (e.g. National Joint Registry, Audiology, Cardiac Rhythm Management etc.).

Services will have been unable to demonstrate through audit their ability to meet standards of care. There will also be little or no improvement work being undertaken during this time. Whilst the focus of all clinical services will be on COVID-19, there will be insufficient data available or collected to inform these audits. The advice from WG is that the burden of retrospective data collection as well recovering from the outbreak would not be tenable.

The Clinical Audit Department (CAD) has recruited to the vacant posts within the department and is now almost at a full complement. Training of new staff has been challenging but the CAD is continuing to progress audit work for 2021. A new Clinical Director for Clinical Audit was appointed in February 2021. The new Director will work with the Clinical Audit Manager and the clinical teams to build a stronger clinical audit programme, as well as consider the processes and governance around clinical audit projects.

We have resumed our programme of Whole Hospital Audit Meetings (WHAM) for 2021 in line with pre-COVID plans with 4 dates agreed for 2021 to support shared learning through clinical audit.

The Health Board will continue to finalise the outcomes of the 2019/21 programme ready for reporting in August 2021. Development of the 2021/22 programme is also underway. The new programme will seek to focus on the recovery from COVID-19, reflecting audits that assess care during and after, provide evidence for effective new ways of working, service redesign or areas that have been identified as a risk during the pandemic.

ARAC continues to seek assurance on the clinical audit activity within the Health Board.

Mortality Reviews

Mortality is one of the indicators used to measure quality of care, however the dimensions of health service quality include safety, patient centred care, timeliness, equity, effectiveness and efficiency. Mortality information needs to be considered within this context and alongside other information about service quality including other outcome data, harm, patient satisfaction and experience information, access information and measures of end of life care, etc.

The Board receives a regular report as part of the IPAR on the mortality key indicators. The targets are:

- Mortality reviews should be undertaken within 28 days (stage 1 – Universal Mortality Reviews);
- 12 month improvement on:
  - Crude mortality rate for persons under 75 years old;
  - Deaths within 30 days of emergency admission for a heart attack (patients aged 35 to 74);
  - Deaths within 30 days of emergency admission for a stroke; and
  - Deaths within 30 days of emergency admission for a hip fracture.

Mortality information is regularly reported at Directorate and Board level and monthly returns are provided to the WG. The Mortality Review Group, a group of the Effective Clinical Practice Group, focuses on the actions required to improve Universal Mortality Review figures.

The Mortality Review Group has considered and reported the impact of COVID-19 in relation to both crude mortality measures and the impact on those patients waiting for an elective procedure. This report is available here - https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/quality-safety-and-experience-assurance-committee-qseac/qseac/quality-safety-and-experience-assurance-committee-meeting-2-february-2021/item-3-6-mortality-review-of-the-impact-of-patients-waiting-for-a/

The Medical Examiner Service is in the process of being introduced across Wales. Hosted by NWSSP, it will provide an independent scrutiny of all deaths that are not investigated by the coroner. Scrutiny will be undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

Clinical Executive's Quality Panels

Quality Panels are held by the clinical Executive Directors when a potential issue or concern is identified through triangulation of quality data including incidents, patient experience, and staff experience. For example a service may be asked to attend a panel to discuss a cluster of incidents. The purpose of the panel is to give the clinical Executive Directors an opportunity to discuss the issue with the service/directorate management team and to identify possible solutions or areas where support can be provided.

The meetings are scheduled six-weekly, or more frequently if required. The focus for the next meeting will be agreed with the clinical Executive Directors and will depend on what potential issues or concerns are arising.

Weekly "Hot and Happening" meetings are held with the clinical Executive Directors and representatives from quality assurance and safety to discuss any "hot" issues arising in the week prior to the meeting. The item to be discussed at the next Quality Panel may be identified at the weekly meeting.

The Impact of the Pandemic on Quality Governance Arrangements

In response to the pandemic, the Health Board ceased or restricted some quality governance arrangements either to reduce the risk to its staff or to allow for staff to be redeployed to provide support. For example, a decision was made to stop Board to Floor visits during the pandemic as it was considered that these visits posed a risk to the visiting Board Members as well as increasing the risk of transfer of COVID-19. A second example, the Quality Improvement Team were redeployed to the command centre to support management of the pandemic; therefore the Ensuring Quality Improvement Programme (EQIiP) was put on hold and there was also a reduction in Quality Improvement projects.

Governance, Leadership and Accountability (GLA)

The Health Board undertook a self-assessment to consider how it operated in accordance with the following criteria for the HCS for GLA Standard in 2020/21:

- Health Services demonstrate 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. The approach is through collaboration building on common purpose;
- Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models, and manage performance and value for money; and
- Health Services foster a culture of learning and self-awareness, and personal and professional integrity.

Further information can be found in the Board Effectiveness report to ARAC in May 2021. This report is agenda item 3.6 on the following webpage https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/audit-and-risk-assurance-committee-arac/arac/audit-and-risk-assurance-committee-meeting-5-may-2021/.

Corporate Governance Code

Whilst there is no requirement to comply with all elements of the Corporate Governance Code for Central Government Departments, an assessment was undertaken in March 2021 against the main principles as they relate to an NHS public sector organisation in Wales. This assessment was informed by the AW Structured Assessment 2020, the IA of 'Governance Arrangements during COVID-19' and its assessment against HCS 1 GLA Module (as noted on previous page). The Health Board is satisfied that it is complying with the main principles of, and is conducting its business in an open and transparent manner in line with, the Code. There were no reported/identified departures from the Corporate Governance Code during the year, other than those detailed on page 151.

Performance Reporting, Management and Improvements

With the exception of April 2020, when the Health Board temporarily paused performance reporting to committees to allow staff some additional time to focus on the pandemic response, performance continued to be reported monthly on its performance throughout 2020/21. The monthly performance report provides assurance on the most recent outturn position for key deliverable areas and gives an overview on the impact of COVID-19 pandemic, the risks being faced, and actions taken. The supporting report highlights where improvements are needed. The performance reports and supporting documents can be accessed: https://hduhb.nhs.wales/about-us/performance-targets/our-performance-areas/monitoring-our-performance/

Work started in February 2021 with the *Making Data Count* team from NHS Improvement to introduce statistical process control (SPC) charts in the performance report. Initial feedback from Board Members has been very supportive as SPC charts allow better focus on areas requiring improvement. Further information can be found in the Making Data Count section of the Performance Report.

As a result of the COVID-19 pandemic, many internal processes for assurance, performance management and financial turnaround were scaled down or suspended in March 2020. This included internal 'holding to account' meetings, regular executive team performance reviews of directorates and IA activity. In lieu of these processes, corporate teams established separate processes to monitor and highlight areas of poor performance such as:

- Weekly scrutiny of incidents by a central team, with concerns on themes and significant events escalated to the Head of Quality and Governance and/or relevant senior manager;
- Weekly reports to all Directorates detailing outstanding complaints, and escalated where required;
- Monthly reports on workforce matters such as sickness, mandatory training and staff appraisals to General Managers and county Directors;
- Monthly assurance and risk reports circulated to service leads; and
- Sharing the finance dashboard monthly with senior service leads, alongside frequent meeting to discuss value for money and efficiencies.

The Health Board has been working with an external organisation who aim to assist healthcare organisations move to a flow-based system-wide approach through better use of data. An advanced analyst training programme for staff commenced in March 2021 and will continue into 2021/22.

The Performance Team is in the process of developing a suite of performance dashboards in order to provide management at all level with reliable, user-friendly performance data in an easily accessible format using Power BI. The risk dashboard was published in December 2020 and is used across the Health Board. Dashboards for Workforce and Organisational Development, and Finance are nearing completion and will be published in early 2021/22.

A new 'Improving Together' framework has been developed which aims to empower staff to make improvements across all areas including performance, quality, workforce and finance.

Health and Safety

As part of a national programme of inspections for 2019/20, the Health and Safety Executive (HSE) attended Health Board between 2 and 11 July 2019 with the targeted intention of examining the management arrangements for violence and aggression, musculoskeletal disorders (MSDs) and asbestos in selected clinical and non-clinical areas. Whilst the HSE found some areas of good practice, they also found evidence of contraventions of health and safety law and subsequently issued 8 Improvement Notices and 13 other Material Breaches. These required the Health Board to take action to ensure that it is managing health and safety more effectively and complying with the law by 1 May 2020. The HSE have extended the compliance dates for outstanding work several times in light of COVID-19.

Work has continued to be undertaken to address the findings and the HSE have confirmed, following their follow up in January 2021 that 4 of the Improvement Notices have been fully complied with, and they recognised that progress had been made on all of them, as well as on many the other matters ('Material Breaches'). In recognition of the work completed thus far, with further work required on 4 remaining notices to achieve full compliance, the HSE have agreed further extensions of time for full compliance however are confident that the remaining work on Material Breaches will be completed by the Health Board without the need for HSE scrutiny.

Following the visit, the Health Board received 2 actions in a Material Breaches-Notification of Contravention letter regarding COVID-19 arrangements. Appropriate action in relation to these matters have been implemented. The Health Board also received 3 actions from a Material Breaches Notification of Contravention letter regarding shielding arrangements. Progress of work undertaken was reported to HSAC and the Health Board's SPF. Actions are in place to address the concerns raised.

In 2020/21, the new HSAC which reports directly to the Board, was constituted to demonstrate its commitment to improving health and safety for it patients, staff and visitors. This Committee has provided assurance to the Board on the work undertaken towards compliance with the HSE notices.

In March 2021, IA undertook a follow up review of health and safety which provided the Health Board with 'reasonable' assurance, demonstrating further improvement in this area.

Fire Safety

Mid and West Wales Fire and Rescue Service (MWWFRS) has issued the Health Board with 7 Fire Enforcement Notices (FENs) for:

- Withybush Hospital;
- St Caradogs;
- St Non's (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices);
- Llys Stephen;
- Tenby Cottage Hospital; and
- South Pembrokeshire Hospital.

The Health Board continues to work with MWWFRS to address the findings, with extensions for some works agreed due to COVID-19.

As of March 2021, the Health Board has 6 FENs and 3 Letters of Fire Safety Matters (LoFSMs) outstanding. The Health Board has regular meetings with MWWFRS in respect of the delivery programme which addresses the issues identified within the FENs and LoFSMs and continues to work closely with both MWWFRS and WG in communicating progress as the schemes develop.

Regular progress updates are also reported to the HSAC, which provides assurance to the Board on the work undertaken towards improving compliance. In March 2021, IA carried out an audit on the management of FENs which provided substantial assurance, which clearly demonstrates the progress that has been made during 2020/21.

OTHER CONTROL FRAMEWORK ELEMENTS

Counter Fraud

In line with the NHS Protect Fraud, Bribery and Corruption Standards for NHS Bodies (Wales), the Local Counter Fraud Specialist (LCFS) and Executive Director of Finance agreed at the beginning of the financial year a work plan for 2020/21 which was approved by the ARAC in April 2020. The workplan can be accessed via the following link - https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/audit-and-risk-assurance-committee-arac/arac/audit-and-risk-assurance-meeting-21-april-2020/item-9-2-counter-fraud-workplan/.

The work plan for 2020/21 was completed and covered all the requirements under WG directions. The Counter Fraud Service provided regular reports to the ARAC throughout 2020/21.

The NHS Counter Fraud Authority (formerly NHS Protect) provides national leadership for all NHS counter fraud, bribery and corruption work and is responsible for strategic and operational matters relating to it. A key part of this function is to quality assure the delivery of anti-fraud, bribery and corruption work with stakeholders to ensure that the highest standards are consistently applied.

The Board Secretary is the Health Board's Champion for counter fraud.

Post Payment Verification (PPV)

In accordance with the WG directions, the Post Payment Verification (PPV) Department role (which is undertaken for the Health Board by the NHS Wales Shared Services Partnership) is to review claims submitted by contractors in General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

Due to the COVID-19 Pandemic, WG Primary Care Chief Officers, in collaboration with associated Clinical Directors within the service, agreed that PPV processes would be stood down. This decision was taken to protect front-line services, to maintain colleagues' safety, and to remove any pressure on primary care contractors and their teams during unprecedented times. A review of opportunities and a recovery plan was considered during this time, to return with an acceptable level of PPV, which would continue to provide Health Boards with reasonable assurance that public monies are being appropriately claimed. PPV reinstatement was 1 October 2020, however in recognition of the ongoing pressures on the health service including primary care, WG and the General Practitioners Committee (GPC) extended the suspension (and the associated PPV) until the end of March 2021. This is inclusive of the payment provisions/guarantee that applied during that time.

A PPV Progress Report for the period 1 October 2020 to 31 January 2021 was presented to ARAC in February 2021, along with a report detailing the process for each of the 4 contractor services within Hywel Dda. The report can be accessed following link: https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/audit-and-risk-assurance-committee-arac/arac/audit-and-risk-assurance-committee-meeting-23-february-2021/item-3-3-post-payment-verification-ppv-report/

Equality, Diversity and Human Rights

The Health Board is committed to putting people at the centre of everything it does. The vision is to create an accessible and inclusive organisational culture and environment for everyone. This includes staff, those who receive care (including their families and carers), as well as partners who work with the organisation - whether this is statutory organisations, third sector partners or communities. This means thinking about people as individuals and taking a person centred approach, so that everyone is treated fairly, with integrity, dignity and respect, whatever their background and beliefs.

"... Making a difference...We have to see people in the context of their lives and ask them what matters to them so that people make decisions that are right for them." We have published our Strategic Equality Plan and Objectives 2020-2024, which sets out the intended direction of travel over the next 4 years to advance equality,

eliminate discrimination and foster good relations between those who share a protected characteristic and those who do not. The plan relates to the Health Board's role as an employer, as well as in the way in which it provide services to patients, families, carers and the wider population.

Through a values based approach, we aim to deliver services which are safe, sustainable and kind for all and to offer an inclusive and nurturing working environment for all staff. Within the suggested objectives, the words "culture", "inclusion" and "well-being" are used in their broadest terms to encompass considerations in relation to Welsh Language and socio-economic influences. The responsibility for implementing the plan and objectives falls to all employees. This includes Board Members, staff and volunteers, agents or contractors delivering services or undertaking work on behalf of the Health Board.

We recognise that creating a fair and inclusive environment often involves changing cultures, challenging long held practices and breaking down barriers, and we will work together to achieve its objectives and create a fairer, more equitable and inclusive environment for all.

Equality Objectives

Staff at all levels, including Board Members, actively promote and facilitate a culture of inclusion and wellbeing across the organisation. Working with the population, staff, stakeholders and partners, particularly those identified as having worse experiences, will shape the design and delivery of services. Staff will be suitably skilled and experienced to develop and deliver services that are informed by local needs, improve access and reduce inequalities.

We will offer equal opportunities for employment and career progression and support the health and well-being of its staff and volunteers within a fair and inclusive environment.

The work to progress the equality agenda is inter-linked with our work around the Well-being of Future Generations (Wales) Act 2015 (WFGA) and the Social Services and Wellbeing (Wales) Act 2014. For more information on the Strategic Equality Plan and objectives, visit https://hduhb.nhs.wales/about-us/governance-arrangements/equality-diversity-and-inclusion/equalities-accordion/strategic-equality-plan/.

Examples of key highlights for 2020/21 include:

- In response to evidence of the disproportionate impact of COVID-19 on BAME staff, the Health Board Chair established a BAME Advisory Group, demonstrating the Board level leadership and commitment to addressing inequalities. Actions have included an analysis to understand the demographic profile of our workforce, ensuring that the concerns and lived experiences of members are acted upon, supporting staff development, raising awareness of diversity and inclusion and establishing a BAME staff network and a group to focus on bullying and harassment;
- The Health Board has a diverse range of faiths and a richness of different cultures, and strives to create an inclusive environment where everyone can reach their full potential and have a real opportunity to participate in a variety

of activities throughout the year. As a small step towards celebrating and understanding each other more, to gain inspiration and strength from all our beliefs, the BAME Advisory Group produced a calendar celebrating diversity, which was distributed to all staff and volunteers;

- During the pandemic, online interpretation services were introduced across the organisation, to ensure that patients and carers had access to interpreters for unscheduled episodes of care when it was not possible for the interpreter to be in the same room, and for online consultations; and
- Undertaking 123 Equality Impact Assessments during 2020/21, including 7 associated with service change, 80 related to clinical policies (10 of which were associated with COVID-19) and 19 assessments of employment policies. We remain committed to conducting appropriate equality impact assessments, closely linked with our commitment towards continuous engagement.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments 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 Health Board confirms 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.

Social and Community issues

The Health Board is keen to do all it can to support the regeneration and growth of local communities and economy. This can be evidenced by the Board approved planning objectives. This will require a shift in focus and approach across a number of areas. We have been exploring a community wealth building model with its focus on enabling wealth to stay within a local community and be recirculated as much as possible building a firm foundation for regeneration.

Anchor institutions such as ours can exert sizable influence by using their commissioning and procurement processes, their workforce and employment capacity, and their assets such as facilities and land, to affect the economic, social, and environmental wellbeing of the localities they operate within.

We have been working with the Centre for Local Economic Strategies (CLES) and PSB partners to develop a community wealth building approach focussing on the foundation economy and food procurement.

Environmental

The Hywel Dda Green Health Network provides opportunities for staff across the Health Board to share ideas, project work and expertise in Green Health – working to benefit staff, patients, visitors and the natural living world. It was established in October 2018 and is open to any member of staff across the organisation.

The Network aims to:

- Create the opportunity for staff to find out more about what's going on in Green Health across the organisation;
- Facilitate bi-annual events where staff can showcase their projects, explore ideas, gain inspiration and share the learning;
- Provide support for Green Health projects to ensure viability and long term success; and
- Provide a forum for learning and development by bringing in external speakers on a range of Green Health related topics

The first Green Health Group in the Health Board was set up at Withybush Hospital in January 2019 as a way of developing specific projects on site. A second group was established at Glangwili Hospital, Carmarthen in early 2020 and a third at South Pembrokeshire Hospital during the summer of 2020.
The vision is that each site in the Health Board will have its own local Green Health Group to undertake green space improvements and engagement activities on that site. A Green Health event was held across the Health Board on 5 March 2021 to share good practice. The development of Green Health, which is championed by the Chair of the Health Board, is aligned to our staff wellbeing and rest and recovery initiative.

There is a commitment from the Executive Team to develop a Green Health Strategy that would link with the Health Board's commitments around the Wellbeing of Future Generations Act as well as its strategic objectives. We are working with colleagues from other NHS organisations across the UK, to learn from their experience of developing Green Health Strategic Frameworks.

Environment, Sustainability and Carbon Reduction

The Health Board has continued to drive performance in key areas over the last year including energy and carbon performance despite the impact from the COVID-19 pandemic. Improved performance has been attained through achievement of the Environmental Standard ISO14001, delivery of a number of energy efficiency projects, robust data reporting, increased agile working, reuse and recycling schemes. NHS Wales has recently published an all Wales Decarbonisation Strategy with targets for all Health Boards to reach at various points by 2030. The aim of this strategy is for the Welsh NHS to contribute towards a carbon neutral position by 2030. In response to the publication of the 'All Wales NHS Decarbonisation Strategy', we are in the process of developing our own Decarbonisation Strategy which will focus upon how the Health Board can reduce its carbon footprint at a local level in a number of key areas including but not limited to buildings, transport and procurement. Delivery and action plans will be developed over the coming months which will map out how we will meet the NHS Wales decarbonisation targets.

From a climate change view point, we recognise the impact of climate change in the work we do around severe weather planning and highlight this within the Dyfed Powys LRF Severe Weather Arrangements. These arrangements cover 4 elements: flooding, severe winter weather, heatwave and drought. The arrangements cover elements such as risk, alerting mechanisms, multi-agency command & control structures, warning and informing and training/exercising.

The Health Board has a well-established Major Incident Plan that 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 other associated emergency plans, details 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 Health Board 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 Health Bodies, including PHW, we are part of 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.

Information Governance (IG)

The Health Board has well established arrangements through its information governance framework to ensure that information is managed in line with relevant information governance law, regulations and Information Commissioner's Office (ICO) guidance. The framework includes the following:

- An Information Governance Sub Committee (IGSC), whose role is to support and drive the broad information governance (IG) agenda and provide the Health Board with the assurance that effective IG best practice mechanisms are in place within the organisation;
- A Caldicott Guardian who is the responsible person for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing;
- A Senior Information Risk Owner (SIRO) is responsible for setting up an accountability framework within the organisations to achieve a consistent and comprehensive approach to information risk assessment;
- A Data Protection Officer (DPO) whose role it is to ensure the Health Board is compliant with data protection legislation; and
- Information Asset Owners (IAOs) are in place for all service areas and information assets held by the Health Board and a programme of compiling a full asset register for the Health Board is underway and due to be completed by in 2021. Unfortunately, the programme of work has been paused during the COVID-19 pandemic.

We have responsibilities in relation to freedom of information, data protection, subject access requests and the appropriate processing and sharing of personal identifiable information.

Assurances that the Health Board has compliant information governance practices are evidenced by:

- Quarterly reports to the IGSC, including key performance indicators;
- A detailed operational General Data Protection Regulations (GDPR) work plan, taken to IGSC bi-monthly, detailing progress made against actions required to ensure compliance with data protection legislation;
- A suite of IG and information security policies, procedures and guidance documents;
- IG Intranet pages for our employees with guidance and awareness;
- A comprehensive bi-annual mandatory IG training programme for all staff, including proactive targeting of any staff non-compliant with their IG training;
- A robust management of all reported IG breaches, including proactive reporting to the ICO;
- Regular monitoring of the our systems for inappropriate accesses to patients' personal data through the National Intelligent Integrated Audit Solution (NIIAS) platform;
- An Information Asset Register (IAR) used to manage information across the organisation; and
- The IGSC Chair's assurance report taken to a sub-committee of and to the Board following all IGSC's meetings.

The NIIAS that audits staff access to patient records has been fully implemented within the organisation, with an associated training programme for staff, and procedures for managing any inappropriate access to records. In addition to the above training, there are regular staff communications, group training sessions, as well as IG 'drop in' sessions held across the Health Board. Posters, leaflets, 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.

We are in the process of undertaking a full review of our position against the Caldicott Principles into Practice Assessment (CPIP) and Welsh IG Toolkit. It is anticipated these assessments will demonstrate a good level of assurance of information governance risks, as in the previous year.

Data Security

The Health Board has adopted and implemented a robust procedure for managing IG incidents across the organisation that ensures incidents are reported in line with statutory requirements and lessons are learnt to improve future practice. We have had contact with the ICO in relation to 2 incidents during the year. Both incidents involved health records accessed by an unauthorised individual. The investigations related to these incidents are on-going.

In line with the revised 2020/2021 IA Plan for the Health Board, a review of the local Implications of COVID-19 on the information governance function was undertaken which resulted in a 'substantial' assurance rating. NHS Wales organisations, including the Health Board, have had to work quickly and flexibly under extraordinary pressure to meet the needs of its workforce and the public. The scale of co-ordination and data management required for effectively implementing strategic

plans to deal with the situation has relied on adopting digital technology and integrating it within the Health Board. Digital health technology has facilitated responses to the pandemic in ways that are difficult to achieve manually, however we have ensured that essential controls are maintained or quickly established to mitigate issues information governance related risks.

To ensure that information governance risks were managed during the COVID-19 pandemic, NWSSP undertook an audit on the effectiveness of the system of internal control in place to manage the risks associated with implications of COVID-19 on information governance which gained a substantial assurance. The review of implications of COVID-19 on information governance highlighted the significant and positive work undertaken by our IG team during extremely challenging times.

Ministerial Directions

The WG has issued a number of Non-Statutory Instruments during 2020/21. Details of these and a record of any Ministerial Direction given is available on the following link: https://gov.wales/publications.

A schedule of the Directions, outlining the actions required and the Health Board'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 Health Board was not impeded by any significant issues in implementing the actions required as has been the situation in previous years. All of the Directions issued have been fully considered by the Finance Committee, on behalf of the Board, and where appropriate implemented (See Appendix 4).

In respect of the Ministerial Direction issued in December 2019 regarding the NHS Pension Tax Proposal 2019 to 2020, we have made all reasonable endeavours to comply with the Direction. Further guidance was issued from WG in February 2021 and the Health Board is aware of 1 individual that has elected onto the 'Scheme Pays Scheme'. The Scheme opens in April 2021 and applies to the year 2019/2020 only.

Welsh Health Circulars (WHCs)

Welsh Health Circulars (WHCs) are published by the WG to provide a streamlined, transparent and traceable method of communication between NHS Wales and NHS organisations. WHCs relate to different areas such as policy, performance and delivery, planning, legislation, workforce, finance, quality and safety, governance, information technology, science, research, public health and letters to health professionals.

Following receipt, these are assigned to a lead Director who is responsible for the implementation of required actions. The Board has designated oversight of this process to Board level Committees, with an end of year report provided to the ARAC.

Audits, Inspections and Reviews

Audits, inspections 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, both internal and external, and inspections, are implemented in a timely way.

The levels of audit, inspectorate and regulatory activity has fluctuated through the year as these bodies recognised the unprecedented pressures in which we, and the whole of the NHS, were working. We appreciate their efforts in balancing their statutory obligations with their support as we responded to the first and second waves of the pandemic. During the year, the Health Board has sought to strengthen its relationships by having more frequent discussions and agreeing ways of continuing or adapting audit and inspection activity through the year. The Board Secretary has had weekly meetings with auditors to discuss and adapt the internal and external audit programme. The Executive Director of Nursing, Quality and Patient Experience has had regular relationship meetings with HIW and meetings with the HSE in respect of the current Improvement Notices. Regular meetings have also taken place with MWWFRS in respect of our progress in addressing the issued FENs.

We have a robust process in place to track the implementation of all recommendations made from external audits, inspections and reviews, and holding officers to account where outstanding recommendations remain. A strategic log is in place for where the Health Board does not currently have the resources to implement recommendations. These recommendations are logged and agreed by the Executive Team to take forward and implement via its strategic and capital plans.

The Board agreed in April 2020, that as a minimum during the pandemic, the following recommendations must be progressed, as planned or in line with revised timescales:

- Immediate improvement recommendations (pre-COVID-19) from HIW and recommendations from their current programme of quality checks;
- Enforcement notices from the MWWFRS;
- Improvement Notices and material breaches from HSE; and
- High priority recommendations from IA and AW.

Services and Directorates remained accountable for addressing gaps identified in audits and inspections, and were required to assess this responsibility alongside other operational work and pressures, and continued to receive a bi-monthly assurance and risk reports which detail outstanding recommendations and requests for progress made against these. This paper is Item 3.3 in the April 2020 Board Papers, available via the following link: http://www.wales.nhs.uk/sitesplus/documents/862/Item%203.3%20Management%20of%20Outstanding%20Recommendations%20from%20Auditors%2C%20Inspectorates%20and%20Regulators.pdf. Updates have been provided through the year in the 'Maintaining Good Governance' Reports to Board.

It has been a challenging year and the pace of addressing recommendations has understandably slowed as a result of COVID-19 and non-COVID-19 operational

pressures. At the February 2021 ARAC meeting, it was reported that there were 117 open reports, with 153 recommendations exceeding their original implementation date. Whilst ARAC continued to oversee the Health Board's progress against outstanding recommendations from auditors, inspectorates and regulators, they relaxed their programme of targeted scrutiny in recognition of the pressures being experienced by services. Whilst cognisant of the demands on services, ARAC did report their concerns on the growing number of late and non-delivery of recommendations to the Board in November 2020. This resulted an Executive-led review of recommendations that had not been implemented within agreed timescales. This work was supported by both internal and external auditors and has resulted in a significant number of recommendations being implemented or closed as they were no longer relevant due to how the organisation has changed during the pandemic. A prioritised plan has been developed with revised timescales for the remaining 84 recommendations.

Field Hospital Due Diligence Review

In order to ensure sufficient available capacity to meet the reasonable worst case scenario during the COVID-19 pandemic, all Health Boards were asked to develop additional 'field hospital' capacity outside of the existing estate. This capacity was developed at pace to meet the anticipated demand based on the modelling at the time. Over the summer months, WG commissioned a due diligence review of each organisation's arrangements focusing on governance, significant contracts and the reasonableness of financial cost estimates. This enabled WG to work with the Health Board to address residual risks and share lessons learned in financial governance, planning and contracts under the exceptional circumstances created in the response to COVID. Whilst some examples of good practice governance arrangements were noted, a number of risks were also identified which have since been addressed by the Health Board.

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

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

The Board and Committees rely on a number of sources of internal and external assurances which demonstrate the effectiveness of the Health Board's system of internal control, and advise where there are areas of improvement. These include the following:

Internal Sources of Assurance	External Sources of Assurance
✓ Internal audit ✓ Key performance indicators ✓ Performance reports ✓ Sub-Committee reports ✓ Compliance audit reports ✓ Local counter fraud work ✓ Clinical audit ✓ Staff satisfaction surveys ✓ Staff appraisals ✓ Training records ✓ Training evaluation reports ✓ Results of internal investigations ✓ Serious untoward incident reports ✓ Complaints records ✓ Infection control reports ✓ Information governance toolkit self-assessment ✓ Patient advice and liaison services reports ✓ Workforce and Organisational Development ✓ Patient experience surveys and reports ✓ Internal benchmarking ✓ Board Members Walkarounds	✓ External audit (AW) ✓ Healthcare Inspectorate Wales (HIW) ✓ Royal College visits ✓ Deanery visits ✓ External benchmarking and statistics ✓ Accreditation schemes ✓ National and regional audits ✓ Peer reviews ✓ Feedback from service users ✓ Local networks (for example, cancer networks) ✓ Investors in People and other team development tools ✓ Feedback from healthcare and third sector partners ✓ Community Health Councils (CHC)

The processes in place to maintain and review the effectiveness of the system of internal control include:

- Board and Committee oversight of internal and external sources of assurance and holding to account of Executive Directors and Senior Management;
- Executive Directors and Senior Management who have the responsibility for development, implementation and maintenance of the internal control framework and for continually improving effectiveness within the organisation;
- The review and oversight of principal risks on the CRR and the BAF by the Board and Committees;
- The oversight of operational risks through the Board and Committee;
- Oversight of risks by specialist risk functions such as Counter Fraud, Health and Safety, and other corporate functions;
- The monitoring of the implementation of recommendations, overseen by the ARAC; and
- ARAC oversight of audit, risk management and assurance arrangements.

I am satisfied that generally the mechanisms in place to assess the effectiveness of the system of internal control are working well and that the Health Board has the right balance between the level of assurance I receive from my Executives, Board and Board Committee arrangements and Internal Audit Services. However, a number of areas where improvement is needed have been highlighted by AW and IA. These areas will continue to be addressed through 2021/22, as far as reasonably practicable as the Health Board continues to manage the pandemic and its recovery, with the implementation overseen by the ARAC. Some areas of improvement will be addressed over the medium to long term through delivery of the Health Board's Strategy, with risks being mitigated as far as reasonably practicable in the meantime.

The Health Board has received positive feedback from both AW Structured Assessment 2020 and the Internal Audit reviews which both considered the Health Board's governance arrangements during the COVID-19 pandemic. However due to operational pressures, it has not been possible for the normal level of audit activity within operational services due to significant levels of COVID and non-COVID activity throughout the year. The aim is to return to a more balanced audit programme in 2021/22.

Internal Audit (IA)

IA provide me as Accountable Officer, and the Board through ARAC, with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NWSSP. The scope of this work is agreed with the ARAC and is focussed on significant risk areas and local improvement priorities.

Throughout 2020/21, the Head of Internal Audit has met weekly with the Board Secretary and Director of Finance to discuss and consider any changes to the Internal Audit plan, either to accommodate fluctuations in operational demand or to support the Health Board in testing how it has responded to the pandemic, for example, the mass vaccination programme and the Information Technology Response to COVID-19.

The ARAC has received progress reports against delivery of the NWSSP Audit and Assurance 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'.

During 2020/21, Executive Directors or other Officers of the Health Board have been requested to attend in order to be held to account and to provide assurance that remedial action is being taken to address the findings within the IA reports. 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 its drive for continuous improvement.

The programme has been impacted by the need to respond to the COVID-19 pandemic with some audits deferred, cancelled or curtailed as the organisation responded to the pandemic. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

Head of Internal Audit Opinion

As a result of the considerable impact of the pandemic, the IA programme has been subject to significant change during the year, to ensure that key developing risks are covered. Although changes have been made to the plan during the year, IA have undertaken sufficient audit work during the year to be able to provide an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

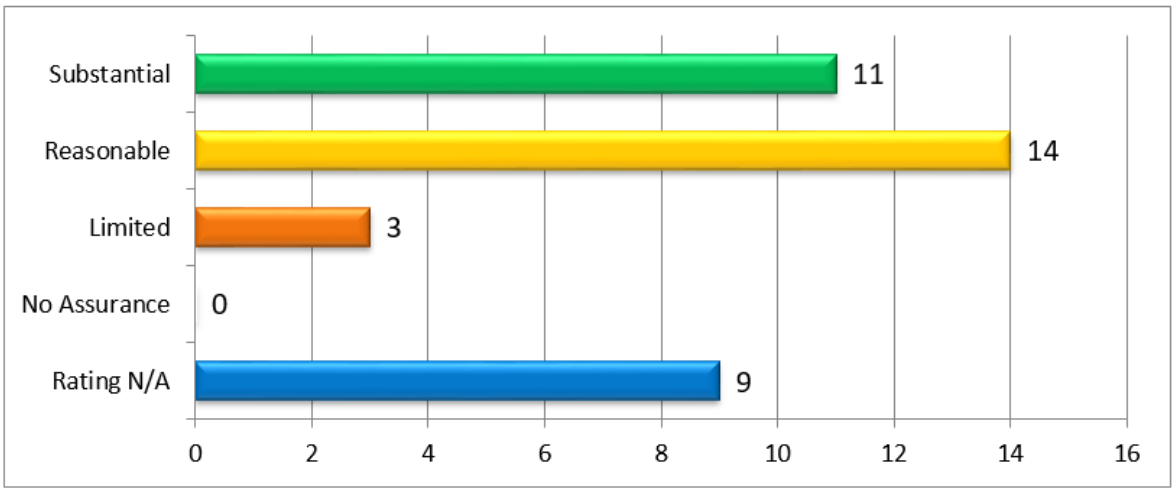
The Internal Audit Plan for 2020/21 year was initially presented to the ARAC in April 2020, however as a result of the impact of the pandemic a revised version of the plan was prepared, with this version receiving approval at the Committee in June 2020. The below opinion is primarily based on the delivery of the June 2020 IA plan, and includes subsequent changes to the plan that have been reported to ARAC at every meeting.

The Head of Internal Audit has concluded for 2020/21:

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

In reaching this opinion, IA identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas. From the reports issued during the year, 11 were allocated Substantial Assurance, 14 were allocated Reasonable Assurance and 3 were allocated Limited Assurance. No reports were allocated no assurance. In addition, 9 Advisory and Non opinion reports were also issued.

The 37 audit reviews reported during the 2020/21 are outlined below:



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.

Whilst there were no audited areas that resulted in 'no assurance', the following audit reports were issued with a conclusion of limited assurance. These areas have been included on Internal Audit Plan for 2021/22:

Report Title	Objectives	Issues leading conclusion	Actions
Partnership Governance	The overall objective of this audit was to confirm that the appropriate arrangements and management of allocated integrated care funds in line with national legislation.	4 high priority findings were identified in regard of lack of clear approval of proposed projects, breaches of WG submissions deadlines (including the lack of an audit trail), lack of regular detailed impact outcome updates from project owners, and whether the level of information and scrutiny discussed at the RPB provides sufficient assurance that projects are on target in terms of delivery and financially. 4 medium priority findings with regards to missing project information on the RIP and proposal forms, no formal approval of the rolled over Written Agreement for 2019/20 and the continued lack of a finance representative at the local ICF Panel meetings.	A management response was developed and this was presented to the IEG of the RPB. The IEG will further strengthen governance arrangements in 2021/22.
Records Management Follow up	The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.	Out of the 10 recommendations from the previous report, 4 recommendations had been fully implemented. However, due to the impact of COVID-19 the progress on 5 management actions have only been partially addressed, with 1 management actions not addressed to date.	The Health Board acknowledges that this area requires an in-depth and detailed review of the organisational strategic approach for records management including plans for improvement and modernisation.

			This has been included in the 2021/22 IA Plan.
Women and Children's Capital Scheme	The audit was undertaken to evaluate the processes and procedures established to support the management and control of the Women and Children's project (Phase 2) at Glangwili Hospital.	Whilst recommendations have been made to improve systems of control and/or compliance, generally this was positively assessed. However, the project has suffered from poor delivery performance, notably time delays and is significantly outside its key delivery parameters, as reflected in the Health Board's own 'Red' assessment of project risk/ performance.	A management response has been developed in response to the 13 new recommendations within the report. The Health Board is currently reviewing its capital governance arrangements.

Management responses that detail the actions to address gaps in control were included in all final IA reports presented to ARAC. The delivery of these actions is tracked via the Health Board's audit tracker which is overseen by the ARAC. The minutes and all final IA reports can be found within the ARAC section of the website https://hduhb.nhs.wales/about-us/governance-arrangements/statutory-committees/audit-and-risk-assurance-committee-arac/.

Where audit assignments planned this year did not proceed to full audits following preliminary planning work, these were either removed from the plan, removed from the plan and replaced with another audit, or deferred until a future audit year. Subsequent to the approval of the updated plan in June 2020, the following audits were deferred.

Review Title	Reason
IT Infrastructure	Replaced by an audit of Data Modelling.
Job plan following up	Deferred due to the impact of the pandemic on the job planning process.
Transformation steering group	Deferred due to operational pressure as a result of the pandemic.
Operational response to COVID-19	Deferred due operational pressure as a result of the pandemic.
Field hospitals x 3	An external review was commissioned by WG.
Outpatients	Deferred due operational pressure as a result of the pandemic.
Annual Quality Statement	Requirements changed for 2020/21.

Audit Wales (AW) Structured Assessment

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. AW undertakes the External Auditor role for the Health Board on behalf of the Auditor General. AW is responsible for scrutinising the Health Board's financial systems and processes, performance management, key risk areas and the IA function. AW undertake financial and performance audit work specific to the Health Board, with all individual audit reviews being considered by the ARAC with additional assurances sought from Executive Directors and Senior Managers as appropriate. AW also provides information on the Auditor General's programme of national value for money examinations which impact on the Health Board, with best practice being shared.

The Structured Assessment work took place at a time when NHS bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Therefore, AW designed this work in the context of the ongoing response to the pandemic to ensure a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they respond to the COVID-19 pandemic. The key focus of the work was on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations where these related to important aspects of organisational governance and financial management especially in the current circumstances.

Overall, AW found that the Health Board has maintained good governance throughout the COVID-19 pandemic and had developed its operational plans in line with the WG guidance. Innovation and learning had been embedded throughout the revised governance arrangements to enable recovery and the acceleration of its strategic vision, however operational and structural pressures continue to present challenges for the financial position which would only be addressed by delivery of the strategic vision. No new recommendations were issued. The full report can be accessed in the Board papers via the following link:https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-24th-september-2020/24-september-2020-documents/item-2-8-audit-wales-structured-assessment-2020/.

The work undertaken as part of Structured Assessment contributed towards the AW Annual Audit Report 2020. The key findings and conclusions emanating from both the assessment and the report are summarised as follows:

- An unqualified opinion was issued on the accuracy and proper preparation of the 2019/20 financial statements of the Health Board; however due to the Health Board not achieving a financial balance for the three year period ending 31 March 2020, a qualified audit opinion on the regularity of the financial transactions was given within the 2019/20 financial statements. This was accompanied with a substantive report alongside this opinion to highlight the Health Board's failure to meet its statutory financial duties and its failure to have an approved three-year plan in place;
- An Emphasis of Matter paragraph was placed in the report to draw attention to disclosures in the accounts relating to Note 21 of the financial statements,

which describes the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund NHS Clinicians' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year;
- The Health Board maintained good governance throughout the COVID-19 pandemic;
- the Health Board continues to face financial challenges, exacerbated by the impact of COVID-19 but has maintained effective financial controls, monitoring and reporting;
- Operational plans are informed by strengthened data modelling, and a commitment to stakeholder engagement, regional solutions and staff well-being, with clear arrangements for monitoring performance and delivery. However, another peak in COVID-19 poses a significant risk to workforce arrangements; and
- The Health Board demonstrated a strong commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

The full report can be accessed on the following link: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-28th-january-2021/28th-january-2021-documents/item-2-6-2-audit-wales-annual-audit-report-2020/.

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement plan which routinely assesses the quality of our data across key clinical systems.

Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits. In 2019/2020, AW undertook a follow-up review on recommendations previously made in respect of clinical coding. All recommendations relating to the clinical coding teams have been progressed and actioned.

During 2020/2021, we have further strengthened the clinical coding department with the appointment of 4 additional clinical coders, and the full benefit of the additional staff will start to be recognised in 2021/2022. COVID-19 has had a significant impact across the NHS and the clinical coding team were also impacted, resulting in a reduced service. Under a recovery plan, work streams have been developed to make better use of clinically coded data via several dashboards for operational teams and clinical leads. This ties in as part of the clinical coding development plan that looks to re-establish the clinical coding service as a key enabler across the Health Board.

CONCLUSION

It is now just over a year since the country went into its first national lockdown. The terms ‘unprecedented’ and ‘challenging’ have been frequently used during the last year to describe how it has felt. For many, it has been a sad and distressing one, as the Health Board count the physical and emotional cost. Within the Hywel Dda community, 476 people have lost their lives to COVID-19 at the time of writing (these are patients in hospitals or care home residents where COVID-19 has been confirmed with a positive laboratory test and the clinician suspects this was a causative factor in the death. Actual deaths of local people with COVID-19 will be higher). Many others are still struggling with the direct and indirect consequences of the virus. However, as a leader, I have also been inspired, humbled and in awe of the compassion, commitment and innovation shown by our workforce, and I would firstly like to express my, and the Board’s gratitude to them, for keeping the organisation, patients and the wider community safe during 2020/21.

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 2020/21. The Board and its Executive Directors are fully accountable in respect of the system of internal control. During the year, we have identified emerging areas of work relating to our response to the pandemic, such as the Mass Vaccination Programme, which have been reviewed by IA to provide assurance that we are managing and mitigating the associated risks. In addition to this work, IA have also undertaken 2 advisory reviews of our governance arrangements during the pandemic, these have been positive with the Health Board taking forward any opportunities for develop and learn.

We have also received extremely positive feedback from AW on our corporate arrangements for ensuring that resources are used efficiently, effectively and economically during the pandemic. AW found that the Health Board developed its operational plans in line with the WG guidance, and also worked within revised frameworks to discharge Board duties and maintain good governance throughout the COVID-19 pandemic. Adapting quickly to virtual meetings, the Board continued to conduct its business in an open and transparent way with revised governance arrangements which supported rapid decision making and effective scrutiny, with a focus on learning and improvement embedded. Systems of assurance were maintained, with a strong focus on the quality and safety of services. This was also supported by the reviews undertaken by IA on the Health Board’s governance and operating arrangements during the pandemic which provided reasonable and substantial assurances. These included the reviews into the Governance Arrangements during the COVID-19 Pandemic, the Information Technology in Response to COVID, the Agility to Flex Workforce to COVID Planning, the Mass Vaccination Programme and Quality and Safety Governance.

I, and the Board, were pleased with the recognition from WG on the Health Board’s professional and considered response to the COVID-19 pandemic, as well as our continued good performance prior to the pandemic, and their decision to reduce our escalation status from ‘targeted intervention’ to ‘enhanced monitoring’. To move into ‘routine monitoring’ arrangements with WG, we need to focus on our future financial plans, which will be dependent on delivering our clinical strategy. We should be proud of our achievements in recent years, these have provided solid foundations

which have enabled us to be innovative and leaders in NHS Wales in a number of areas during the pandemic. For example, the degree of change implemented across the organisation has been remarkable, new ways of working were introduced within days and weeks which would have taken months and years prior to the pandemic. The Health Board was the first to establish Coronavirus Testing Units, the first to develop specifications for field hospital design, and the first to re-establish live-streaming public board meetings. In addition to this, we developed an escalation tool, regarded as best practice for adoption across Wales, for the support and management of the care home sector during the COVID-19 pandemic period.

Whilst 2020/21 has been challenging, the learning that has been embedded throughout the revised governance arrangements has enabled us to emerge stronger with a focus on recovery and the acceleration of the delivery of its strategic vision. Between the first and second wave, we reflected, took stock and learnt that some of our long term ambitions, articulated in our strategy, '*A Healthier Mid and West Wales'*, had already been partly delivered through necessity: for example, a shift towards delivering some services virtually, through digital platforms, which could have a positive impact on productivity and decrease our carbon footprint by reducing the need for patients to travel. Some of our ambitions to transform our hospitals and patient pathways also seemed more achievable having seen how pathways were transformed in a matter of days during the first wave of the pandemic.

To accelerate the Health Board out of the pandemic, the Board now has a refreshed set of strategic objectives that set out the aims of the organisation – the horizon it is driving towards over the long term – as well as a set of specific, measurable planning objectives, which moves the organisation towards that horizon over the next three years. The Annual Recovery Plan for 2021/22 should be understood within the wider context of this refreshed set of strategic objectives and planning objectives - however the focus of this plan, first and foremost, is how we recover from the pandemic, how we support staff to recover after what has been an exhausting year, and how we lay the foundations to recover our services and support our communities. We have started to develop our revised BAF, which is made up of 2 elements – measures of progress, and the principal risks that could slow or prevent that progress.

Whilst we did not achieve our financial duty of breakeven for the 3 years to 31 March 2021, the Health Board did operate within its capital resource for the 3 years to 31 March 2021. More detail is provided in the financial statements. Therefore the Health Board did not have an approved IMTP at the start of the 2020/21 financial year, although we did approve and submit a Three Year Plan for 2020/23, which incorporated the Annual Plan for 2020/21 (developed prior to the pandemic). However in March 2020, WG took the unprecedented decision to pause the IMTP and annual plan process to enable NHS Wales organisations to focus their attention on the immediate planning and preparations to deal with the pandemic. During 2020/21, we developed quarterly operational plans in line with the NHS Wales Operating Framework.

Despite the increased operational pressures, we managed to undertake a great deal of work to address both the Improvement Notices and Material Breaches issued by the HSE and the FENs issued by the MWWFRS. The new HSAC has provided the

additional rigour required to improve compliance, and the Health Board has developed improved relationships with its regulators through regular meetings.

As indicated throughout this statement and the Annual Report, the need to plan and respond to the COVID-19 pandemic has had a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition the risks. The need to respond and recover from the pandemic will be with the organisation and wider society throughout 2020/21 and beyond. I will ensure the Governance Framework considers and responds to this need.

As a result of the governance structures established at the start of the pandemic, the continuation of the Board and its Committees, and continued work of Executive Directors and Independent Members, I am confident that the Health Board's systems of internal control have not been materially affected and am assured that there have been no significant internal control or governance issues during the time of the pandemic.

In summary, my review confirms that the Board has sound systems of internal control in place to support the delivery of policy aims and objectives and that there are no significant internal control or governance issues to report for 2020/21.

Signed by: **Date:**

Steve Moore
Chief Executive Officer

Appendix 1 – Advisory Group Activity

SRG

The SRG has brought the following matters, risks and issues to the attention and to be dealt with by the Board during the year:

- Recommend a review of the SRG agenda and workplan as a result of COVID-19 and the link to the Transformation Discovery Strategy;
- Recommend consideration of a wider public services partnership approach to developing a Children and Young People charter;
- Link the SRG to the EngagementHQ platform; and
- The increase in mental health problems among young people during the pandemic, recognising it has been a challenge to engage with Young Adult Carers. Virtual contact cannot replace physical contact, and this has contributed to mental health problems in young people.

SPF

Any matters, risks or issues for the attention of the Board during the year were included in the COVID-19 Report to Board.

HPF

The HPF has brought the following matters, risks and issues to the attention and to be dealt with by the Board during the year:

- Primary care members reported instances of patients returning to primary care, having been referred to secondary care, with HPF querying the capacity required to address the backlogs created. HPF was satisfied to hear that the COVID-19 outbreak had been a situation where all parties have had to learn and rethink many established systems and pathways which had resulted in instances of unintended circumstances occurring. Work continued to identify and address the capacity and backlog; and
- Patients' digital solutions had not always allowed for virtual consultations, meaning that this model did not suit all circumstances. HPF was satisfied that this challenge was understood, and that alternative access would be necessary for these patients.

BAME Advisory Group

Since its establishment in July 2020, the BAME Advisory Group has begun work to mainstream equality, diversity and inclusion by:

- Inviting all staff who have identified as BAME to participate in a wider BAME network to offer views, lived experiences and feedback to inform decision making by the BAME Advisory Group, for example, the development of a Charter to be launched in 2021;
- Establishing mentors for newly recruited staff; developing training opportunities;
- Signing off a Faith and Diversity Calendar which celebrates the diversity of the workforce promoting key dates and celebrations throughout the year. This will be gifted to all staff in December 2020;

- Progressing the development of an “active bystander” video to challenge unconscious bias;
- Offering feedback to inform the development of BAME Outreach workers to support the Test, Trace, Protect (TTP) programme which is being undertaken, led by the Director of Public Health through the Regional TTP Oversight Group, in collaboration with local authority partners;
- Progressing the development of a charter for Specialty and Associate Specialist (SAS) doctors and the establishment of a reverse mentoring scheme for Board members who will become “mentees” mentored by BAME staff;
- Establishing a task and finish group to consider the effectiveness of bullying and harassment policies for BAME staff following the Ministerial Statement on NHS anti-bullying policies;
- Inviting the Board and leaders to attend the Race in the Workplace event on 7 December 2020;
- Considering the data currently available on the Electronic Service Record (ESR) to inform future action. The number of staff who have not recorded their ethnicity is reducing; and
- Circulating a questionnaire to the BAME Staff Network regarding the COVID-19 vaccine and suggestions to encourage uptake.

Appendix 2 – Principal Risks closed/de-escalated during 2020/21

Below are the Principal Risks managed in 2020/21 and were closed or de-escalated from the Board Assurance Framework/Corporate Risk Register:

Risk 44 - Ability to manage patients awaiting follow up	Closed

Following discussions with the Scheduled Care Directorate Senior Management Team, this risk would be replaced by a different risk in relation to outpatient management when plans have been developed.

Risk 245 - Inadequate facilities to store patient records and investment in electronic solution for sustainable solution	Extreme (20)

Whilst records storage remains a significant risk, the planned work will continue, however the Director of Operations de-escalated the risk to Directorate level during COVID-19.

Risk 295 - Inability to maintain routine and emergency services in the event of a severe pandemic influenza event	Closed

Under the current circumstances, this risk was closed by the Director of Public Health. This risk has been superseded by COVID-19 as the Health Board is currently operating in a pandemic, although it is noted that the pandemic is a coronavirus rather than influenza. The risk of a pandemic event will need to be assessed when learning from this emerges.

Risk 730 - Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20	Closed

This risk was closed as it related to 2019/20 Turnaround Programme. A new risk relating to the delivery of the 2020/21 Financial Plan was assessed (Risk 856 which has subsequently closed) which incorporated delivery of savings plans as part of the risk statement.

Risk 735 - Ability to deliver the Financial Plan for 2019/20 affecting the whole Health Board	Closed

This risk was closed as it related to 2019/20 financial plan. A new risk relating to the delivery of the 2020/21 Financial Plan has been assessed (Risk 856 which has subsequently closed).

Risk 627 - Ability to implement the Health Board Digital Strategy within current resources to support the Health Board's long term strategy	Moderate (6)

This risk was de-escalated to reflect the additional funding provided by the Health Board to support taking forward the digital plan and ensuring that the fundamentals of cyber security and a robust infrastructure are maintained.

Risk 733 - Failure to meet its statutory duties under Additional Learning Needs and Education Tribunal Act (Wales) 2018 by September 2021	High (12)

This risk was de-escalated to Directorate level following work that had been undertaken.

Risk 91 - Insufficient number of Consultant Cellular Pathologists to meet 14 day timescale set out in the new Single Cancer Pathway	High (12)

The Executive Team agreed to de-escalate this risk to Directorate level as this was only one of the factors that made delivering the Single Cancer Pathway challenging notwithstanding COVID-19. In addition, the Health Board was not being performance managed during COVID-19. This would be discussed as part of the wider risks of delivering essential services in Quarters 3 and 4.

Risk 686 - Delivering the Transforming Mental Health (TMH) Programme by 2023	High (8)

The Executive Team agreed to de-escalate this risk as the Business Case for capital funding has been submitted to WG and was awaiting a decision. The Directorate managed to make a number of services changes during COVID-19 in line with (TMH) Programme. If the Business Case is not supported, the Health Board will need to review the TMH programme.

Risk 632 - Ability to fully implement WG Eye Care Measures (ECM)	Extreme (16)

The Executive Team agreed to de-escalate this risk as the Health Board was not being performance managed by WG and was clinically prioritising patients in line with the ECM. This would be discussed as part of the wider risks of delivering essential services in Quarters 3 and 4.

Risk 718 - Failure to undertake proactive health and safety (H&S) management	High (8)

The Executive Team agreed to de-escalate this risk as it had been reduced to the agreed tolerance level following the work undertaken to address the outstanding HSE improvement notices, which remain under the oversight of the HSAC.

Risk 810 - Poor quality of care within the Unscheduled Care pathway	Closed

The Executive Team agreed to close this risk as the risk of delivering unscheduled care needs to be assessed as part of the wider service/system risk(s) to delivering the Quarter 3 and Quarter 4 Plan.

Risk 890 - Delivery of Quarter 2 Plan – Ability to respond effectively and swiftly to changes in workforce demand as COVID-19 progresses	Closed

The Executive Team agreed to close this risk as it relates to delivery of the Quarter 2 plan and workforce needs to form part of the wider service/system risk(s) to delivering the Quarter 3 and Quarter 4 Plan.

Risk 891 - Delivery of Quarter 2 Operating Plan - Delayed Discharges affecting the whole Health Board	Closed

The Executive Team agreed to close this risk as the risk of delayed discharges needs to be assessed as part of the wider service/system risk(s) to delivering the Quarter 3 and Quarter 4 Plan.

Risk 892 - Delivery of Quarter 2 Operating Plan - Delayed Discharges affecting the whole Health Board	Closed

The Executive Team agreed to close this risk as the risk of insufficient numbers of registered nurses needs to be assessed as part of the wider service/system risk(s) to delivering the Quarter 3 and Quarter 4 Plan.

Risk 893 - Delivery of Quarter 2 Operating Plan – Estate Capacity required for Social Distancing Measures	Closed

The Executive Team agreed to close this risk as it was no longer relevant. Screens were used to minimise the closure of beds due to social distancing measures. A new risk (1016) was assessed in relation to the risk of poor social distancing and its impact on the delivery of Quarter 3 and Quarter 4 Plan.

Risk 371 - Inability to meet WG target for clinical coding and decision-making will be based on inaccurate/incomplete information	High (9)

The Executive Team agreed to de-escalate the risk as funding for new clinical coders was agreed, with trainees in place. Although it will take up to 18 months for individuals to be fully trained, it was agreed this risk would be managed at Directorate level going forward. A recovery plan was requested by the Information Governance Sub Committee to address the backlog.

Risk 635 - No deal Brexit affecting continuity of patient care	Closed

The Executive Team agreed to close this risk as the UK has left the European Union and any residual issues or risks within the supply chain would be managed as part of the Health Board's routine processes going forward

Risk 856 - Risk to delivery of the Financial Plan for 2020/21	Closed

The Executive Team agreed to de-escalate the risk as the Health Board was forecast to deliver a planned deficit of £25m.

Risk 894 - Delivery of Quarter 2 Operating Plan – Reduced clinical workforce due to underlying medical condition, pregnancy or ethnicity (BAME)	Closed

The Executive Team agreed to de-escalate this risk as there was some overlap with the workforce Corporate Risk 1018. The risk has now been closed as the majority of those shielding have now returned to work and are being managed appropriately.

Risk 956 - Risk that the Health Board will breach its Capital Resource Limit in 2020/21	Closed

The Executive Team agreed to de-escalate the risk as the risk had been reduced within tolerance. Detailed work was undertaken with the Operational Teams to enable the prioritised set of COVID-19 schemes deliverable by 31st March 2021 to be agreed and progressed.

Risk 1028 - Delivery of the Quarter 3/4 Operating Plan - Risk that Primary Care contractors may not be able to operate	Closed

The Executive Team agreed to close this risk as the level of infection in the community reduced and the risk was within tolerance.

Appendix 3 – HIW Activity at Hywel Dda during 2020/21

The Health Board has been subject to 2 COVID-19 specific reviews by HIW during the course of the financial year. The first was a Tier 3 review of Ysbyty Enfys Carreg Las, Pembrokeshire and Ysbyty Enfys Selwyn Samuel, Llanelli as part of HIW's first review of Field Hospitals in October 2020. The inspection was undertaken when both sites were empty and in the final stages of preparation to receive patients. The published report noted that extensive planning had been undertaken by the service in preparation for the provision of safe and effective care to patients, and saw evidence of good leadership and staff who were engaged and passionate in their roles. No recommendations were raised during the course of the inspection.

Another Tier 3 review was undertaken in March 2021, where 2 of the 7 mass vaccination centres set up by the Health Board were visited, namely Halliwell Centre, Carmarthen and Cardigan Leisure Centre. HIW recognised the significant work undertaken in the planning, preparation and delivery of the vaccine programme. 2 immediate recommendations were raised from the review regarding the undertaking of environmental audits, and compliance with fire regulations and emergency evacuation procedures. Both recommendations have been addressed and completed, and the Health Board has received the draft report resulting from the inspection where all but 1 of the recommendations have been completed.

In respect of inspection activity in the Health Board's acute hospitals, a Tier 1 follow-up quality check was undertaken at Ward 10, Withybush Hospital in September 2020. This was undertaken to review progress made on recommendations raised in the original inspection undertaken in November 2018. HIW noted that the service provided a positive experience, and safe and effective care to patients. It was also noted that the service had implemented and sustained the majority of improvements identified within the original inspection report. An improvement was identified regarding the consistent completion of falls assessments, which has since been actioned and closed. No further recommendations remain outstanding as at 31 March 2021.

A Tier 1 quality check was also undertaken at Towy Ward in Glangwili Hospital in November 2020. HIW commented positively on the ward environment during a period of refurbishment, and also noted the good standards of infection, prevention and control. Improvements were identified in relation to action plans for falls and pressure and tissue damage, along with staff training compliance. Towy Ward was in a prolonged period of management as a result of COVID-19 outbreaks between December 2020 and January 2021 which impacted on the ability to address recommendations raised as part of the quality check. As at 31 March 2021, the two recommendations raised are partially completed, with plans in place to fully address the outstanding required actions.

A further Tier 1 quality check was scheduled for December 2020 at Steffan Ward, Glangwili Hospital, however as a result of the COVID-19 pressures on site at the time, HIW postponed the check. The Health Board are currently awaiting a revised date for this quality check.

An unannounced inspection of wards 7 and 11 at Withybush Hospital was undertaken in February 2020, with the finalised report published in August 2020. The

report noted that the service provided respectful and dignified care to patients, who were happy with the care which they received. 5 immediate assurance recommendations were raised with issues identified including resuscitation trolleys, storage of medications, fire doors and servicing programme for patient beds and clinical equipment. 39 recommendations were raised in the main improvement plan, with 2 outstanding as at 31 March 2021, 1 of which is outside the gift of the Health Board.

An unannounced inspection of the Paediatric Ambulatory Care Unit at Withybush Hospital was undertaken in February 2020, with the finalised report published in May 2020. The report noted that patients and their parents/carers reported a positive experience on the ward, and that staff were professional and committed to working collaboratively to provide patient care. 8 recommendations were raised in the main improvement plan, with 1 outstanding as at 31 March 2021

A further unannounced inspection of the Paediatric Ambulatory Care Unit at Glangwili Hospital was undertaken in March 2020, with the finalised report published in August 2020. The report noted that the service provided safe and effective care to patients, with staff happy within their roles and good arrangements in place for the reporting and management of clinical incidents. 17 recommendations were raised in the main improvement plan, with 2 outstanding as at 31st March 2021.

Inspections were also carried out at community hospitals across the Health Board. A Tier 1 quality check was undertaken at Tregaron Community Hospital October 2020, with the report noting that effective arrangements were in place in relation to COVID-19 issues, and positive comments on the hospital environment and governance. 1 area of improvement was noted in relation to infection prevention and control training. The recommendation has since been confirmed as implemented.

A Tier 1 quality check was also undertaken on the Cleddau Ward, South Pembrokeshire Hospital in September 2020. The report noted that effective arrangements had been implemented in relation to COVID-19 issues, and positive comments relating to infection prevention and control, and governance arrangements. 1 recommendation was raised from this review relating to the completion of environmental risk assessments, which has since been confirmed as implemented.

In respect of inspection activity across the Health Board's Mental Health and Learning Disabilities Services, a Tier 1 quality check was undertaken in October 2020 at Bryngofal Ward, Prince Philip Hospital. Effective COVID-19 arrangements were noted in the report, including arrangements around infection prevention and control. 4 recommendations were raised from the review relating to compliance with fire regulations, ward processes relating to the reviewing of incidents, staff training compliance, and further work on the recommendations raised in a C4C audit. All recommendations have since been confirmed as completed.

A further Tier 1 quality check was undertaken at the Bryngolau Ward at Prince Philip Hospital in October 2020. The report noted effective arrangements in relation to governance and infection prevention and control arrangements. 2 recommendations were raised relating to annual risk assessments on ligature risks, and staff training

compliance. The service has confirmed that all recommendations have been completed, and the Health Board is currently awaiting assurance confirmation from HIW on the progress made.

A Tier 1 quality check was held at Morlais Ward, Glangwili Hospital in March 2021. The Health Board has received a draft of the report which includes 3 recommendations relating to the completion of actions raised from a Cleaning for Credits (C4C) audit, staff training compliance and further information required by HIW relating to restraint data. The service has completed its responses to the recommendations raised, and awaiting publication of the final report by HIW.

A Tier 1 quality check was scheduled at Enlli Ward, Bronglais Hospital in November 2020, but was postponed and re-scheduled for February 2021 as a result of COVID-19 pressures. No recommendations were raised during the course of the quality check.

A Tier 1 quality check was scheduled for December 2020 at 10 Church Close, Begelly, Pembrokeshire however this was delayed due to COVID-19 pressures. This review was rescheduled for April 2021, with the Health Board currently awaiting receipt of the final report from HIW. .

HIW conducted a Tier 1 IR(ME)R compliance inspection of the Diagnostic Imaging Department at Prince Philip Hospital in February 2021. The inspection focussed on quality of patient experience, the delivery of safe and effective care, and the quality of management and leadership. The Health Board has received a draft of the report which includes 15 recommendations relating to areas including staff training, clarification of process and procedural documents and quality of the patient experience. The service has completed its responses to the recommendations raised, and the Health Board is currently awaiting receipt of the final report.

The Health Board has also been involved in the National Review of Maternity Services, with Phase One of the review complete. The Health Board has provided HIW with progress updates against recommendations raised from the Phase One report which was published in November 2020. Of the 33 recommendations raised on a national level, 8t remain outstanding as at 31 March 2021.

Phase Two will commence in the summer of 2021, and will focus upon the following key areas:

- Antenatal Care – to consider the quality of care provided by community midwifery teams;
- Postnatal Care – to consider the periods after the birth and up to the stage of Health Visitor engagement; and
- Follow-up on some of the inspection undertaken as part of Phase One, to understand what progress is being made.

All outstanding recommendations will be reviewed and re-prioritised accordingly in light of the additional capacity pressures on services as a result of planning and managing the COVID-19 pandemic.

Appendix 4 – Ministerial Directions

Ministerial Direction/ Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
WG20-18 - The Primary Medical Services Easter Weekend and Bank Holiday Provision of Essential General Medical Services during the COVID 19 Pandemic) (Directed Enhanced Service) Directions 2020	08/04/2020	This relates to a unique service provision. This has been enacted and the service provided.
WG20-20 - The National Health Service (General Medical Services – Recurring Premises Costs during the COVID-19 Pandemic) (Wales) Directions 2020	20/04/2020	This direction confirms that current premises payments to practices are to continue at the same rate as before COVID-19. No further action required.
WG20-24 - The National Health Service (Wales Eye Care Services payments during the COVID-19 Pandemic) (Wales) Directions 2020	23/05/2020	This direction informed of payments to NHS Opticians as per the Chief Optometric Advisor's letter of 17th March 2020 which outlined the reduction of optometric services due the COVID-19 pandemic, while also explaining that optometrists would still receive a monthly NHS income. The Statement of General Ophthalmic Services Remuneration (COVID-19 Average Monthly Payment) and the National Health Service Directions 2020 (Wales Eye Care Services payments during the COVID-19 Pandemic) (Wales) outlined the legal framework of the calculations to be used for optometrists to receive a monthly NHS income during the COVID-19 period. These calculations have been coordinated by a Payments Team based in Pontypool, who are managed by the All Wales Payments Manager.
WG20-27 - The National Health Service (General Medical Services - Premises Costs) (Wales)	03/06/2020	This direction has been implemented with the following assurance from the NWSSP Premises Payments Supervisor: • The reviews will continue to be done by Specialist Estates as normal;

(Amendment) Directions 2020		• The review will be done/completed around 1 to 3 months prior to the review date unless it is a negotiated lease /rent with the landlord, which can take a lot longer; • Specialist Estates will liaise with the practices regarding any changes; and • Timelines relating to the process do not change, except due to the current circumstances where the surveyors cannot access the practices but have all the information required to complete a review remotely.
WG20-30 - The Primary Medical Services (COVID-19 Care Homes) (Directed Enhanced Services) (Wales) Directions 2020	01/07/2020	This direction was implemented across GP Practices by the Assistant Director of Primary Care by the deadline of 01 July 2020. Practices were contacted to ask for Expression of Interests (EOIs) to deliver the service. One practice has declined to deliver, and is therefore working with neighbouring practices to provide cover to its registered patients who live in Care Homes. Nationally, through Heads of Primary Care (HOPC), it was noted that any contractual changes normally require 3 months' notice, which is preferable.
WG20-28 - Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2020	23/06/2020	Quality Assurance and Improvement Framework Achievement payments were completed in December 2020, therefore Ministerial Direction has been fully implemented.
WG20-25 - Directions to Local Health Boards as to the Statement of Financial Entitlements (Provision of Enhanced Services during the Recovery Phase of the COVID-19 Pandemic) Directions 2020	29/06/2020	This Direction relates to the payments to be made by Local Health Boards to a GMS contractor under a GMS contract. Practices had options regarding claiming for Enhanced Services, which were confirmed as implemented in January 2021. It is noted that this direction is superseded by WG20-59.
WG20-39 - Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2020	15/07/2020	This Direction has been enacted
WG20-44 - The National Health Service (Wales Eye Care Services) Directions 2020	28/08/2020	This Direction has been enacted, however is subject to opticians being open again.

WG20-51 - Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2020	16/09/2020	This Direction has been enacted
WG20-45 - The Primary Medical Services (Directed Enhanced Services) (Wales) (Amendment) Directions 2020	18/09/2020	This Direction has been enacted. Practices are now claiming for influenza administration.
WG20-55 - The Primary Medical Services (Directed Enhanced Services)	28/10/2020	This Direction has been enacted. Practices are now claiming for influenza administration.
WG20-70 - The Primary Medical Services General Practice Seasonal Influenza Additional Immunisation Scheme Directed Enhanced Service) (Wales) Directions 2020	02/12/2020	This direction provides for the influenza vaccination to be given to people aged 50 – 64. This Direction has been enacted. All necessary action has been taken as this is contractual.
WG20-73 - The Primary Medical Services (Provision of Essential General Medical Services over the Christmas and New Year Period during the COVID 19 Pandemic) (Directed Enhanced Service) (Amendment) Directions 2020	16/12/2020	This Direction highlighted changes to GMS payments over the Christmas period. This Direction has been enacted.
WG20-29 - Directions to Local Health Boards as to the Statement of Financial Entitlements (COVID-19 Suspension of Enhanced Services) (Amendment) Directions 2020	19/06/2020	This Direction has been enacted.
WG20-59 - Directions to Local Health Boards as to the Statement of Financial Entitlements (Provision of Enhanced Services during the Relaxation Phase of the COVID-19	20/11/2020	This Direction related to how GPs should deliver enhanced services during the relation phase of COVID-19, and superseded WG20-25 (above). This Direction has been implemented.

Pandemic) Directions 2020		
Oxford/AstraZeneca COVID-19 vaccine: Directions and immunisation scheme specification for primary care (No reference provided by WG)	30/12/2020	This has been commissioned from GP practices week commencing 04 January 2021 and will be used in accordance with the Directions for the roll out of the vaccination scheme in Primary Care. This Direction has been enacted.
WG21-04 - Directions to Local Health Boards as to the Statement of Financial Entitlements (COVID 19 Suspension of QAIF and Alteration of Enhanced Services) Directions 2021	09/02/2021	This Direction has been implemented as part of the monthly claiming procedures for GP practices.
WG21-24 - The National Health Service (General Medical Services Premises Costs) (Wales) (Amendment) Directions 2021	09/03/2021	This Direction has been implemented with rent review requests for leased premises sent to practices. For non-leased premises this is a continuance of the assurance that the rent won't reduce during COVID-19, therefore is considered to be business as usual..
WG21-21 - The Directions to Local Health Boards as to the Personal and General Dental Services Statement of Financial Entitlements (Amendment) Directions 2021	04/03/2021	This refers to the interim payments arrangements for 2020/21 for Dental Services which the Health Board is following.

Hywel Dda University Health Board

PART B: REMUNERATION AND STAFF REPORT 2020/21

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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Introduction

The HM Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410 https://www.legislation.gov.uk/uksi/2008/410/contents made to the extent that they are relevant. The Remuneration Report contains information about senior manager's remuneration. The definition of "Senior Managers" is:

> *"those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."*

This section of the Accountability Report meets these requirements. The following disclosures are subject to audit:

- Single total figure of remuneration for each director;
- Cash Equivalent transfer Value (CETV) disclosures for each director;
- Payments to past directors, if relevant;
- Payments for loss of office, if relevant;
- Fair pay disclosures (Included in Annual Accounts) note 9.6;
- Exit packages, (Included in Annual Accounts) if relevant note 9.5; and
- Analysis of staff numbers.

ReMUNERATION REPORT

The Remuneration and Terms of Service Committee (RTSC)

The RTSC will comment specifically upon:

- Remuneration and terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) and others not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by WG are applied consistently;
- Objectives for Executive Directors and other VSMs and their performance assessment;
- Performance management systems in place for those in the positions mentioned above and its application;
- Proposals to make additional payments to medical Consultants outside of normal terms and conditions;
- Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant WG guidance;
- Consider and ratify Voluntary Early Release scheme applications and severance payments in respect of Executive Director posts, in line with Standing Orders and extant WG guidance. The Committee to be advised also of **all** Voluntary Early Release Scheme applications and severance payments; and
- To approve the University Health Board's honours submission recommendations.

The membership of the RTSC Committee during 2020/21 was as follows:

Name	Position	Role on the RTSC
Maria Battle	Chair	Chair
Paul Newman	Independent Member and Chair of Audit and Risk Assurance Committee (ARAC)	Vice Chair
Professor John Gammon	Independent Member and Chair of People, Planning and Performance Assurance Committee (PPPAC)	Member
Anna Lewis	Independent Member and Chair of Quality, Safety and Experience Assurance Committee (QSEAC)	Member

Independent Members' Remuneration

Remuneration and tenures of appointment for Independent Members is decided by the WG.

Senior Managers' Remuneration

The remuneration of Senior Managers who are paid on the Very Senior Managers Pay Scale is determined by WG, and the Health Board 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 Health Board 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 Health Board does not have a system for performance related pay for its Very Senior Managers.

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

Annually the RTSC receives a summary performance report of Executive Director 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.

The Health Board issues All Wales Executive Director contracts which determine the terms and conditions for all Very Senior Managers. The Health Board 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 2020/21 year, no termination payments were made.

The £735 NHS staff bonus payment has not been included within the Remuneration Report as this is paid to staff in the 2021/22 financial year.

Service Contract Details for Senior Managers

Name of Manager	Role	Date of contract	Date of Contract Expiration	Compensation for early termination
Steve Moore	Chief Executive	05/01/2015	N/A	N/A
Dr Philip Kloer	Deputy Chief Executive /Executive Medical Director	25/06/2015	N/A	N/A
Andrew Carruthers	Executive Director of Operations	01/12/2019	N/A	N/A
Mandy Rayani	Executive Director of Nursing, Quality & Patient Experience	19/06/2017	N/A	N/A
Karen Miles	Executive Director of Planning, Performance & Commissioning	01/01/2017	11/10/2020	N/A
Huw Thomas	Executive Director of Finance	10/12/2018	N/A	N/A
Lisa Gostling	Executive Director of Workforce & Organisational Development	09/01/2015	N/A	N/A
Alison Shakeshaft	Executive Director of Therapies & Health Sciences	01/01/2018	N/A	N/A
Ros Jervis	Executive Director of Public Health	17/07/2017	N/A	N/A
Jill Paterson	Director of Primary Care, Community & Long Term Care	19/01/2018	N/A	N/A
Sarah Jennings	Director of Partnerships & Corporate Services	01/01/2018	04/09/2020	N/A
Joanne Wilson	Board Secretary	01/01/2018	N/A	N/A

All Directors are subject to a 3 month notice period.

Changes to Board Membership in 2020/21

During 2020/21, there were the following changes to Board membership:

- Mo Nazemi was appointed Chair of the Healthcare Professionals Forum from 1 April 2020.
- Sarah Jennings left the post on Director of Partnerships and Corporate Services on 4 September 2020.
- Hazel Lloyd-Lubran was appointed Chair of the Stakeholder Reference Group from 10 October 2020.
- Karen Miles left the post of Executive Director of Planning, Performance and Commissioning on 11 October 2020. The Executive Director of Finance had interim responsibility for performance, commissioning, and digital services, until the appointment of a new Executive Director of Strategic Development and Operational Planning, who commenced in post on 26 April 2021.

Single Total Figure of Remuneration

The amount of pension benefits for the year which contributes to the single total figure is calculated similar 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 x 20) + (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 Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors such as changes in a person's salary, whether or not they choose to make additional contributions to the pension scheme from their pay, and other valuation factors affecting the pension scheme as a whole.

2020/21

Name and Title	Salary (Bands of £5k)	Bonus Payments (£000)	Benefits in Kind (£000)	Pension Benefits (£000)	Other Remun-eration ** (£000)	Total (Bands of £5k)
Executive Members and Directors						
Steve Moore, Chief Executive Officer	195 - 200	0	0	10	0	205 - 210
Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience	130 - 135	0	0	23	0	155 - 160
Karen Miles, Executive Director of Planning, Performance and Commissioning (to 11/10/20)	80 - 85	0	0	0	167	250 -255

Name and Title	Salary (Bands of £5k)	Bonus Payments (£000)	Benefits in Kind (£000)	Pension Benefits (£000)	Other Remun-eration ** (£000)	Total (Bands of £5k)
Lisa Gostling, Executive Director of Workforce and Organisational Development	130 - 135	0	0	51	0	180 - 185
Phil Kloer, Executive Medical Director/ Deputy Chief Executive	175 - 180	0	0	51	0	225 - 230
Andrew Carruthers, Executive Director of Operations	130 - 135	0	0	64	0	195 - 200
Alison Shakeshaft, Executive Director of Therapies and Health Science	115 - 120	0	0	55	0	170 - 175
Ros Jervis, Executive Director of Public Health	115 - 120	0	0	31	0	145 - 150
Huw Thomas, Executive Director of Finance	135 - 140	0	0	5	0	140 -145
Jill Paterson, Director of Primary, Community and Long Term Care	120 - 125	0	8.2	29	0	155 - 160
Sarah Jennings, Director of Partnerships and Corporate Services (to 04/09/20)	45 - 50	0	0	4	0	50 - 55
Joanne Wilson, Board Secretary	105 - 110	0	0	27	0	130 - 135

** Other remuneration includes VERS for Executive Director

Independent Members						
Maria Battle, Chair	55 - 60	0	0	0	0	55 - 60
Judith Hardisty, Vice Chair	45 - 50	0	0	0	0	45 - 50
Mike Lewis	10 - 15	0	0	0	0	10 - 15
Paul Newman	10 - 15	0	0	0	0	10 - 15
Professor John Gammon	10 - 15	0	0	0	0	10 - 15
Simon Hancock	10 - 15	0	0	0	0	10 - 15
Delyth Raynsford	10 - 15	0	0	0	0	10 - 15
Anna Lewis	10 - 15	0	0	0	0	10 - 15
Owen Burt	10 - 15	0	0	0	0	10 - 15
Maynard Davies	10 - 15	0	0	0	0	10 - 15
Ann Murphy	5 - 10	0	0	0	0	5 - 10

2019/20

Name and Title	Salary (Bands of £5k)	Bonus Payments	Benefits in Kind (£000)	Pension Benefits (£000)	Other Remuneration	Total (Bands of £5k)
Executive Members and Directors						
Steve Moore, Chief Executive Officer	190 - 195	0	0	0	0	190 - 195
Joe Teape, Deputy Chief Executive / Executive Director of Operations (to 30/11/19)	100 - 105	0	0	0	0	100 - 105
Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience	130 - 135	0	0	13	0	140 - 145
Karen Miles, Executive Director of Planning, Performance and Commissioning	130 - 135	0	0	26	0	155 - 160
Lisa Gostling, Executive Director of Workforce and Organisational Development	125 - 130	0	0	73	0	200 - 205
Phil Kloer, Executive Medical Director	170 - 175	0	0	50	0	220 - 225
Andrew Carruthers, Turnaround Director (to 30/11/19), Executive Director of Operations (from 01/12/19)	120 - 125	0	0	42	0	165 - 170
Alison Shakeshaft, Executive Director of Therapies and Health Science	110 - 115	0	0	92	0	200 - 205
Ros Jervis, Executive Director of Public Health	115 - 120	0	0	27	0	140 - 145
Huw Thomas, Executive Director of Finance	125 - 130	0	0	52	0	175 - 180
Jill Paterson, Director of Primary, Community and Long Term Care	115 - 120	0	6	39	0	160 - 165
Sarah Jennings, Director of Partnerships and Corporate Services	105 - 110	0	0	35	0	140 - 145
Joanne Wilson, Board Secretary	95 - 100	0	0	44	0	140 - 145
Libby Ryan-Davies, Transformational Director (to 30/04/19)	5 - 10	0	0	2	0	10 - 15

Name and Title	Salary (Bands of £5k)	Bonus Payments	Benefits in Kind (£000)	Pension Benefits (£000)	Other Remuneration	Total (Bands of £5k)
Independent Members						
Maria Battle, Chair (from 19/08/19)	35 - 40	0	0	0	0	35 - 40
Judith Hardisty, Interim Chair (to 18/08/19), Vice Chair (from 19/08/19)	50 - 55	0	0	0	0	50 - 55
Mike Lewis	10 - 15	0	0	0	0	10 - 15
Paul Newman, Interim Vice Chair (to 18/08/19)	20 - 25	0	0	0	0	20 - 25
Professor John Gammon	10 - 15	0	0	0	0	10 - 15
David Powell (to 30/11/19)	5 - 10	0	0	0	0	5 - 10
Simon Hancock	10 - 15	0	0	0	0	10 - 15
Delyth Raynsford	10 - 15	0	0	0	0	10 - 15
Adam Morgan (to 12/07/19)	0 - 5	0	0	0	0	0 - 5
Anna Lewis	10 - 15	0	0	0	0	10 - 15
Owen Burt	10 - 15	0	0	0	0	10 - 15
Maynard Davies (from 01/12/19)	0 - 5	0	0	0	0	0 - 5
Ann Murphy (from 09/01/20)	0-5	0	0	0	0	0-5

Remuneration Relationship

The details of the remuneration relationship are reported in the Financial Statements in Section 9.6.

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 Health Board in the financial year 2020/21 was £195,000-£200,000 (2019/20, £190,000 - £195,000). This was 6 times (2019/20: 6 times) the median remuneration of the workforce, which was £34,027 (2019/20, £33,758).

In 2020/21, 24 (2019/20, 32) employees received remuneration in excess of the highest-paid Director. Remuneration for staff ranged from £21,879 to £318,973 (2019/20, £21,450 to £360,373). The staff who received remuneration greater than the highest paid Director are all medical and dental who have assumed additional responsibilities to their standard job plan commitments and in some cases medical managerial roles, necessitating extra payment.

	2020/2021	2019/2020
Band of Highest paid Director's Total Remuneration £000	195 - 200	190 - 195
Median Total Remuneration £000	34	34
Ratio	6 times	6 times

** As disclosed in the Health Board'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.

Pension Benefits 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 2021 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Steve Moore, Chief Executive*	0-2.5	(2.5)-0	55-60	130-135	1,049	998	35	0
Mandy Rayani, Executive Director of Nursing, Quality & Patient Experience	0-2.5	5-7.5	60-65	190-195	1,481	1,382	75	0
Karen Miles, Executive Director of Finance, Director of Planning, Performance and Commissioning	(10)-(7.5)	(10)-(7.5)	45-50	145-150	0	1,261	0	0
Lisa Gostling, Director of Workforce and Organisational Development	2.5-5	0-2.5	50-55	105-110	953	869	70	0
Dr Phil Kloer, Deputy Chief Executive/Executive Medical Director	2.5-5	0-2.5	60-65	120-125	1,050	962	71	0
Andrew Carruthers, Executive Director of Operations	2.5-5	2.5-5	35-40	65-70	517	451	58	0
Alison Shakeshaft, Executive Director of Therapies and Health Science	2.5-5	2.5-5	50-55	115-120	1,049	954	79	0
Ros Jervis, Executive Director of Public Health	0-2.5	0-2.5	25-30	45-50	478	431	40	0
Huw Thomas, Executive Director of Finance	0-2.5	(2.5)-0	20-25	0-5	255	242	9	0
Jill Paterson, Director of Primary, Community and Long Term Care	0-2.5	5-7.5	45-50	135-140	0	0	0	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 2021 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Sarah Jennings, Director of Partnerships and Corporate Services	0-2.5	0	35-40	0	569	536	10	0
Joanne Wilson, Board Secretary	0-2.5	0-2.5	25-30	50-55	409	372	31	0
* Steve Moore re-entered the NHS pension scheme during the reporting year								

STAFF REPORT

Staff Numbers

As at 31 March 2021, the Health Board employed 12,476 staff including bank and locum staff; this equated to 9,402.23 Full Time Equivalent (FTE). The numbers (headcount) of female and male Board Members and employees are as follows:

	Female	Male	Total
Board Members	11	10	21
Employees	9,675	2,780	12,455
Total	9,686	2,790	12,476

*Included in the Board Members figures is 1 additional Director and the Board Secretary (both non-voting) who are members of the Executive Team and attend Board meetings.

Staff Composition as at 31 March 2021

	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Executive Team*	6.00	6	4.00	4	10.00	10
Independent Members	5.00	5	6.00	6	11.00	11
Total	**11.00**	**11**	**10.00**	**10**	**21.00**	**21**

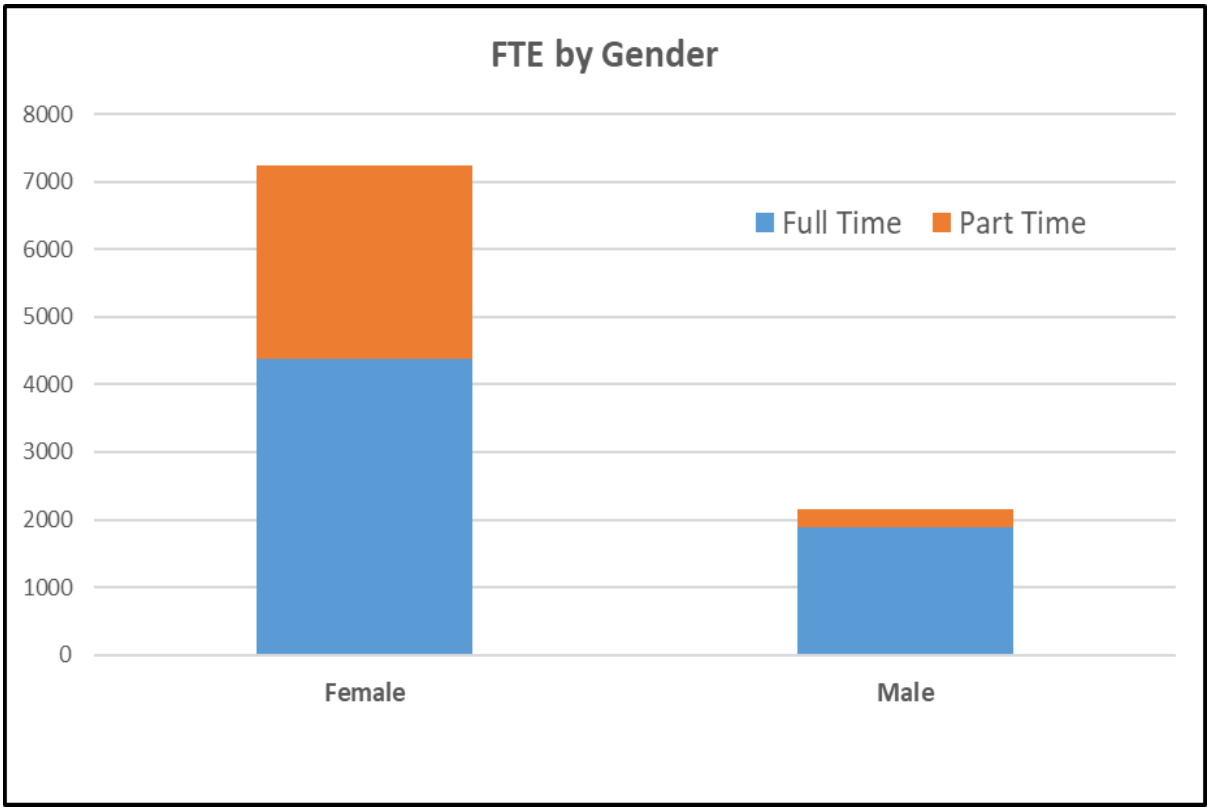
* The Executive Team consists of 9 Executive Directors who are voting members of the Board (there is 1 vacancy at present which will be filled on 19/04/21), and 2 non-voting members (1 additional Director and the Board Secretary).

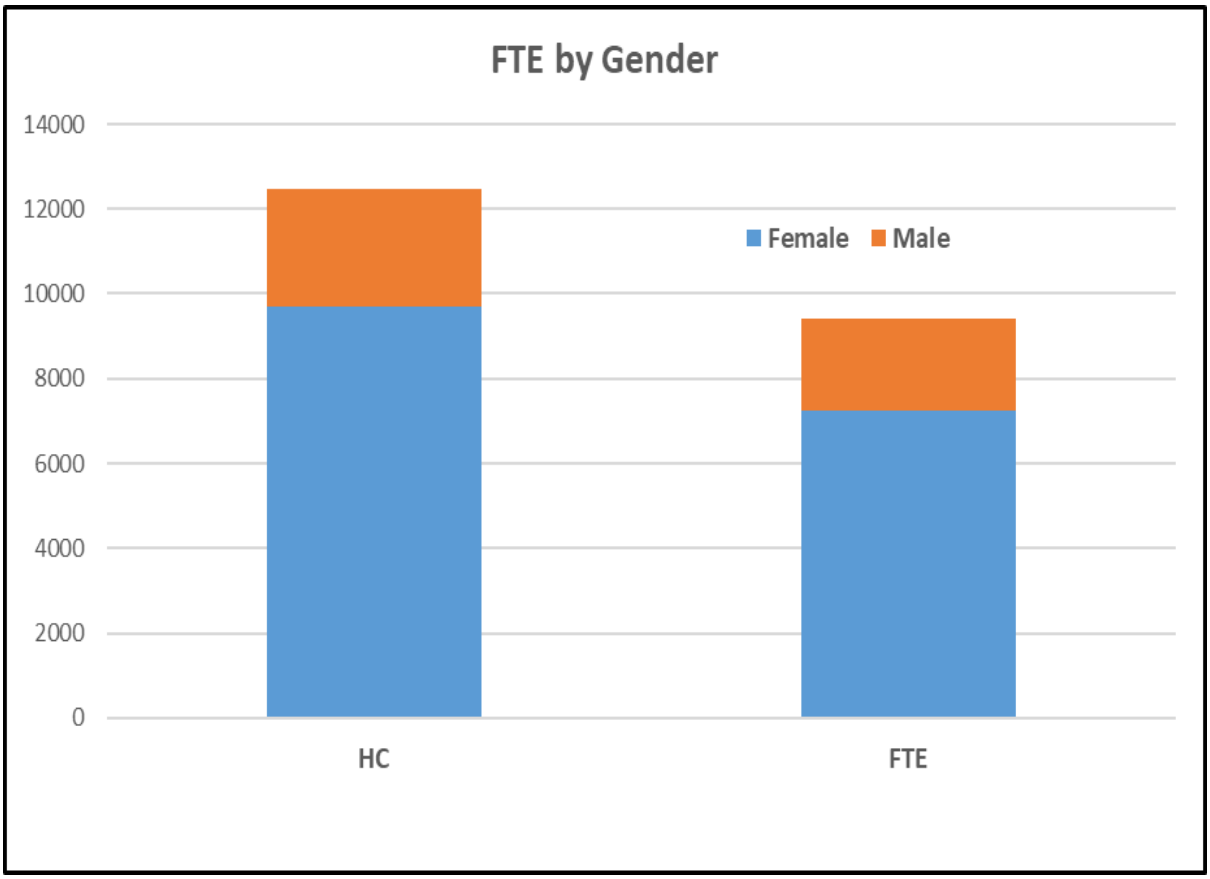
	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Additional Professional Scientific and Technical	230.95	266	107.89	124	338.84	390
Additional Clinical Services	1,698.45	2,568	368.57	452	2,067.02	3,020
Administrative and Clerical	1,519.50	1,799	331.29	355	1,850.79	2,154
Allied Health Professionals	483.09	572	108.29	118	591.38	690
Estates and Ancillary	440.82	782	502.26	731	943.08	1,513
Healthcare Scientists	104.87	117	75.20	77	180.07	194
Medical and Dental	214.04	336	427.21	647	641.25	983
Nursing and Midwifery Registered	2,549.11	3,245	239.70	286	2,788.80	3,531

Students	1.00	1	0	0	1.00	1
Total	**7,241.82**	**9,686**	**2,160.41**	**2,790**	**9,402.23**	**12,476**

	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Band 8a	45.01	46	29.91	30	74.92	76
Band 8b	39.80	40	22.60	23	62.40	63
Band 8c	15.00	15	10.40	10	25.40	25
Band 8d	9.00	9	7.00	7	16.00	16
Band 9	3.00	3	6.85	7	9.85	10
Total	**111.81**	**113**	**76.76**	**77**	**188.57**	**190**

- 77% of the Health Board's workforce was female by FTE and 23% male;
- The staff covered a wide range of professional, technical and support staff groups;
- Over 50% of all staff were within the Nursing and Midwifery and Additional Clinical Services staff groups;
- Senior Manager (Band 8a and above) were 2% of the workforce - 59% of these by FTE were female and 41% male; and
- The Board does not have any issue with its staff composition. Detailed information on the Health Board's composition is contained in the Health Board's Workforce Annual Equality Report' published in September each year.


FTE by Gender
8000
7000
6000
5000
4000
3000
2000
1000
0
Full Time
Part Time
Female
Male


FTE by Gender
14000
12000
10000
8000
6000
4000
2000
0
Female
Male
HC
FTE

Sickness Absence Data

Sickness absence remains a priority for the Health Board. The cumulative sickness rate for the 12-month period up to and including March 2021 is 5.18% which is 0.39% above the 2020/21 year-end target of 4.79%. 3.67% of this sickness was attributed to long-term absence and 1.51% to short-term absence. The top reasons recorded for absence during 2020/21 were anxiety/stress/depression/other psychiatric illnesses, chest and respiratory problems, other musculoskeletal problems and infectious diseases. The following table provides information on the number of days lost due to sickness:

	2020-21	2019-20
Days lost (long term)	153,993	136,170
Days lost (short term)	59,136	57,086
Total days lost	213,129	193,256
Total Staff Years	9,252.40	8,571.70
Average Working Days Lost	11.83	11.67
Total Staff employed as at 31 March (headcount)	12,476	11,245
Total Staff employed in period with no absence (headcount)	4,542	3,878
Percentage of staff with no sick leave	45.37%	38.38%

The Health Board has one of the lowest sickness rates of the largest Health Boards in Wales and has seen a 0.01% reduction in the sickness rate for the 12 month period up to the 31 March 2021, which was 5.18% (31 March 2020: 5.19%) The sickness absence rate of 5.18% is made up of 4.12% non-COVID sickness and 1.06% COVID sickness. There was additional absence from the workplace associated with periods of COVID-related self-isolation and shielding which represented a further 2.46%.

The percentage and total number of staff with no sickness absence reported during 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.

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

The All Wales Attendance at Work Policy is now well established within the Health Board, with its focus on compassionate leadership and the ability for manager discretion. The training package is now being delivered remotely which has positively increased the numbers of attendees. The audit programme has not progressed over the last 12 months due to other COVID-19 commitments however the Health Board is in the process of looking at how it can reinstate the audit programme virtually for this year. The issue of COVID-19 will also have impacted on attendance during 2020/21 which may continue into 2021/22, and could result in continued higher sickness absence levels than normal.

The Health Board 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. The Staff Wellbeing service has been enhanced to include a 24 hour bilingual employee telephone assistance service.

Staff Policies

The Health Board has a combination of internally generated workforce policies, and also a number of core policies which apply throughout NHS Wales. The Health Board policies are initiated and reviewed by the Policy Sub Group which consists of managers and trade union representatives. New and revised policies are then subject to consultation at the Hywel Dda Staff Partnership Forum and Local Negotiating Committee in respect of medical staff. All Health Board policies are equality impact assessed at the drafting and review stage by the Policy Sub Group. The Employment Policy Sub Group includes a specialist advisor for equality and diversity.

Local policies are subject to formal sign off through both the Partnership Forum and Health Board's PPPAC. All Wales policies are drafted and negotiated at national level. All Health Board policies and procedures continued to apply throughout the pandemic, with the exception of pay progression which was paused during the pandemic.

The Health Board has reviewed its approach to policy formation and has determined that it needs to change the process going forward. The new approach will ensure wider engagement of all stakeholders, while ensuring their alignment with Health Board strategic objectives.

The Health Board is committed to ensuring that the recruitment and selection of staff promotes equality of opportunity at all times, eliminating discrimination and promoting good relations between all. It is committed to equal opportunities in recruitment and career development/promotion and demonstrates this by displaying the Disability Confident symbol in all adverts, as well as Supporting Age Positive, Mindful Employer, Armed Forces Covenant and Stonewall Cymru symbols. Values Based Recruitment training is offered to all managers which includes comprehensive guidance on the principles of equality of opportunity during all stages of the recruitment pathway.

The Health Board is committed to the principles of equality of opportunity in the delivery of all its training, development and education programmes. Reasonable adjustments are considered in the event that these are needed in relation to accessibility issues. All new training provision will be co-created to ensure it is accessible and meets the needs of the workforce.

An All Wales Managing Attendance Policy exists which advises managers to consider reasonable and tailored adjustments, ensuring that employees with a physical or mental health impairment are not disadvantaged in the workplace. It also provides for a consistent approach to support employees with a disability. The Health Board has an Attendance Management Advisor post within the Workforce team who acts as the key contact for attendance management issues and advises managers on the type of adjustments that should be considered. The post also provides training on the Attendance at Work Policy which includes an element of compassionate leadership and the Equality Act. The Health Board also has an in-house Occupational Health Service, with a full time Occupational Health Physician who provides advice and support to both employees and managers if a staff member is unable to continue with the full range of duties of their substantive post, or if there is a requirement for the employee to be redeployed to another role or other duties. Types of adjustments considered

include reduction of specific duties, not working specific shifts (for example night duty), reduction in hours, days or length of shifts and recommending what type of roles maybe suitable for redeployment purposes. The aim is to retain the skills of our workforce in whatever capacity is possible.

Other employee matters

- ### Equality, Diversity and Inclusion

The Workforce, Organisational Development and Education Strategy confirms the intention to establish the Health Board as an inclusive organisation. Inclusiveness means making sure the voices of the workforce are heard and valued, ensuring equal access to opportunities and resources for people who might otherwise be excluded or marginalised. This will not only help to attract and retain the best people to form the workforce, but it will also help to provide better services making the Health Board a great place to work. We need to move beyond ensuring equality to promoting diversity, which, ultimately, is about how it builds the organisation with talented individuals from a wide range of backgrounds.

We review our workforce statistical data on an annual basis to help identify aims and positive actions to initiate to support members of the workforce in accordance with their protected characteristics. The Health Board wants all employees, no matter what their identity, culture or background to have the best possible employment experience in Hywel Dda.

During the pandemic, the issue of the Health and Wellbeing of Black, Asian and minority ethnic groups of staff has received a much higher profile nationally. A formal Advisory Group to the Board with specific Terms of Reference has been established to advise the Health Board on mainstreaming equality, diversity and inclusion and to provide a forum to discuss, influence and advise on issues affecting staff with key decision makers.

The Equality and Diversity Policy is being reviewed by a group of stakeholders, many of whom identify themselves with one or more protected characteristics. Engaging staff to co-design the policy is key to ensuring it addresses the lived experiences of the workforce. The performance against a target of 85% for equality and diversity mandatory training is 83.6%.

- ### Supporting Research, Innovation and Improvement

This year saw a small team appointed, funded by WG, to establish alongside Local Authority partners, the Research, Innovation and Improvement Hub. The team was responsible for a Regional Project mapping exercise to review the effectiveness of different funding streams managed by the RPB. It has developed a new framework to upscale and spread innovation, including those emerging from the Bevan Exemplar network within the Health Board. The team are currently working on a Staff Discovery piece of work to understand more about staff experiences during the pandemic so that the Health Board can put measures in place to best support their rest, recuperation and recovery.

• Bilingual Skills Policy

The Health Board's Bilingual Skills Policy was launched on St David's Day. The WG's ambition is for the number of people able to enjoy speaking and using Welsh to reach a million by 2050. We are committed to bilingual skills development as part of its workforce planning process. The aim of the policy is to ensure that the Health Board is able to deliver a bilingual healthcare service to the public and facilitate staff to use the Welsh language naturally within the workplace. The policy will not be delivered instantly as language planning is a long-term endeavour. However, the Health Board aims to be an exemplar in this area, leading by example by promoting and facilitating increased use of Welsh by the own workforce. Whether a fluent speaker, a speaker lacking in confidence who wishes to improve their skills, or a new speaker, the workplace provides opportunities to use, practise and learn Welsh. 35.9% of the Health Board's workforce have Welsh Language skills at Foundation level or above.

• Learning and Development

During the last 12 months, Workforce Education and Development on-boarded in excess of 2,000 new employees and supported the training and development of staff deployed to critical areas. In order to do this effectively, there was a need to redesign processes which included:

- Creating a bespoke Clinical Induction Programme for Health Care Support Workers (HCSW);
- Providing telephone/email support towards mandatory training e-learning to cope with increased demand;
- Arranging and co-ordinating face to face training for clinical skills, complying with social distancing guidelines;
- Registered nurse redeployment programme was developed to support nurses to go back into clinical practice from corporate or non-clinical roles should the need arise;
- Managed the database and training of 471 immunisers for the vaccination programme, providing governance that all training requirements were met;
- Co-designed a training package in line with the introduction of the Family Liaison Officer role, ensuring competence towards their role; and
- Created new data recording processes to cope with multiple user requirements.

Despite the occupational specific training delivered, the Agored Centre Status has been on hold due to COVID-19 pressures. The Workforce Development team have developed e-portfolios through Office 365 to allow for clinical employees to continue to progress. An Assessor Network has also been formed to support the registered workforce to deliver, assess and verify accredited qualifications internally, and full standardisation of assessment practices has been achieved. There are currently circa 90 employees registered on level 3 qualifications including Occupational Therapy Support, Physiotherapy Support, Perioperative Care and Podiatry Support. Generic delivery has now been moved to the Clinical Skills Team to support clinical services and creating a holistic delivery model.

Despite the demands upon the Health Board, mandatory training compliance has been continually monitored and compliance levels have been maintained throughout the pandemic. Performance is monitored to ensure that we are moving towards our 85% compliance target. Core training compliance is 82.8%. The majority of training that was delivered face to face prior to the pandemic has been delivered virtually via the use of Microsoft Teams and recorded on ESR, with the Learning and Development Department providing support in relation to this.

• Leadership Development

During the last 12 months, leadership programme delivery was initially paused due to the pandemic. However, the design and delivery was adapted in year and has continued on a virtual course or wherever possible in a socially distanced way.
Programme delivery has included:

- Two cohorts of the Band 7 Nurse (STAR) programme;
- A new ILM Level 5 Coaching Skills Development Framework;
- Finance Senior Leader Programme;
- Peer Mentoring for Consultants and a virtual network established; and
- Planning phases for the introduction of a reverse mentoring programme for Board Members.

• Workforce Development

Workforce development activities have continued over the past year. The Health Board was unable to proceed with a new intake for the Apprenticeship Academy programme in 2020 due to the pandemic. The apprentices appointed in 2019 continued their development and academic studies and were invaluable in our COVID-19 response, working in the areas of greatest need.

The current Apprenticeship Academy will provide more opportunities than in previous years. 2021 will see the recruitment of a further cohort of Healthcare Apprentices and Patient Experience Apprentices as well as other new opportunities in Corporate Governance, Digital Services and Workforce. The Apprentice Academy recently hosted their first live events, attended by 503 individuals. The Healthcare Apprentice Programme alone generated 517 applications, with 158 candidates having been invited to the assessment days.

• Volunteers

Volunteers have played an important role in supporting the Health Board during the pandemic, with many volunteering in field hospitals, delivering vital supplies including PPE, supporting in vaccination centres with meet and greet roles or car park attendants, and much more. In excess of 150 volunteers have provided some great stories of their experiences and have been a true asset to us during the pandemic.

• Culture and Workforce Experience

Several staff surveys have been conducted during the last year including the national staff survey. All of these responses are helping the Health Board to understand more about the experience of its staff so that it can respond appropriately and develop health and wellbeing initiatives which will have impact. All of the focus on health and wellbeing has been important for the successful status check for the Gold Standard of Corporate Health.

Working closely with the local Charities team, the Health Board has been successful in bidding for national charities funds to focus on the health and wellbeing of staff. Monthly awards for Employees and Teams, and presented by the Chair of the Health Board, have been well received by the award winners. The Thankyou cards which were distributed to over 12,000 staff and volunteers in the summer were also well received, and were a small step in helping to create a more positive culture where staff can feel appreciated and valued.

Listening to staff has been important with the creation of 'listening spaces' for staff to share experiences and support each other. Where possible these listening spaces have been held physically, such as in the field hospitals, but where not possible, these have been held virtually.

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 Health Board spent £1,837,669 on consultancy services as follows:

Transforming Clinical Services	**£402,305**
Legal / Redress Claims Advice	£863,679
VAT / Tax Advice	£120,649
IT Consultancy	£269,040
Estates Advice	£23,327
Other Service Reviews / Advice	£158,669

Tax Assurance for Off-Payroll Appointees

In response to the WG'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 Health Board's website http://www.wales.nhs.uk/sitesplus/862/page/100005 following publication of the Annual Report.

During the year, the Health Board has developed the Tax Status of Workers financial procedure. This was developed in order to formally document the considerations and actions that must be taken by Health Board employees before entering into contracts involving the services of individuals so that payment for any such services is made by tax compliant means. In particular, the procedure discusses the Health Board's obligation to determine the employment status of such individuals for tax purposes or whether the contract entered into will be one which falls within the Off-payroll Working (or "IR35") legislation.

This procedure has been finalised in conjunction with changes to the Off-payroll Working legislation which will take effect from 1 April 2021. Changes being introduced include the requirement for Off-payroll Working status assessments to be accompanied by a written Status Determination Statement, which must be presented to the individual worker in question and the body being contracted with for the individual worker's services (if different), and the requirement to establish and operate a Status Disagreement Process.

Exit Packages

There have not been any costs associated with redundancy in the last year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). £215,132 exit costs were paid in 2020-21 in relation to settlement claims, the year of departure (2019-20 £24,800). 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 Health Board has agreed voluntary early retirement, the additional costs are met by the Health Board 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 Health Board receives a full business case in respect of each application supported by the line manager. The Executive Director of Finance and Executive Director of Workforce and 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 Health Board approval. Details of exit packages and severance payments are as follows:

	2020/21	2020/21	2020/21	2020/21	2019/20
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	1
£10,000 to £25,000	0	2	2	2	2
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	1	1	1	0
£150,000 to £200,000	0	1	1	1	0
more than £200,000	0	0	0	0	0
Total	**0**	**5**	**5**	**5**	**3**
	2020/21	**2020/21**	**2020/21**	**2020/21**	**2019/20**
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	1,000	1,000	1,000	2,500
£10,000 to £25,000	0	45,287	45,287	45,287	22,300
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	143,529	143,529	143,529	0
£150,000 to £200,000	0	167,471	167,471	167,471	0
more than £200,000	0	0	0	0	0
Total	**0**	**357,287**	**357,287**	**357,287**	**24,800**

Hywel Dda University Health Board

PART C: PARLIAMENTARY AND AUDIT ACCOUNTABILITY REPORT 2020/21

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Parliamentary ACCOUNTABILITY AND AUDIT REPORT

Regularity of Expenditure

Common with the public sector in general the Health Board has faced unprecedented challenges in 2020/21 to deal with the COVID-19 pandemic. Significant funding has been provided from WG to support with delivering the response to COVID-19. However, the Health Board has not been able to deliver a balance over 3 years to meet its financial duty. The expenditure of £95.3m which it has incurred in excess of its resource limit over that period is deemed to be irregular. The Health Board will continue to identify efficiency and cost reduction measures in order to mitigate against future cost and service pressures and to establish financial balance in due course.

Fees and Charges

The Health Board levies charges or fees on its patients in a number of areas. Where the Health Board makes such charges or fees, it does so in accordance with relevant Welsh Health Circulars and charging guidance. Charges are generally made on a full cost basis. None of the items for which charges are made are by themselves material to the Health Board, however details of some of the larger items (Dental Fees, Private and Overseas Patient income) are disclosed within Note 4 of the Annual Accounts.

Managing Public Money

This is the required Statement for Public Sector Information Holders. In line with other Welsh NHS bodies, the Health Board has developed Standing Financial Instructions which enforce the principles outlined in HM Treasury on Managing Public Money. As a result the Health Board confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

Material Remote Contingent Liabilities

Remote contingent liabilities are those liabilities which due to the unlikelihood of a resultant charge against the Health Board are therefore not recognised as an expense nor as a contingent liability. Detailed below are the remote contingent liabilities as at 31 March 2021:

	2020-2021	2019-2020
	£000's	£000's
Guarantees	0	0
Indemnities*	27	175
Letters of Comfort	0	0
Total	**27**	175

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

Chapter 3

Financial Accounts

HYWEL DDA LOCAL 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

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2020-21. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

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 2021

	Note	2020-21 £'000	2019-20 £'000
Expenditure on Primary Healthcare Services	3.1	**199,452**	191,967
Expenditure on healthcare from other providers	3.2	**252,310**	211,453
Expenditure on Hospital and Community Health Services	3.3	**665,902**	587,107
		1,117,664	990,527
Less: Miscellaneous Income	4	**(63,335)**	(61,806)
LHB net operating costs before interest and other gains and losses		**1,054,329**	928,721
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**(20)**	(55)
Finance costs	7	**(30)**	(16)
Net operating costs for the financial year		**1,054,279**	**928,650**

See note 2 on page 26 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 74 form part of these accounts.

Other Comprehensive Net Expenditure

	2020-21 £'000	2019-20 £'000
Net (gain) / loss on revaluation of property, plant and equipment	**(3,020)**	(1,522)
Net (gain) / loss on revaluation of intangibles	**0**	0
(Gain) / loss on other reserves	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
Transfers between reserves	**0**	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	246
Other comprehensive net expenditure for the year	**(3,020)**	(1,276)
Total comprehensive net expenditure for the year	**1,051,259**	927,374

The notes on pages 8 to 74 form part of these accounts.

Statement of Financial Position as at 31 March 2021

	Notes	31 March 2021 £'000	31 March 2020 £'000
Non-current assets			
Property, plant and equipment	11	**290,648**	278,649
Intangible assets	12	**1,349**	1,461
Trade and other receivables	15	**59,024**	58,101
Other financial assets	16	**0**	0
Total non-current assets		**351,021**	338,211
Current assets			
Inventories	14	**9,029**	9,216
Trade and other receivables	15	**42,207**	68,507
Other financial assets	16	**0**	0
Cash and cash equivalents	17	**2,313**	1,654
		53,549	79,377
Non-current assets classified as "Held for Sale"	11	**392**	832
Total current assets		**53,941**	80,209
Total assets		**404,962**	418,420
Current liabilities			
Trade and other payables	18	**(152,942)**	(119,136)
Other financial liabilities	19	**0**	0
Provisions	20	**(21,116)**	(39,837)
Total current liabilities		**(174,058)**	(158,973)
Net current assets/ (liabilities)		**(120,117)**	(78,764)
Non-current liabilities			
Trade and other payables	18	**(1,123)**	0
Other financial liabilities	19	**0**	0
Provisions	20	**(59,381)**	(58,365)
Total non-current liabilities		**(60,504)**	(58,365)
Total assets employed		**170,400**	201,082
Financed by :			
Taxpayers' equity			
General Fund		**140,985**	173,027
Revaluation reserve		**29,415**	28,055
Total taxpayers' equity		**170,400**	201,082

The financial statements on pages 2 to 7 were approved by the Board on 10th June 2021 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 10th June 2021

The notes on pages 8 to 74 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2021

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2020-21			
Balance at 1 April 2020	173,027	28,055	**201,082**
Net operating cost for the year	(1,054,279)		**(1,054,279)**
Net gain/(loss) on revaluation of property, plant and equipment	0	3,020	**3,020**
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	10	**10**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	1,670	(1,670)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2020-21	(1,052,609)	1,360	**(1,051,249)**
Net Welsh Government funding	1,001,297		**1,001,297**
Notional Welsh Government Funding	19,270		**19,270**
Balance at 31 March 2021	140,985	29,415	**170,400**
Included in Net Welsh Government Funding:			
Welsh Government Covid 19 Capital Funding	12,580		**12,580**
Welsh Government Covid 19 Revenue Funding	82,924		**82,924**

The Welsh Government Covid 19 Capital and Revenue funding totals in this note is the cash draw down only.

A breakdown of the Welsh Government Revenue and capital allocation to fund Covid 19 costs is detailed in Note 34.2.

The notes on pages 8 to 74 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2020

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2019-20			
Balance at 1 April 2019	167,572	26,806	**194,378**
Net operating cost for the year	(928,650)		**(928,650)**
Net gain/(loss) on revaluation of property, plant and equipment	0	1,522	**1,522**
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**
Other reserve movement	0	0	**0**
Transfers between reserves	273	(273)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2019-20	(928,377)	1,249	**(927,128)**
Net Welsh Government funding	916,303		**916,303**
Notional Welsh Government Funding	17,529		**17,529**
Balance at 31 March 2020	173,027	28,055	**201,082**

The notes on pages 8 to 74 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2021

	Notes	2020-21 £'000	2019-20 £'000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,054,279)**	(928,650)
Movements in Working Capital	27	**62,450**	(24,862)
Other cash flow adjustments	28	**41,945**	91,269
Provisions utilised	20	**(17,690)**	(13,944)
Net cash outflow from operating activities		**(967,574)**	(876,187)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(33,949)**	(40,957)
Proceeds from disposal of property, plant and equipment		**475**	378
Purchase of intangible assets		**(228)**	(442)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(33,702)**	(41,021)
Net cash inflow/(outflow) before financing		**(1,001,276)**	(917,208)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,001,297**	916,303
Capital receipts surrendered		**0**	0
Capital grants received		**638**	1,099
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,001,935**	917,402
Net increase/(decrease) in cash and cash equivalents		**659**	194
Cash and cash equivalents (and bank overdrafts) at 1 April 2020		**1,654**	1,460
Cash and cash equivalents (and bank overdrafts) at 31 March 2021		**2,313**	1,654

The notes on pages 8 to 74 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 2020-21 Manual for Accounts. The accounting policies contained in that manual follow the 2020-21 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, except for IFRS 16 Leases, which is deferred until 1 April 2022; to the extent that they are meaningful and appropriate to the NHS in Wales.

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 LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. 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 has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

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

1.4.1. 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.

1.4.2. 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.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

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 NHS Wales organisation 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 NHS Wales organisation’s 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.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. 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

1.6.1. 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 NHS Wales organisation;

● 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.

1.6.2. 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 services or for administrative purposes are stated in the Statement of Financial Position (SoFP) 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' organisations 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 (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with 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. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

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 NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation 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

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.

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.

1.6.3. 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. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation 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

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the 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 NHS Wales organisation; 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

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 NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation 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 NHS Wales organisation 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 SoCNE. 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 NHS Wales organisation 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 SoCNE.

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 NHS Wales organisation as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Wales organisation 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 NHS Wales organisation’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 (SoCF), 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 NHS Wales organisation has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Wales organisation 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 NHS Wales organisation 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 NHS Wales organisation 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 Services (WRPS) 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 implemented in both 2020-21 and 2019-20. The WRP is hosted by Velindre NHS Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was 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 recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation 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.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 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 SOFP date, the NHS Wales organisation 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 SoCNE 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 SoCNE 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 SOFP when the NHS Wales organisation 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 SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the 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 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 (VAT)

Most of the activities of the NHS Wales organisation 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 SoCNE. At the SoFP 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 NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes 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 the NHS Wales organisation 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 NHS Wales organisation accounts for all losses and special payments gross (including assistance from the WRP).

The NHS Wales organisation accrues or provides for the best estimate of future pay-outs 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 between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The NHS Wales organisation has/has not 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 the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation 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 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 SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these

claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The NHS Wales organisation 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 NHS Wales organisation, 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.

1.24.2. 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 minus 0.25%.

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.

1.24.3 Additional accruals as a result of COVID-19

Included in the Accounts are additional accruals as a result of the response to the COVID-19 pandemic in which the Health Board had to provide estimates, although not necessarily material, examples include:

- Annual leave accrual, the impact of staff not taking leave within the year and the cost of carrying forward into the following year

- the impact of de-commissioning of the Field Hospitals including Onerous Contracts

- Bonus payment to staff

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 NHS Wales organisation 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'.

1.25.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.25.2. 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 NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.25.2. 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 SoCNE.

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 SoCNE.

1.25.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's 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.

1.25.4. Assets contributed by the NHS Wales organisation 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 NHS Wales organisation's SoFP.

1.25.5. Other assets contributed by the NHS Wales organisation to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Wales organisation 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 NHS Wales organisation, 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 NHS Wales organisation 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 NHS Wales organisation, 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 NHS Wales organisation. 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. 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.

1.28. 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
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 16 Leases is to be effective from 1st April 2022.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.29. Accounting standards issued that have been adopted early

During 2020-21 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.30. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the NHS Wales

organisation has established that as it is the corporate trustee of the Hywel Dda University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Hywel Dda University LHB NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Hywel Dda University LHB NHS Charitable Fund within the statutory accounts of the NHS Wales organisation.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Hywel Dda University LHB NHS Charitable Fund or its independence in its management of charitable funds.

However, the NHS Wales organisation 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 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			
	2018-19	2019-20	2020-21	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	862,414	928,650	1,054,279	**2,845,343**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,722	1,400	1,889	**5,011**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Total operating expenses	864,136	930,050	1,056,168	**2,850,354**
Revenue Resource Allocation	828,698	895,107	1,031,258	**2,755,063**
Under /(over) spend against Allocation	(35,438)	(34,943)	(24,910)	**(95,291)**

Hywel Dda University LHB **has not** met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2018-19 to 2020-21.

The health board received £16m strategic cash only support in 2020-21.

This cash only support is provided to assist the health board with payments to staff and suppliers, there is no requirement to repay this strategic cash assistance.

2.2 Capital Resource Performance

	2018-19	2019-20	2020-21	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	31,820	41,686	35,483	**108,989**
Add: Losses on disposal of donated assets	0	0	0	**0**
Less NBV of property, plant and equipment and intangible assets disposed	0	(323)	(455)	**(778)**
Less capital grants received	0	0	0	**0**
Less donations received	(952)	(1,099)	(637)	**(2,688)**
Charge against Capital Resource Allocation	30,868	40,264	34,391	**105,523**
Capital Resource Allocation	30,893	40,295	34,451	**105,639**
(Over) / Underspend against Capital Resource Allocation	25	31	60	**116**

Hywel Dda University LHB **has** met its financial duty to break-even against its Capital Resource Limit over the 3 years 2018-19 to 2020-21.

2.3 Duty to prepare a 3 year integrated plan

Due to the pandemic, the process for the 2020-23 integrated plan was paused in spring 2020 and a temporary quarterly planning arrangement put in place for 2020-21.

As a result the extant planning duty for 2020-21 remains the requirement to submit and have approved a 2019-22 integrated plan, as set out in the NHS Wales Planning Framework 2019-22.

The Hywel Dda University Health Board did not submit a 2019-22 integrated plan in accordance with the planning framework.

The LHB **has not** therefore met its statutory duty to have an approved financial plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2020-21	2019-20
Total number of non-NHS bills paid	**201,912**	195,925
Total number of non-NHS bills paid within target	**192,345**	188,489
Percentage of non-NHS bills paid within target	95.3%	96.2%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £'000	Non-cash limited £'000	2020-21 Total £'000	2019-20 £'000
General Medical Services	74,179		**74,179**	73,954
Pharmaceutical Services	20,722	(6,112)	**14,610**	14,057
General Dental Services	19,578		**19,578**	21,035
General Ophthalmic Services	1,239	4,223	**5,462**	5,543
Other Primary Health Care expenditure	5,644		**5,644**	4,801
Prescribed drugs and appliances	79,979		**79,979**	72,577
Total	**201,341**	**(1,889)**	**199,452**	191,967

3.2 Expenditure on healthcare from other providers

	2020-21 £'000	2019-20 £'000
Goods and services from other NHS Wales Health Boards	**41,765**	38,048
Goods and services from other NHS Wales Trusts	**13,560**	6,218
Goods and services from Health Education and Improvement Wales (HEIW)	**0**	3
Goods and services from other non Welsh NHS bodies	**2,193**	44
Goods and services from WHSSC / EASC	**102,617**	94,452
Local Authorities	**31,529**	15,521
Voluntary organisations	**3,393**	2,672
NHS Funded Nursing Care	**2,799**	3,102
Continuing Care	**49,440**	45,118
Private providers	**4,870**	6,038
Specific projects funded by the Welsh Government	**0**	0
Other	**144**	237
Total	**252,310**	211,453

In Note 3.1, Staff Costs of £11.075m paid by the Health Board are included in General Medical Services

3.3 Expenditure on Hospital and Community Health Services

	2020-21 £'000	2019-20 £'000 Reclassified
Directors' costs	2,294	2,445
Operational Staff costs	496,799	432,363
Single lead employer Staff Trainee Cost	4,209	3,874
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	76,804	78,038
Supplies and services - general	7,708	6,392
Consultancy Services	1,838	1,518
Establishment	8,819	8,447
Transport	1,642	1,817
Premises	35,259	18,003
External Contractors	676	719
Depreciation	19,184	16,171
Amortisation	457	496
Fixed asset impairments and reversals (Property, plant & equipment)	6,970	13,119
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	371	344
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,649	1,755
Research and Development	0	0
Other operating expenses	1,223	1,606
Total	**665,902**	587,107

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2020-21 £'000	2019-20 £'000
Clinical negligence;		
Secondary care	(5,209)	49,957
Primary care	0	0
Redress Secondary Care	103	1,083
Redress Primary Care	0	0
Personal injury	2,399	450
All other losses and special payments	342	253
Defence legal fees and other administrative costs	522	1,355
Gross increase/(decrease) in provision for future payments	(1,843)	**53,098**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	(62)	118
Less: income received/due from Welsh Risk Pool	3,554	(51,461)
Total	**1,649**	1,755

	2020-21 £	2019-20 £
Permanent injury included within personal injury £:	213,187	269,446

Note 3.3 above - 2019-20 Reclassified to show the comparative figure in relation to the 'Single lead employer S

4. Miscellaneous Income

	2020-21 £'000	2019-20 £'000
Local Health Boards	19,673	19,360
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	2,459	2,370
NHS Wales trusts	6,790	5,581
Health Education and Improvement Wales (HEIW)	2,588	2,028
Foundation Trusts	0	0
Other NHS England bodies	2,210	4,445
Other NHS Bodies	0	0
Local authorities	6,515	5,316
Welsh Government	5,539	3,753
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	4	5
Dental fee income	1,077	3,159
Private patient income	5	13
Overseas patients (non-reciprocal)	29	266
Injury Costs Recovery (ICR) Scheme	784	1,080
Other income from activities	463	562
Patient transport services	0	0
Education, training and research	7,035	6,836
Charitable and other contributions to expenditure	819	1,089
Receipt of NWSSP Covid centrally purchased assets	3,189	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	348	1,099
Receipt of Government granted assets	364	0
Non-patient care income generation schemes	348	496
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	48	446
Contingent rental income from finance leases	0	0
Rental income from operating leases	39	353
Other income:		
Provision of laundry, pathology, payroll services	108	102
Accommodation and catering charges	1,112	1,523
Mortuary fees	178	202
Staff payments for use of cars	235	224
Business Unit	0	0
Other	1,376	1,498
Total	**63,335**	61,806

Other income Includes;

	0	0
	0	0
	0	0
Creche Fees	143	168
Design Fees Recharge	341	428
Werndale Recharge of CSSD packs	195	70
Total	**679**	666

Welsh Government Covid 19 income included in total above;. **0**

Injury Cost Recovery (ICR) Scheme income

	2020-21 %	2019-20 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	22.43	21.79

Covid-19 note
As part of the NHS Wales response to the Covid pandemic, a number of consumable and revenue equipment items have been purchased centrally within NWSSP and provided to UHBs/Trusts free of charge. The Health Board received £3,188,593 worth of stock which has been fully utilised within the Health Board, this is included above under the heading 'Receipt of NWSSP Centrally Purchased assets'.

Included within 'Education, Training and research' is £60,790 of Covid-19 income sources in the form of grants and research income.

Welsh Government Covid-19 allocation is not included above and is detailed in Note 34.2.

5. Investment Revenue

	2020-21	2019-20
	£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

	2020-21	2019-20
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	20	55
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	20	55

7. Finance costs

	2020-21	2019-20
	£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	(30)	(16)
Other finance costs	0	0
Total	(30)	(16)

8. Operating leases

LHB as lessee

As at 31st March 2021 the LHB had 433 operating leases agreements in place for the leases of 27 premises, 239 arrangement in respect of equipment and 167 in respect of vehicles, with 3 premises, 29 equipment and 94 vehicle leases having expired in year. Rental / licence to occupy payments for Field Hospitals have been included as lease payments in 2020-21. These amount to £7.2m.

Payments recognised as an expense	**2020-21**	2019-20
	£000	£000
Minimum lease payments	**9,656**	2,296
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**9,656**	2,296

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**1,326**	1,358
Between one and five years	**2,584**	2,536
After 5 years	**2,288**	2,607
Total	**6,198**	6,501

LHB as lessor

Rental revenue	**£000**	£000
Rent	**162**	303
Contingent rents	**0**	0
Total revenue rental	**162**	303

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**426**	303
Between one and five years	**1,501**	1,210
After 5 years	**1,280**	1,718
Total	**3,207**	3,231

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2019-20
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	383,888	4,502	15,590	3,752	0	7,073	**414,805**	359,850
Social security costs	34,601	0	0	165	0	668	**35,434**	32,568
Employer contributions to NHS Pension Scheme	62,608	0	0	293	0	26	**62,927**	57,535
Other pension costs	199	0	0	0	0	0	**199**	167
Other employment benefits	0	0	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	0	0	**0**	0
Total	481,296	4,502	15,590	4,210	0	7,767	**513,365**	450,120

Charged to capital	**97**	578
Charged to revenue	**513,268**	449,542
	513,365	450,120
Net movement in accrued employee benefits (untaken staff leave accrual included above)	0	(394)
Covid 19 Net movement in accrued employee benefits (untaken staff leave accrual included in above)	11,877	0

Please give detail of staff under "Other".

Included in 'Other costs' are contracted medical and dental staff and therapists

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2019-20
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	1,840	42	1	0	0	0	**1,883**	1,695
Medical and dental	641	25	2	69	0	27	**764**	760
Nursing, midwifery registered	2,789	1	204	0	0	0	**2,994**	2,937
Professional, Scientific, and technical staff	339	0	0	0	0	0	**339**	334
Additional Clinical Services	2,067	0	0	0	0	0	**2,067**	1,832
Allied Health Professions	591	1	0	0	0	22	**614**	572
Healthcare Scientists	180	0	0	0	0	0	**180**	179
Estates and Ancilliary	943	0	10	0	0	0	**953**	782
Students	1	0	0	0	0	0	**1**	1
Total	**9,391**	**69**	**217**	**69**	**0**	**48**	**9,794**	9,092

9.3. Retirements due to ill-health

	2020-21	2019-20
Number	12	8
Estimated additional pension costs £	246,309	487,916

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2020-21 Number of compulsory redundancies	2020-21 Number of other departures	2020-21 Total number of exit packages	2020-21 Number of departures where special payments have been made	2019-20 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	1
£10,000 to £25,000	0	2	2	2	2
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	1	1	1	0
£150,000 to £200,000	0	1	1	1	0
more than £200,000	0	0	0	0	0
Total	**0**	**5**	**5**	**5**	3

Exit packages cost band (including any special payment element)	2020-21 Cost of compulsory redundancies	2020-21 Cost of other departures	2020-21 Total cost of exit packages	2020-21 Cost of special element included in exit packages	2019-20 Total cost of exit packages
	£'s	£'s	£'s	£'s	£'s
less than £10,000	0	1,000	1,000	1,000	2,500
£10,000 to £25,000	0	45,287	45,287	45,287	22,300
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	143,529	143,529	143,529	0
£150,000 to £200,000	0	167,471	167,471	167,471	0
more than £200,000	0	0	0	0	0
Total	**0**	**357,287**	**357,287**	**357,287**	24,800

Exit costs paid in year of departure	Total paid in year 2020-21	Total paid in year 2019-20
	£'s	£'s
Exit costs paid in year	312,000	24,800
Total	**312,000**	24,800

Redundancy and 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 Pensions 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 /employee in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Hywel Dda LHB in the financial year 2020-21 was £195,000 to £200,000 (2019-20, £190,000 to £195,000. This was 6 times (2019-20, 6 times) the median remuneration of the workforce, which was £34,027 (2019-20, £33,758).

In 2020-21, 24 (2019-20, 32) employees received remuneration in excess of the highest-paid director. Remuneration for all staff ranged from £21,879 to £318,973 (2019-20, £21,450 to £360,373).

Total remuneration includes salary 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 and Social Care 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,000 for the 2020-2021 tax year (2019-2020 £6,136 and £50,000).

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.

	2020-21	**2020-21**	2019-20	2019-20
NHS	**Number**	**£000**	Number	£000
Total bills paid	**3,795**	**273,347**	3,623	247,454
Total bills paid within target	**3,402**	**265,111**	3,199	244,394
Percentage of bills paid within target	**89.6%**	**97.0%**	88.3%	98.8%
Non-NHS				
Total bills paid	**201,912**	**504,230**	195,925	451,748
Total bills paid within target	**192,345**	**486,363**	188,489	438,423
Percentage of bills paid within target	**95.3%**	**96.5%**	96.2%	97.1%
Total				
Total bills paid	**205,707**	**777,577**	199,548	699,202
Total bills paid within target	**195,747**	**751,474**	191,688	682,817
Percentage of bills paid within target	**95.2%**	**96.6%**	96.1%	97.7%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2020-21	2019-20
	£	£
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 2020	25,456	219,844	7,719	20,459	72,551	93	24,457	7,913	378,492
Indexation	(299)	3,475	225	0	0	0	0	0	3,401
Additions									
- purchased	0	4,462	0	8,756	11,528	0	5,665	4,090	34,501
- donated	0	0	0	0	310	0	25	12	347
- government granted	0	0	0	0	290	0	0	0	290
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	16,691	0	(16,785)	0	0	94	0	0
Revaluations	0	0	0	0	5	0	0	0	5
Reversal of impairments	0	2,927	0	0	0	0	0	0	2,927
Impairments	(205)	(10,462)	0	0	0	0	0	0	(10,667)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,256)	0	(746)	(14)	(3,016)
At 31 March 2021	24,952	236,937	7,944	12,430	82,428	93	29,495	12,001	406,280
Depreciation at 1 April 2020	0	20,919	1,053	0	57,295	93	14,940	5,543	99,843
Indexation	0	356	30	0	0	0	0	0	386
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	253	0	0	0	0	0	0	253
Impairments	0	(1,023)	0	0	0	0	0	0	(1,023)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,251)	0	(746)	(14)	(3,011)
Provided during the year	0	8,984	360	0	5,393	0	3,297	1,150	19,184
At 31 March 2021	0	29,489	1,443	0	60,437	93	17,491	6,679	115,632
Net book value at 1 April 2020	25,456	198,925	6,666	20,459	15,256	0	9,517	2,370	278,649
Net book value at 31 March 2021	24,952	207,448	6,501	12,430	21,991	0	12,004	5,322	290,648
Net book value at 31 March 2021 comprises :									
Purchased	24,705	203,267	6,501	12,430	20,844	0	11,833	5,119	284,699
Donated	247	4,181	0	0	863	0	153	203	5,647
Government Granted	0	0	0	0	284	0	18	0	302
At 31 March 2021	24,952	207,448	6,501	12,430	21,991	0	12,004	5,322	290,648
Asset financing :									
Owned	24,952	207,448	6,501	12,430	21,991	0	12,004	5,322	290,648
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 2021	24,952	207,448	6,501	12,430	21,991	0	12,004	5,322	290,648

The net book value of land, buildings and dwellings at 31 March 2021 comprises :

	£000
Freehold	237,210
Long Leasehold	1,692
Short Leasehold	0
	238,902

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

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 which an 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 2019	26,209	203,080	7,569	22,076	67,694	240	20,861	6,141	**353,870**
Indexation	(157)	1,900	150	0	0	0	0	0	**1,893**
Additions									
- purchased	0	4,074	0	24,284	6,701	0	3,534	1,658	**40,251**
- donated	0	326	0	305	239	0	115	114	**1,099**
- 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	375	25,816	0	(26,206)	0	0	15	0	**0**
Revaluations	0	(245)	0	0	22	0	0	0	**(223)**
Reversal of impairments	0	2,121	0	0	0	0	0	0	**2,121**
Impairments	(35)	(17,032)	0	0	0	0	0	0	**(17,067)**
Reclassified as held for sale	(936)	(196)	0	0	0	0	0	0	**(1,132)**
Disposals	0	0	0	0	(2,105)	(147)	(68)	0	**(2,320)**
At 31 March 2020	25,456	219,844	7,719	20,459	72,551	93	24,457	7,913	**378,492**
Depreciation at 1 April 2019	0	14,490	689	0	54,869	240	12,330	5,030	**87,648**
Indexation	0	134	14	0	0	0	0	0	**148**
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	153	0	0	0	0	0	0	**153**
Impairments	0	(1,980)	0	0	0	0	0	0	**(1,980)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(2,082)	(147)	(68)	0	**(2,297)**
Provided during the year	0	8,122	350	0	4,508	0	2,678	513	**16,171**
At 31 March 2020	0	20,919	1,053	0	57,295	93	14,940	5,543	**99,843**
Net book value at 1 April 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Net book value at 31 March 2020	25,456	198,925	6,666	20,459	15,256	0	9,517	2,370	**278,649**
Net book value at 31 March 2020 comprises :									
Purchased	25,203	194,977	6,666	20,154	14,372	9,316	2,099	0	**272,787**
Donated	253	3,948	0	305	884	189	271	0	**5,850**
Government Granted	0	0	0	0	0	12	0	0	**12**
At 31 March 2020	25,456	198,925	6,666	20,459	15,256	9,517	2,370	0	**278,649**
Asset financing :									
Owned	25,456	198,925	6,666	20,459	15,256	0	9,517	2,370	**278,649**
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 2020	25,456	198,925	6,666	20,459	15,256	0	9,517	2,370	**278,649**

The net book value of land, buildings and dwellings at 31 March 2020 comprises :

	£000
Freehold	**229,335**
Long Leasehold	**1,714**
Short Leasehold	**0**
	231,049

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. **0**

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 which an 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)

Disclosures:

i) Donated Assets
Hywel Dda LHB has received the following donated assets during the year.
Acquisitions shown as donated assets within Note 11 were bought using monies donated by the public into the Charitable Funds, Granted contributions from Department of Health and other charities.
During 2020-21 fixed assets purchased to the following value were funded by the following :

Hywel Dda General Fund Charity (1147683) Plant and Machinery	£259,817
Hywel Dda General Fund Charity (1147863) Furniture and Fittings	£12,433
Hywel Dda General Fund Charity (1147863) Information Technology	£8,280
UK Government Department of Health & Social Care Granted Assets	£289,825
Other Contributions	£67,847
Total Donated Assets	**£638,202**

ii) Valuations
The LHBs 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.

The LHB is 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 which an 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 operation.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
There have not been write downs.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are assets held for sale or sold in the period.
Assets held for sale include Cardigan Health Centre and Neyland Health Centre.
Asset sold in the period is Cardigan Hospital.

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 2020	636	196	0	0	0	**832**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	10	0	0	0	0	**10**
Less assets sold in the year	(450)	0	0	0	0	**(450)**
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 2021	196	196	0	0	0	**392**
Balance brought forward 1 April 2019	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	936	196	0	0	0	**1,132**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	(300)	0	0	0	0	**(300)**
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 2020	636	196	0	0	0	**832**

12. Intangible non-current assets

2020-21

	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 2020	3,695	0	77	0	0	0	3,772
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	345	0	0	0	0	0	345
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 2021	4,040	0	77	0	0	0	4,117
Amortisation at 1 April 2020	2,234	0	77	0	0	0	2,311
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	457	0	0	0	0	0	457
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 2021	2,691	0	77	0	0	0	2,768
Net book value at 1 April 2020	1,461	0	0	0	0	0	1,461
Net book value at 31 March 2021	1,349	0	0	0	0	0	1,349
At 31 March 2021							
Purchased	1,349	0	0	0	0	0	1,349
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2021	1,349	0	0	0	0	0	1,349

12. Intangible non-current assets
2019-20

	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 2019	3,359	0	77	0	0	0	**3,436**
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	336	0	0	0	0	0	**336**
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 2020	**3,695**	**0**	**77**	**0**	**0**	**0**	**3,772**
Amortisation at 1 April 2019	1,738	0	77	0	0	0	**1,815**
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	496	0	0	0	0	0	**496**
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 2020	**2,234**	**0**	**77**	**0**	**0**	**0**	**2,311**
Net book value at 1 April 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**
Net book value at 31 March 2020	**1,461**	**0**	**0**	**0**	**0**	**0**	**1,461**
At 31 March 2020							
Purchased	1,614	0	0	0	0	0	**1,614**
Donated	7	0	0	0	0	0	**7**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2020	**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 and 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 31st March 2021 was £1,726,089.

13 . Impairments

	2020-21 Property, plant & equipment £000	2020-21 Intangible assets £000	2019-20 Property, plant & equipment £000	2019-20 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	100	0
Others (specify)	9,440	0	15,238	0
Reversal of Impairments	(2,470)	0	(1,973)	0
Total of all impairments	**6,970**	**0**	13,365	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	6,970	0	13,119	0
Charged to Revaluation Reserve	0	0	246	0
	6,970	**0**	13,365	0

14.1 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	4,008	4,081
Consumables	4,853	4,888
Energy	168	247
Work in progress	0	0
Other	0	0
Total	9,029	9,216
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2021	31 March 2020
	£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

Covid 19 Disclosure

As part of the NHS Wales response to the Covid pandemic, a number of consumable and revenue equipment items have been purchased centrally within NWSSP and provided to UHBs/Trusts free of charge. The Health Board received £3,188,593 worth of stock which has been fully consumed within the Health Board. The stock value of these items as at 31 March 2021 was zero.

15. Trade and other Receivables

Current	**31 March 2021 £000**	31 March 2020 £000
Welsh Government	**4,653**	2,829
WHSSC / EASC	**585**	1,180
Welsh Health Boards	**577**	1,294
Welsh NHS Trusts	**2,076**	1,391
Health Education and Improvement Wales (HEIW)	**277**	494
Non - Welsh Trusts	**10**	27
Other NHS	**308**	939
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	**25,233**	51,437
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**1,347**	1,549
Other	**0**	0
Local Authorities	**1,050**	1,016
Capital debtors - Tangible	**0**	0
Capital debtors - Intangible	**0**	0
Other debtors	**4,163**	5,121
Provision for irrecoverable debts	**(967)**	(1,171)
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**2,895**	2,401
Other accrued income	**0**	0
Sub total	**42,207**	68,507
Non-current		
Welsh Government	**0**	0
WHSSC / 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
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	**59,024**	58,101
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**0**	0
Capital debtors - Tangible	**0**	0
Capital debtors - Intangible	**0**	0
Other debtors	**0**	0
Provision for irrecoverable debts	**0**	0
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**59,024**	58,101
Total	**101,231**	126,608

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2021 £000	31 March 2020 £000
By up to three months	**197**	589
By three to six months	**13**	449
By more than six months	**35**	24
	245	1,062

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April 2020	**(1,171)**	(1,053)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**0**	59
Amount recovered during the year	**0**	0
(Increase) / decrease in receivables impaired	**204**	(177)
Bad debts recovered during year	**0**	0
Balance at 31 March 2021	**(967)**	(1,171)

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	**(90)**	401
Other	**0**	0
Total	**(90)**	401

16. Other Financial Assets

	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£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**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**

17. Cash and cash equivalents

	2020-21	2019-20
	£000	£000
Balance at 1 April 2020	**1,654**	1,460
Net change in cash and cash equivalent balances	**659**	194
Balance at 31 March 2021	**2,313**	1,654
Made up of:		
Cash held at GBS	**1,902**	1,273
Commercial banks	**384**	355
Cash in hand	**27**	26
Cash and cash equivalents as in Statement of Financial Position	**2,313**	1,654
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**2,313**	1,654

The movement relates to cash, no comparative information is required by IAS 7 in 2020-21.

18. Trade and other payables

Current	**31 March 2021 £000**	31 March 2020 £000
Welsh Government	**0**	39
WHSSC / EASC	**1,007**	78
Welsh Health Boards	**1,766**	1,922
Welsh NHS Trusts	**918**	2,059
Health Education and Improvement Wales (HEIW)	**0**	3
Other NHS	**9,009**	7,157
Taxation and social security payable / refunds	**4,669**	2,066
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	**5,794**	2,160
Non-NHS payables - Revenue	**18,164**	12,807
Local Authorities	**11,993**	8,382
Capital payables- Tangible	**9,367**	8,178
Capital payables- Intangible	**294**	177
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
Non NHS Accruals	**69,118**	66,075
Deferred Income:		
Deferred Income brought forward	**67**	418
Deferred Income Additions	**218**	67
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**(48)**	(418)
Other creditors	**20,606**	7,966
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**152,942**	119,136
Non-current		
Welsh Government	**0**	0
WHSSC / 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 payables - Revenue	**0**	0
Local Authorities	**321**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**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
Non NHS Accruals	**699**	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	**103**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**1,123**	0
Total	**154,065**	119,136

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.
Other creditors includes £11,250k in relation to the NHS Staff Bonus payment
Non NHS Accruals includes £11,839k in relation to accrued annual leave as a result of untaken leave due to Covid-19

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2021 £000**	31 March 2020 £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 2021 £000**	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £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 2020	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 2021
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	33,990	0	(750)	11,027	9,356	(15,124)	(27,448)	0	11,051
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	1,111	0	(52)	(1)	569	(268)	(466)	0	893
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,170	0	(77)	33	2,444	(601)	(45)	(30)	4,894
All other losses and special payments	0	0	0	0	342	(342)	0	0	0
Defence legal fees and other administration	781	0	0	177	824	(555)	(403)		824
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	29			0	11	(20)	0	0	20
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	0
Restructuring	0			0	0	0	0	0	0
Other	756		0	0	2,923	(48)	(197)		3,434
Total	39,837	0	(879)	11,236	16,469	(16,958)	(28,559)	(30)	21,116
Non Current									
Clinical negligence:-									
Secondary care	57,440	0	0	(11,027)	14,143	(595)	(1,259)	0	58,702
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	1	0	0	(1)	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	33	0	0	(33)	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	892	0	0	(177)	375	(137)	(274)		679
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	0
Restructuring	0			0	0	0	0	0	0
Other	0		0	0	0	0	0		0
Total	58,365	0	0	(11,236)	14,518	(732)	(1,534)	0	59,381
TOTAL									
Clinical negligence:-									
Secondary care	91,430	0	(750)	0	23,499	(15,719)	(28,707)	0	69,753
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	1,111	0	(52)	0	569	(268)	(467)	0	893
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,203	0	(77)	0	2,444	(601)	(45)	(30)	4,894
All other losses and special payments	0	0	0	0	342	(342)	0	0	0
Defence legal fees and other administration	1,673	0	0	0	1,199	(692)	(677)		1,503
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	29			0	11	(20)	0	0	20
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	0
Restructuring	0			0	0	0	0	0	0
Other	756		0	0	2,923	(48)	(197)		3,434
Total	98,202	0	(879)	0	30,987	(17,690)	(30,093)	(30)	80,497

Expected timing of cash flows:

	In year to 31 March 2022	Between 1 April 2022 31 March 2026	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	11,051	58,702	0	69,753
Primary care	0	0	0	0
Redress Secondary care	893	0	0	893
Redress Primary care	0	0	0	0
Personal injury	4,894	0	0	4,894
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	824	679	0	1,503
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	20	0	0	20
2019-20 Scheme Pays - Reimbursement	0	0	0	0
Restructuring	0	0	0	0
Other	3,434	0	0	3,434
Total	21,116	59,381	0	80,497

20. Provisions (continued)

	At 1 April 2019	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 2020
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	17,221	0	(8,185)	2,804	37,138	(8,291)	(6,697)	0	**33,990**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	384	0	0	0	1,309	(358)	(224)	0	**1,111**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,146	0	0	(28)	530	(372)	(90)	(16)	**3,170**
All other losses and special payments	0	0	0	0	253	(253)	0	0	**0**
Defence legal fees and other administration	693	0	0	96	1,353	(659)	(702)		**781**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	37			0	14	(22)	0	0	**29**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	2,060		0	0	1,166	(1,501)	(969)		**756**
Total	**23,541**	**0**	**(8,185)**	**2,872**	**41,763**	**(11,456)**	**(8,682)**	**(16)**	**39,837**
Non Current									
Clinical negligence:-									
Secondary care	43,048	0	0	(2,804)	27,165	(2,318)	(7,651)	0	**57,440**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	0	0	0	28	24	(5)	(14)	0	**33**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	449	0	0	(96)	836	(165)	(132)		**892**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**43,497**	**0**	**0**	**(2,872)**	**28,025**	**(2,488)**	**(7,797)**	**0**	**58,365**
TOTAL									
Clinical negligence:-									
Secondary care	60,269	0	(8,185)	0	64,303	(10,609)	(14,348)	0	**91,430**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	384	0	0	0	1,309	(358)	(224)	0	**1,111**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,146	0	0	0	554	(377)	(104)	(16)	**3,203**
All other losses and special payments	0	0	0	0	253	(253)	0	0	**0**
Defence legal fees and other administration	1,142	0	0	0	2,189	(824)	(834)		**1,673**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	37			0	14	(22)	0	0	**29**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	2,060		0	0	1,166	(1,501)	(969)		**756**
Total	**67,038**	**0**	**(8,185)**	**0**	**69,788**	**(13,944)**	**(16,479)**	**(16)**	**98,202**

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2020-21 £'000**	2019-20 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**71,875**	93,702
Primary care	**0**	0
Redress Secondary care	**0**	0
Redress Primary care	**0**	0
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**1,894**	2,669
Continuing Health Care costs	**1,196**	1,841
Other	**0**	693
Total value of disputed claims	**74,965**	98,905
Amounts (recovered) in the event of claims being successful	**(71,081)**	(93,443)
Net contingent liability	**3,884**	5,462

"In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that: clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement. Welsh Government, on behalf of (Hywel Dda UHB), will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction. This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants. Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026. At the date of approval of these accounts, there was insufficient data of take-up of the scheme by the Welsh clinical staff to enable a reasonable assessment of future take up to be made. As no reliable estimate can therefore be made to support the creation of a provision at 31 March 2021, the existence of an unquantified contingent liability is instead disclosed."

21.2 Remote Contingent liabilities

	2020-21 £'000	2019-20 £'000
Please disclose the values of the following categories of remote contingent liabilities :		
Guarantees	0	0
Indemnities	27	175
Letters of Comfort	0	0
Total	**27**	**175**

21.3 Contingent assets

	2020-21 £'000	2019-20 £'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2020-21 £'000	2019-20 £'000
Property, plant and equipment	4,411	6,305
Intangible assets	0	0
Total	**4,411**	6,305

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 2021	
	Number	**£**
Clinical negligence (CN)	62	23,903,837
Personal injury (PI)	33	600,018
All other losses and special payments	189	610,274
Total	284	25,114,129

Analysis of cases which exceed £300,000 and all other cases:

Cases where cumulative amount exceeds £300,000	**Number**	**Case type**	**Amounts paid out in year** £	**Cumulative amount** £
	06RR6MN0026	Clinical Negligence	0	665,465
	07RR6MN0006	Clinical Negligence	0	1,608,405
	12RYNMN0056	Clinical Negligence	1,582,980	2,989,200
	12RYNMN0077	Clinical Negligence	7,739,479	9,354,500
	13RYNMN0017	Clinical Negligence	22,000	1,442,000
	13RYNMN0032	Clinical Negligence	6,810,000	8,440,000
	13RYNMN0041	Clinical Negligence	250,000	1,150,000
	14RYNMN0069	Clinical Negligence	0	2,810,000
	14RYNMN0070	Clinical Negligence	177,000	542,000
	15RYNMN0034	Clinical Negligence	80,000	1,072,345
	15RYNMN0041	Clinical Negligence	0	785,000
	15RYNMN0044	Clinical Negligence	58,500	553,500
	16RYNMN0060	Clinical Negligence	354,520	385,000
	16RYNMN0063	Clinical Negligence	551,046	996,046
	17RYNMN0094	Clinical Negligence	3,400,000	3,750,878
	18RYNMN0022	Clinical Negligence	293,000	363,000
	20RYNMN0011	Clinical Negligence	4,000	305,000
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			0	0
Sub-total	**0**		**21,322,525**	**37,212,339**
All other cases	0		3,791,604	10,328,249
Total cases	**0**		**25,114,129**	**47,540,588**

24. Finance leases

24.1 Finance leases obligations (as lessee)

The Local Health Board has no finance leases receivable as a lessee.

Amounts payable under finance leases:

Land	**31 March 2021 £000**	31 March 2020 £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) continued

Amounts payable under finance leases:

Buildings	**31 March 2021**	31 March 2020
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 2021**	31 March 2020
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 2021	31 March 2020
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
Less finance charges allocated to future periods	**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 off-statement of financial position.

Commitments under off-SoFP PFI contracts	Off-SoFP PFI contracts	Off-SoFP PFI contracts
	31 March 2021	31 March 2020
	£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 2021	**31 March 2021**	**31 March 2021**
	£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 2020	31 March 2020	31 March 2020
	£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

	31 March 2021
	£000
Total present value of obligations for on-SoFP PFI contracts	**0**

25.3 Charges to expenditure	2020-21	2019-20
	£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 2021 £000	31 March 2020 £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

25.5 The LHB has no Public Private Partnerships

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

	2020-21 £000	2019-20 £000
(Increase)/decrease in inventories	**187**	(1,132)
(Increase)/decrease in trade and other receivables - non-current	**(923)**	(14,918)
(Increase)/decrease in trade and other receivables - current	**26,300**	(34,177)
Increase/(decrease) in trade and other payables - non-current	**1,123**	0
Increase/(decrease) in trade and other payables - current	**33,806**	25,652
Total	**60,493**	(24,575)
Adjustment for accrual movements in fixed assets - creditors	**(1,306)**	(287)
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**3,263**	0
	62,450	(24,862)

28. Other cash flow adjustments

	2020-21 £000	2019-20 £000
Depreciation	**19,184**	16,171
Amortisation	**457**	496
(Gains)/Loss on Disposal	**(20)**	(55)
Impairments and reversals	**6,970**	13,119
Release of PFI deferred credits	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0
Covid assets received credited to revenue but non-cash	**(3,189)**	0
Donated assets received credited to revenue but non-cash	**(348)**	(1,099)
Government Grant assets received credited to revenue but non-cash	**(364)**	0
Non-cash movements in provisions	**(15)**	45,108
Other movements	**19,270**	17,529
Total	**41,945**	91,269

29. Events after the Reporting Period

Donation of Oxygen Concentrators & CPAP machines to India

As a result of India experiencing a high level of coronavirus deaths and hospitals unable to meet the increased demand for treatment, in May 2021, Welsh Government requested NHS Wales Shared Services Partnership (NWSSP) to coordinate the release of surplus oxygen delivery equipment from across Wales to support the Indian healthcare system.

In response to this, following approval from Executive Team on the 11th May 2021, Hywel Dda University Health Board has donated 450 Oxygen Concentrators and 50 CPAP (Continuous Positive Airway Pressure) machines, worth £618,250. This amount will feature in the 2021/22 Annual Accounts as a write off.

30. Related Party Transactions

A number of the LHB's Board members have interests in related parties as follows:

Name	Details	Interests
Ann Murphy	Independent Member	Member of Royal College of Nursing (RCN)
Anna Lewis	Independent Member	Visiting Senior Lecturer in Swansea University Consultancy work undertaken in Betsi Cadwaladr University Health Board Consultancy work undertaken in Cwm Taf Morgannwg University Health Board
Huw Thomas	Director of Finance	Partner working in Ceredigion County Council
Judith Hardisty	Independent Member	Assessor for the Corporate Health Standard under auspices of A2 Consultancy who are instructed by Welsh Government
Karen Miles	Director of Planning, Performance & Commissioning	Close Family Member working in Swansea University Close Family Member working in University of Wales Trinity St David
Maria Battle	Chair	Board Member, Social Care Wales
Maynard Davies	Independent Member	Member of the Information Governance Review Panel for the SAIL Databank run by Swansea University
Michael Hearty	Associate Member	Non-Executive Director in Public Health England Non-Executive Director in HM Revenue & Customs (HMRC) Independent Advisor, Financial Reporting Council
Mike Lewis	Independent Member	Independent Member, City & County of Swansea Standards Committee Close family member working at Velindre NHS Trust
Mo Nazemi	Associate Member, Chair Healthcare Professionals Forum	Director & Shareholder & Ownership in Magawell Ltd Shareholder & Ownership in Jamo Group Ltd Board member of Community Pharmacy Wales Close family member is a Director and shareholder in Jamo Group Ltd
Owen Burt	Independent Member	Close Family Member working in University of Wales Trinity St David
Philip Kloer	Medical Director	Honorary Professor in Swansea University
Ros Jervis	Director of Public Health	Close family member working at Sandwell & West Birmingham Hospital NHS Trust
Simon Hancock	Independent Member	Member of Pembrokeshire Mencap Chair of Pembrokeshire County Council Member of Court of Swansea University Part time employee of Bluestone Ltd
Steve Moore	Chief Executive	Honorary Professor in University of Wales Trinity St David

Total value of transactions are with entities at which Board members and key senior staff have influential interests in 2020-21:

	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Royal College of Nursing	41	0	0	0
City & County of Swansea	4	0	0	0
Magawell Ltd	1997	0	0	0
Jamo Group Ltd	4	0	0	0
Community Pharmacy Wales	44	0	0	0
Mencap	14	0	0	0
Pembrokeshire County Council	16721	3,619	606	17
Ceredigion County Council	11056	358	5	62
Public Health England	7	0	0	0
Swansea University	380	418	-38	38
University of Wales Trinity St David	53	1	5	-1
HM Revenue & Customs	113365	0	0	0
Social Care Wales	23	0	0	0
Financial Reporting Council	3	0	3	0
Bluestone Ltd	7987	0	0	0
Sandwell & West Birmingham Hospitals NHS Trust	8	19	0	0
	151,707	**4,415**	**581**	**116**

The Welsh Government is regarded as a related party. During the year the LHB have 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, namely

	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	94	1,008,330	0	4,653
Aneurin Bevan University Health Board	714	748	5	228
Betsi Cadwaladr University Health Board	236	5,012	1	0
Cardiff & Vale University Health Board	6,317	492	375	70
Cwm Taf Morgannwg University Health Board	685	546	43	30
Powys Teaching Health Board	269	8,743	0	200
Public Health Wales NHS Trust	2,236	3,422	5	555
Swansea Bay University Health Board	37,062	4,149	247	49
Velindre NHS Trust	19,892	3,199	885	14,342
Welsh Ambulance Services Trust	5,087	122	28	10
Welsh Health Specialised Services Committee	102,631	2,459	1,007	585
Health Education & Improvement Wales (HEIW)	0	7684	0	277
	175,223	**1,044,906**	**2,596**	**20,999**

31. Third Party assets

The LHB held £1,425,138 cash at bank and in hand at 31 March 2021 (31 March 2020, £1,313,859) which relates to monies held by the LHB on behalf of patients. Cash held in Patient's Investment Accounts amounted to £954,366 at 31 March 2021 (31 March 2020, £713,895). This has been excluded from the Cash and Cash equivalents figure reported in the Accounts.

32. Pooled budgets

The 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 £342,000 are accounted for as expenditure in the accounts of the Health Board. The 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.

The 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. The 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.

The 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.

The 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. The 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.

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2020 to 31 March 2021. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2020 and February 2021 alongside Health Board/Trust/SHA data for March 2021.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2020-21	2019-20
Statement of Comprehensive Net Expenditure for the year ended 31 March 2021	**£000**	**£000**
Expenditure on Primary Healthcare Services	**247**	291
Expenditure on Hospital and Community Health Services	**19,023**	17,238
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2021		
Net operating cost for the year	**19,270**	17,529
Notional Welsh Government Funding	**19,270**	17,529
Statement of Cash Flows for year ended 31 March 2021		
Net operating cost for the financial year	**19,270**	0
Other cash flow adjustments	**19,270**	0
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**19,270**	17,529
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**247**	291
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**183**	117
Staff costs	**18,840**	17,121
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**19,270**	17,529
Charged to capital	**6**	36
Charged to revenue	**19,264**	17,493
18. Trade and other payables		
Current		
Pensions: staff	**0**	0
28. Other cash flow adjustments		
Other movements	**19,270**	17,529

34. Other Information

34.2. Other (continued)

Welsh Government Covid 19 Funding

	2020-21 £000
Capital	
Capital Funding Field Hospitals and Equipment	3,590
Capital Funding Equipment	8,990
Capital Funding other (Specify)	0
Welsh Government Covid 19 Capital Funding	**12,580**
Revenue	
Sustainability Funding	47,900
C-19 Pay Costs Q1 (Future Quarters covered by SF)	8,105
Field Hospital (Set Up Costs, Decommissioning & Consequential losses)	17,019
PPE (including All Wales Equipment via NWSSP)	3,275
TTP- Testing & Sampling - Pay & Non Pay	1,193
TTP - NHS & LA Tracing - Pay & Non Pay	3,369
Vaccination - Extended Flu Programme	636
Vaccination - COVID-19	2,248
Bonus Payment	11,250
Annual Leave Accrual - Increase due to Covid	11,733
Urgent & Emergency Care	2,460
Support for Adult Social Care Providers	3,548
Hospices	0
Independent Health Sector	0
Mental Health	625
Other Primary Care	1,304
Other	1,528
Welsh Government Covid 19 Revenue Funding	**116,193**

Additional Information :

The UK Government Department of Health & Social Care donated equipment to the value of £364,273.
These included Ultrasounds, Patient Monitors and Ventilators.
Total value of capital equipment - £289,825
Total value of revenue equipment - £74,448

As part of the NHS Wales response to the Covid pandemic, a number of consumable and revenue equipment items have been purchased centrally within NWSSP and provided to UHBs/Trusts free of charge. The Health Board received £3,188,593 worth of stock which has been fully utilised within the Health Board in 2020/21

34. Other Information

34.3 Implemention of IFRS 16

HM Treasury agreed with the Financial Reporting Advisory Board (FRAB), to defer the implementation of IFRS 16 Leases until 1 April 2022, because of the circumstances caused by Covid-19.

To ease the pressure on NHS Wales Finance Departments the IFRS 16 detailed impact statement has been removed by the Welsh Government Health and Social Services Group,Finance Department.

We expect the introduction of IFRS16 will have a significant impact and this will be worked through for disclosure in our 2021-22 financial statements.

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 : 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.

Appendix 2

Proposed Audit Report

The Certificate and independent auditor's report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Hywel Dda University Health Board for the year ended 31st March 2021 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 Taxpayers' 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 international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Hywel Dda University Local Health Board as at 31 March 2021 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Qualified opinion on regularity

In my opinion, except for the irregular expenditure of £95.291million explained below, in all material respects, the expenditure and income have been applied to the purposes intended by the Senedd 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 £95.291 million over the £2,755.063 million that it was authorised to spend in the three-year period 2018-19 to 2020-21. This spend constitutes irregular expenditure. Further detail is set out in the attached Report.

Basis of opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. 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 opinions.

Emphasis of matter

I draw attention to Note 21 of the financial statements, which describes the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government. My opinion is not modified in respect of this matter.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. 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. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

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; and
- the information given in the Performance and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and the Performance and Accountability Report 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 and Accountability Report or the Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Remuneration Report 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 7 and 8, 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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- enquiring of management, the head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Hywel Dda University Local Health Board policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, and posting of unusual journals and;
- obtaining an understanding of Hywel Dda University Local Health Board's framework of authority as well as other legal and regulatory frameworks that the LHB operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Hywel Dda University Local Health Board.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit & Risk Assurance Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential

bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Hywel Dda University Local Health Board controls, and the nature, timing and extent of the audit procedures performed.

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 Senedd and the financial transactions conform to the authorities which govern them.

Please see my Report on pages 18 to 20.

Adrian Crompton
Auditor General for Wales
15 June 2021

24 Cathedral Road
Cardiff
CF11 9LJ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Hywel Dda University Local Health Board's (the LHB's) financial statements. I am reporting on these financial statements for the year ended 31 March 2021 to draw attention to three key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion, the failure of the second financial duty, and the implications of the ministerial direction on senior clinicians' pensions. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Local Health Boards (LHBs) are required to meet two statutory financial duties – known as the first and second financial duties.

For 2020-21 Hywel Dda University Local Health Board failed to meet both the first and the second financial duty.

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 three-year period being measured under this duty this year is 2018-19 to 2020-21.

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 £2,755.063 million by £ 95.291 million.

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 2020-21 if it submitted a 2019-20 to 2021-22 plan approved by its Board to the Welsh Ministers who then approved it by the 30 June 2019. This duty is unchanged from last year because due to the pandemic, the duty to prepare a new three-year plan for the period 2020-21 to 2022-23 was paused, leaving the previous year's duty in place.

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 in place for the period 2019-20 to 2021-22.

Ministerial direction on senior clinicians' pensions

NHS Pension scheme and pension tax legislation is not devolved to Wales. HM Treasury's changes to the tax arrangements on pension contributions in recent years included the reduction in the Annual Allowance limit from over £200,000 in 2011-12 to £40,000 in 2018-19. As a result, in cases where an individual's pension contributions exceed certain annual and / or lifetime pension contribution allowance limits, then they are taxed at a higher rate on all their contributions, creating a sharp increase in tax liability.

In a Written Statement on 13 November 2019, the Minister for Health and Social Services had noted that NHS Wales bodies were: 'regularly reporting that senior clinical staff are unwilling to take on additional work and sessions due to the potentially punitive tax liability'. In certain circumstances this could lead to additional tax charges in excess of any additional income earned.

On 18 December 2019, the First Minister (mirroring earlier action by the Secretary of State for Health and Social Care for England) issued a Ministerial Direction to the Permanent Secretary to proceed with plans to commit to making payments to clinical staff to restore the value of their pension benefits packages. If NHS clinicians opted to use the 'Scheme Pays' facility to settle annual allowance tax charges arising from their 2019-20 NHS pension savings (i.e. settling the charge by way of reduced annual pension, rather than by making an immediate one-off payment), then their NHS employers would meet the impact of those tax charges on their pension when they retire.

The Ministerial Direction was required because this solution could be viewed by HMRC to constitute tax planning and potentially tax avoidance, hence making the expenditure irregular. Managing Welsh Public Money (which mirrors its English equivalent) specifically states that 'public sector organisations should not engage in…tax evasion, tax avoidance or tax planning'.

A Ministerial Direction does not make regular what would otherwise be irregular, but it does move the accountability for such decisions from the Accounting Officer to the Minister issuing the direction.

The solution applies only to annual allowance tax charges arising from an increase in the benefits accrued in the NHS Pension Scheme during the tax year ended 5 April 2020. For the tax year ended 5 April 2021, the Chancellor increased the thresholds for the tapered annual allowance and, as a result, it is anticipated that the risk to the supply of clinical staff has been mitigated.

The LHB currently has insufficient information to calculate and recognise an estimate of the potential costs of compensating senior clinical staff for pension benefits that they would otherwise have lost, by using the 'Scheme Pays' arrangement. As a result no expenditure is recognised in the financial statements but as required the LHB has disclosed a contingent liability in note 21 of its financial statements.

All NHS bodies will be held harmless for the impact of the Ministerial Direction, however in my opinion any transactions included in the LHB's financial statements to recognise this liability would be irregular and material by their nature. This is because the payments are contrary to paragraph 5.6.1 of Managing Public Money and constitute a form of tax planning which will leave the Exchequer as a whole worse off. The Minister's direction alone does not regularise the scheme. Furthermore, the arrangements are novel and contentious and potentially precedent setting.

I have not modified my regularity opinion in this respect this year because as set out above, no expenditure has been recognised in the year ended 31 March 2021. I have however placed an Emphasis of Matter paragraph in my audit report to highlight this

issue and, have prepared this report to bring the arrangement to the attention of the Senedd.

Adrian Crompton Auditor

General for Wales

15 June 2021