Hywel Dda University Health Board

Annual Report and Accounts 2021-2022

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

What our Annual Report will 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 another extraordinary year, our 2021/22 reports are written in the context of how we have continued to respond to the COVID-19 pandemic, while delivering care and services, and starting our recovery from its impact. It 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.

How to contact us

Publications in print or alternative formats/languages are available on request by contacting us:

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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

While our Annual Report reflects on yet another extraordinary year, it also enables us to thank everyone who has made so many personal sacrifices to keep yourself, your loved ones and your neighbours safe over the last year. Even when another new COVID-19 variant, Omicron, was identified earlier in the winter, everyone dug deep to step up to the challenge yet again.

We thank everyone working in and with Hywel Dda University Health Board, whatever your role, all our volunteers, and our partners, for your extraordinary service caring for patients and our communities in the face of this pandemic.

The second anniversary of the first UK lockdown was marked with a national Day of Reflection (23 March 2022) when we remembered those who lost their lives to COVID-19 in Carmarthenshire, Ceredigion and Pembrokeshire since the start of the pandemic. They and their families remain in our thoughts always. We reflected on the inspiring stories shared in our staff podcast series (https://hyweldda.libsyn.com/), which will help us to learn and improve, showing the value of our staff and what they have achieved in difficult circumstances.

Access to a wide range of services has been constrained over the past two years, resulting in delays in treatment and care within our health board. We are deeply sorry if you have experienced delays and access to your care and treatment. We detail in this report the ways in which we are trying to introduce restart services and tackle the backlog of patients who are waiting through initiatives, such as the waiting list support service, new one-stop diagnostic clinics and additional capacity to provide care.

Our staff across acute, primary and community care settings and have worked tirelessly to continue delivering care. In both physical and mental health care, they have gone above and beyond every day in the face of unparalleled pressures and challenges. A key priority for us is to continue to support our staff at a time when many are exhausted, and the future is uncertain.

Despite our current position, and the unknown course of the pandemic, there is undeniably cause for optimism. As of 31 March 2022, 867,173 vaccines had been delivered to people in the three counties. Additionally, 700,000 RT-PCR tests have been undertaken within the Hywel Dda region. Achieving this was no small feat and the success of our vaccination programme undoubtedly changed the course of the pandemic. Everyone has stepped up to give as many vaccines as possible and to deliver the Test Trace Protect service to safeguard our communities. We are grateful to everyone who has been part of these vital services.

We recognise that the restrictions on hospital visiting have also been difficult for patients and their relatives. We are grateful for your patience and for understanding that the safety of those in our care, and our staff delivering health care services, is of paramount importance.

We have focused on doing everything we can to ensure we are there for you when you need our care and services. Now, we must begin to adjust to the ‘new normal’ and begin

addressing the significant issues we face, particularly in relation to the unprecedented backlogs for services created by the pandemic.

We recently submitted a Programme Business Case (PBC) to Welsh Government in support of our strategy, 'A Healthier Mid and West Wales'. The PBC is an ambitious plan for a £1.3 billion investment in health across our patch. This offers us hope and a vision for the future, focused on care closer to home and a social model for health. Our plan for the next three years (2022-25) is dynamic and responsive to a changing environment, while continuing to put people at the heart of what we do as we work to recover.

We look forward to continuing to work closely with our clinicians, staff, partners, and our communities in taking this work forward this year, with recommendations for the new hospital site, along with the associated clinical, workforce and financial implications and economic benefits, to be presented to our Board in July 2022.

While it has been a very challenging period, we recognise and value the achievements and successes of our staff. Many of our staff have won awards or been recognised in different ways for their incredible work and we could not be prouder of them and what they achieve every single day. At the time of writing this report, we have received the news that we have 11 incredible finalists covering seven of the categories in this year's National BAME Health and Care Awards with an awards ceremony on 9 June. This is a fantastic achievement and is testament to the dedication and hard work of everyone involved.

Through the year, we have also welcomed some exciting new developments to our facilities, including a new state-of-the-art MRI scanner installed at Withybush Hospital; two new operating theatres being built at Prince Philip Hospital; a new clinical research centre and multi-million pound maternity ward both opened at Glangwili Hospital. A fundraising appeal was also launched to raise the remaining £500,000 needed to provide a purpose-built chemotherapy day unit at Bronglais Hospital. Thanks to the generosity of our communities, the appeal has raised more than £73,000 at the time preparing this Annual Report.

We have also successfully led the way in Wales with various projects, such as our community outreach workers helping Black, Asian, and minority ethnic people living in our area during the COVID-19 pandemic. Additionally, nurses in South Pembrokeshire and Withybush hospitals have been the first to go live with the new digital Welsh Nursing Care Record (WNCR), enabling smarter, patient-centred ways of working.

As we have done for the last two years, we will continue to do everything we can to keep mid and west Wales as safe as possible from coronavirus. With the more recent easing of restrictions and reduction in public testing and contact tracing, we are learning to live with the impact of COVID-19. We encourage everyone to continue the behaviours we know protect us, so together we can keep Hywel Dda safe.

Maria Battle, Chair

Signed: _____
9 June 2022

Steve Moore, Chief Executive

Signed: _____
on 9 June 2022

Chapter 1

Performance Report

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Hywel Dda
University Health Board

About us

Hywel Dda University Health Board plans and provides NHS healthcare services for people living in 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 Hospital in Aberystwyth; Glangwili Hospital in Carmarthen; Prince Philip Hospital in Llanelli; and Withybush Hospital in Haverfordwest.
- Five community hospitals: Amman Valley and Llandovery hospitals in Carmarthenshire; Tregaron Hospital in Ceredigion; and Tenby and South Pembrokeshire hospitals in Pembrokeshire.
- Two integrated care centres: Aberaeron and Cardigan in Ceredigion, and a number of other community settings e.g. Bro Preseli, Crymych.
- 48 general practices (four of which are health board managed practices); 53 dental practices (including four orthodontic); 98 community pharmacies; 43 general ophthalmic practices (43 providing Eye Health Examination Wales services and 32 providing 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.
- Sure Start joint services with Carmarthenshire, Ceredigion, and Pembrokeshire local authorities.

The population we serve

Population projection

By 2025 our total resident population is estimated to be at about 390,000 people. In addition, we also provide care for large numbers of tourists and students.

Welsh language

The proportion of residents who can speak Welsh is 48%.

Ageing population

The average age of people in the three counties is increasing steadily, we have a higher proportion of older people than average across Wales. Those aged 65 and over currently comprise a quarter of the health board's population. Projections suggest that by 2043 there will be almost 125,000 people living in Hywel Dda aged over 65, of which almost 22,000 will be aged over 85.

Health inequalities

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

Changing patterns of disease

We anticipate that frailty will become increasingly important in Hywel Dda over the next ten years and is projected to increase by 4% per annum. As our population ages this is leading to an increase in the number of people in our area with one or more chronic condition. In 2020, Dementia and Alzheimer's disease along with Ischaemic heart diseases were the main causes of death in England and Wales. The COVID-19 pandemic has negatively impacted on the health of many individuals. Lockdowns have resulted in an increase of people experiencing mental health issues, particularly anxiety and depression. In addition to this, high risk individuals needed to isolate for long periods which has led to deconditioning and increased frailty for some of our residents.

Tobacco

Almost one in eight adults (13%) in our area smoke. Smoking is a significant risk factor for many diseases and early death. Making Every Contact Count (MECC) 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

4% of people in our area do not eat enough fruit and vegetables, and over three in five people (61%) are overweight or obese. The health board is using the Obesity Pathway Transformation Fund monies for 2021/22 to further strengthen our specialist multi-disciplinary team (MDT) weight management service in line with national standards to enable improved access and equity.

Physical activity

Over 25% 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

15% of our population report feeling lonely. Providing single points of access for information, advice, and assistance for the public, in line with the Social Services and Well-being Wales Act that facilitates access to a directory of services in their local community, such as DEWIS Cymru.

Introduction

In March 2020, the Welsh Government took the unprecedented decision to pause the Integrated Medium Term Plan (IMTP) and annual planning process to enable NHS Wales organisations to focus their attention on the immediate preparations for and response to the COVID-19 pandemic, advising that routine planning arrangements would be restarted at a more appropriate time.

Given the continuation of the pandemic, the Welsh Government requested an annual plan for 2021/22, rather than an IMTP. In March 2021, the board approved its draft Annual Recovery Plan 2021/22 which set out to the organisation and the Welsh Government our priorities for 2021/22. The full plan was submitted to the board in June 2021 for final approval and subsequently submitted to the Welsh Government. The strategic objectives and planning objectives, approved by the board in September 2020, formed 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 we will support staff to recover after the challenges of the past year; and how we will lay the foundations to recover our system/services and support communities to thrive.

Our plan recognised a planned deficit in the 2021/22 financial year and did not recover the cumulative deficit incurred to date (which was reset to 1 April 2020). As a result of this, we presented a budget which breached our statutory financial duty for the three-year period. 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 know that financial planning and the delivery of our strategy is needed for long-term financial stability and sustainability.

We recognise 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 been 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 2021/22, there have been unexpected opportunities presented to reset, accelerate, and expedite, where appropriate, to transform services.

The development of our plan for 2022/25 is underway and was submitted to the Welsh Government in March 2022 as required. The likelihood is that the health board will again not be able to meet its statutory obligation to produce a financially balanced plan over the plan's lifecycle.

Our underlying deficit has worsened over the last two financial years following the gaps in delivery of recurrent savings in 2020/21 and 2021/22.

We are committed to addressing these challenges and are in the process of constructing a clear core plan, focusing on recovery, which will allow us to get back on track with our financial roadmap. For 2022/23 this will be coupled with ensuring that the exceptional economic challenges we face next year are well described and assessed. A significant

review of our COVID-19 response is already underway, which will be transitioned into the new normal through our plans.

Value based health care approaches are being taken across the whole organisation, and it is our aspiration that a target operating model can be constructed to focus our delivery of services in the most optimum way for our patients, with this forming a critical part of our approach to the medium-term outlook and aligning with the design assumptions set out in our strategy and recent Programme Business Case.

We are clear on our long-term destination - articulated in our strategy "A Healthier Mid and West Wales" and reinforced in our Programme Business Case. Reaching that destination requires progress across a number of domains, which we have termed ‘strategic objectives’.

These strategic objectives relate to our people (staff, service users and communities) and our services. Our plan sets out the specific actions, termed ‘planning objectives’, we are taking to make progress in each of these domains. In this way we remain focused on our strategic direction and ensure our day-to-day activities are explicitly aligned, and contributing to, our strategic direction. We have used this approach throughout the year, and it is now well embedded into our business practices.

Each planning objective is led by an executive director and aligned to a committee of the board, with regular update reports provided at every other committee meeting. Our board assurance framework tracks progress and the impact of these actions on our strategic outcome measures.

Our approach to planning now revolves around these strategic and planning objectives, with a systematic review of the planning objectives a critical aspect of the organisation's planning cycle. In the development of this plan, we have undertaken this review, with many planning objectives completed and updated and others revised. Our board formally signs-off all planning objectives and they are not altered or removed without board approval, demonstrating our openness and accountability to the population we serve.

The development of planning objectives takes account of a range of factors, including: our risks and performance, the Minister's priorities, Welsh Government policies and legislation, and work in support of our strategy.

In 2021/22 we took the opportunity to review our committee structures to ensure increased alignment with our strategic objectives:

- Strategic Development and Operational Delivery Committee – responsible for the seeking assurance on delivery of strategic objectives 4 and 5. (4. The best health and well-being for our communities; and 5. Safe, sustainable, accessible, and kind care). This committee also holds the overarching responsibility for the development of our plan and assurance in its delivery.
- People, Culture and Organisational Development Committee – receives assurance on delivery of planning objectives under strategic objectives 1, 2 and 3. (1. Putting people at the heart of everything we do; 2. Working together to be the best we can be; and 3. Striving to deliver and develop excellent services).
- Sustainable Resources Committee – receives an assurance on all planning objectives under strategic objective 6 (Sustainable use of resources) with a focus on financial performance and planning.

We continue to monitor delivery of our Annual Plan 2021/22 and our board outcome measures through the committees of the board and through the board assurance framework. The board assurance framework (BAF) enables the board to focus its attention on areas of poor performance in terms of progress against delivery of planning objectives (which are the core pillars of our plan), slow or no impact on agreed outcome measures, significant risks to the achievement of strategic objectives, where there is little confidence in the assurances provided. Delivery of planning objectives will also be regularly reviewed by committees. Committees may also identify and advise of weaknesses in the assurances that have been provided to them. Steps are now being taken to develop the BAF so that its focus moves away from a 'process tool' and towards informing board agendas and providing information on outcomes.

Throughout 2021/22 we monitored our progress against the NHS delivery framework measures, escalating any concerns to board or committee monthly. We aligned each of the measures to one of our six strategic objectives.

As at the end of March 2022, five planning objectives had been completed. One was ahead of schedule and 32 remained on track, with 15 that continued to be behind schedule. Quarterly action reports are also reported through our Strategic Development and Operational Delivery Committee.

The planning objectives not yet achieved through 2021/22 will continue as part of the planning objectives used to structure our 2022/23 plan.

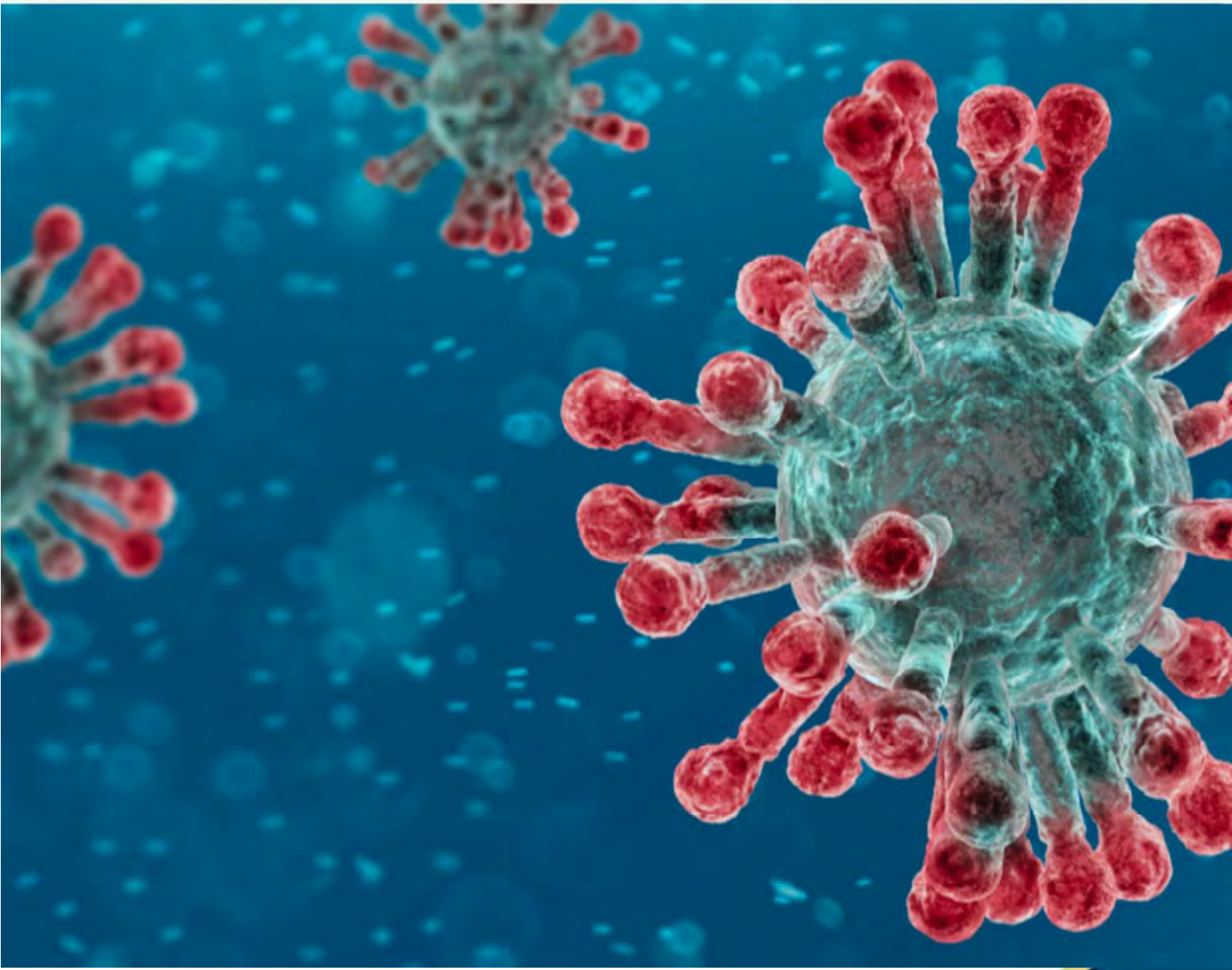
The Health and Social Care (Quality and Engagement) (Wales) Act 2020 has introduced two new requirements to come into force legally in April 2023:

- **The Duty of Quality** is designed to ensure that we have whole system way of working to provide safe, effective, person-centred, timely, efficient, and equitable healthcare in the context of a learning culture; and

- **The Duty of Candour** seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

These new reporting requirements will be captured through processes in place for 2023/24. In the meantime, we anticipate that there will be a non-statutory implementation in autumn 2022. The reporting process for 2022/23 will be a hybrid approach allowing for quality reporting indicators to be tested and for measures and narrative concepts to be developed as part of the implementation phase. In the meantime, quality reporting requirements are embedded throughout the performance section of this Annual Report.

Impact of COVID-19 on our delivery of services



Impact of COVID-19 on our delivery of services

COVID-19 has continued to be of significant impact on our health service and wider communities through 2021/22.

We have responded and made changes required to ensure that we were able to keep our communities as safe as possible and to meet emerging guidance. This has involved continued close working 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, have worked together with commitment, innovation, and kindness.

The NHS Wales Operating Framework acknowledged the massive impact COVID-19 has on NHS and social care and the need for us the do our best to minimise harm.

Four types of harm were identified by the framework:

- Harm from COVID-19 itself
- Harm from overwhelmed NHS and social services
- Harm from reduction in non-COVID-19 activity
- Harm from wider societal actions/lockdown

The narrative of this Annual Report provides the detail on the constant balance we have endeavoured to maintain to provide a COVID-19 response, to provide critical healthcare in our hospitals, primary care services and community-based care, and to reduce risk and harm.

We summarise below our approach to the four harms, and the risks we identified as having the potential to impact our delivery of essential services or 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 of 31 March 2022. For further details please see:

- The planning and delivery of safe, effective, and quality services section on page 21 of this document.
- Risk profile section of the Annual Governance Statement chapter in this report.
- Corporate Risk Register update prepared for March 2022 Board meeting.

Additionally, we monitor and publish monthly key measures (including those that relate to the four harms) so we can identify where we are performing well or where and how we make further improvements. Read our performance information here.

Harm from COVID-19 itself

To reduce the direct harm from COVID-19 itself, the health board has put a range of actions in place:

- We have established and engaged across a number of regional groups including the Regional Incident Management Team (IMT), Outbreak Control Teams (OCTs), the Dyfed Powys Local Resilience Forum (LRF) and Strategic Coordination Group (SCG)
- We have jointly agreed and implemented local plans to support the changing requirements around the Test, Trace, Protect (TTP) programme, including flexible testing arrangements in response to outbreaks and areas of high incidence, promotion of regular health and social care staff testing, testing in care homes, education, and workplaces and to support tourism and returning travellers (see pages 22, 31).
- We have supported our care homes and hospitals with infection, prevention and control assessments and advice and to prevent and manage outbreaks (see pages 44-46).
- We have established a Long COVID-19 service to support those with longer-term impacts of the virus (see page 31).
- We have implemented a successful vaccination programme, as of 31 March 2022, 867,173 COVID-19 vaccinations had been delivered to our residents and staff. This is a continuing programme based on the principle of leaving no one behind.
- Partners from health, local authorities and the third sector formed a Vaccine Equity Group. This group has set out to provide good information for people disproportionately affected by COVID-19. This includes people with protected characteristics, such as those from ethnic minority backgrounds and people with disabilities, those at socio-economic disadvantage living in communities with high deprivation or social exclusion, those within marginalised or under-served groups such as asylum or sanctuary seekers, people experiencing homelessness, people involved in the justice system, mental health clients and people from Traveller communities who do not regularly access traditional healthcare services. Some solutions put in place included provision of information in alternative languages and formats, bespoke vaccination clinics for ease of access and to meet the needs of various groups, access to bespoke clinical advice and opportunities to ask questions. The mobile vaccination vehicle, kindly donated by the fire service provided vaccination clinics in places geographically distant to the mass vaccination centres and for students in higher education.

All of these have been underpinned by regular, consistent, and focused staff and public communications with partners across the region, including local authorities and other public sector organisations, social care, education, tourism, and local businesses to safeguard our communities.

- **Risk 1016 - There is a risk of increasing COVID-19 infections across the health board due to staff and others not adhering to the health board guidance and national social distance legislation (risk score 10: high)**

  We have undertaken social distance risk assessments which highlight ways to allow services to be re-introduced while maintaining the social distance measures. We have continued to encourage staff, visitors, or patients to adhere to the social distance

guidance. As well as the more routine measures such as hand sanitiser stations and use of personal protective equipment including face coverings, some of the measures we have put in place to reduce the risk include installations of safety screens in hospital and ward/clinic reception areas; regular review of our patient visiting guidance including the introduction of agreed timeslots; and continuing to encourage staff to use of IT systems such as Microsoft Teams to reduce the need for face-to-face meetings.

Harm from an overwhelmed NHS and social services

The health board's analytics department have continued to collate, analyse, and present data. This has included case rates, including by county, forward-looking forecasting of rates, admissions, bed occupancy and lengths of stay. This has helped inform our decision-making on the preparations and interventions to provide care safely at all stages of the pandemic, including during waves and in response to new variants.

The NHS Choices Framework has enabled us the flexibility to restart and provide as much care as possible, and conversely to postpone areas of planned care when we have needed to for safety reasons. For example, in October 2021 we took the difficult decision to temporarily suspend elective (planned) orthopaedic surgery at Prince Philip Hospital, Llanelli, and Withybush Hospital, Haverfordwest, so we could provide bed capacity and reduce pressure on our unscheduled care system. In January, a number of measures were taken to maintain the most critical of services. This included urgent cancer surgery for our population being provided primarily only from Prince Philip Hospital, in Llanelli; and less urgent outpatient and therapy clinics being rescheduled.

Our community services have also made tremendous efforts to provide services in different ways and reduce pressure on emergency and unscheduled care. For example, community care centres have been used to provide clinics traditionally operated from acute hospitals, as well as virtual clinics, so that care can be provided closer to home. In our IMTP we express a desire to extend further opening hours of these centres and to enable additional services to be provided from them.

In partnership with our local authorities and allied health professionals in primary and secondary care, we continued to support care homes on the prevention and management of COVID-19 outbreaks. This helped reduce unnecessary admissions of COVID-19 positive residents to hospitals, enabling them to remain within their home environments.

Also, at numerous points in the year, we have had to align our staffing to the most critical need, and our staff have been extremely flexible, for which we are grateful. We acknowledge our services are built on our staff and therefore supporting their well-being during these challenging times has been a critical priority for us. You can read more about the enhancements we have made to our staff psychological and well-being services in the workforce management chapter of this report (from page 82).

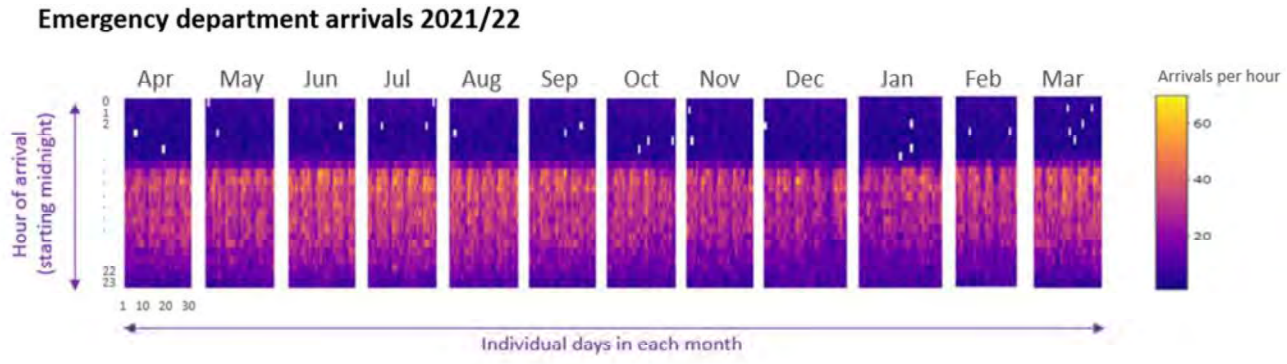
Risk 1219 - There is a risk there will be insufficient workforce available to deliver services required for "Recovery" and the continued response to COVID-19 and other respiratory infections, as outlined in the health board's annual plans 2021/22 (risk score 14: extreme)

This is caused by new variants of COVID-19, increase in the severity and dispersal of respiratory viruses within the population (in children and adults) which could mean an increase in infections and outbreaks within acute, community and social care facilities. As well as the more routine measures such as efficient rostering practice and use of bank and agency, we are continuing to prioritise the recruitment and onboarding of new employees to the highest areas of risk in terms of maintaining service delivery.

Risk 1027 - There is a risk to the consistent delivery of timely and high quality urgent and emergency care (risk score 20: extreme)

This is caused by increasing fragility within the urgent and emergency care (UEC) system, increasing levels of demand above staffed capacity, the impact of COVID-19 on available whole system bed and staffing resources and delays in discharges across the care system which are beyond the direct influence of the health board. We have comprehensive management systems in place to manage the unscheduled care risks daily; processes in place to review the patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled; processes to ensure regular review of long-stay patients; and considered alternative models of medical oversight.

Our health analytics team have undertaken work to visualise the level of activity arriving at the emergency departments (ED) across Hywel Dda. The advanced analytics platform, developed within the health board, has produced the following heat map. It summarises the number of arrivals to ED every hour, of every day, for the entire year. The dark colours represent less arrivals in an hour compared to the light colours. Being able to see the demand across the whole service in a single visual can help support management decisions.



Risk 1342 - There is a risk that the health board will be unable to plan and respond effectively to the pandemic and make effective decisions on critical business continuity issues, the application of Local Choices Framework and delivery of essential services (risk score 12: high)

We rely on the daily COVID-19 case reports to enable us to monitor, track and plan our response to COVID-19. These daily case reports only include polymerase chain reaction (PCR) test results and do not reflect the recent shift in testing policy to a greater reliance on lateral flow device (LFD) test results. The health board continues to have processes and systems in place for collection of data to allow for daily reporting and monitoring of PCR positive cases per 100,000, daily reporting and monitoring of hospitalised cases split by

those that are undergoing active treatment for COVID-19, recovering from COVID-19 and those who have tested positive for COVID-19 as a secondary diagnosis, daily reporting and monitoring of staff sickness absence during anticipated two-week peak period and daily data on incidences and outbreaks in local schools, year groups and classes related to COVID-19. The health board's analytics department collate, analyse and present data to inform decision-making.

Harm from reduction in non-COVID-19 activity

Throughout the pandemic we have strived to maintain our most critical and urgent services, and to restart and recover services that have been impacted by the pandemic response. We are focused on recovery and establishing a 'new normal' for health and care delivery. That said, pressures on our urgent and emergency care system have remained significant, with long waits in our emergency departments and discharge challenges and so we have strived to strike the right balance between providing the services needed but in a safe and clinically prioritised way.

Some measures taken to mitigate the impact of reduction in non-COVID activity and address waiting lists are included below:

Rapid Diagnosis Clinic (RDC) - we opened an RDC in Prince Philip Hospital, Llanelli in October 2021. This has allowed the referral of people from across our area with non-specific but concerning symptoms, aiming to detect those who may have cancer earlier. The plan is to develop further RDCs at sites across the health board.

Waiting list initiative - we have launched a Waiting List Support Service to certain patient groups (orthopaedics and ear, nose and throat (ENT), with more to follow) to support patients awaiting surgery. The service provided patients awaiting treatment clinical support and well-being advice over the telephone and via email. This gives patients a single point of contact and guidance should symptoms deteriorate. We are also able to signpost patients to online well-being resources in help them to maintain and optimise their health.

Modular theatres – work began in December and is due to be finished in spring 2022 to open two new operating theatres at Prince Philip Hospital in Llanelli. This will help us to tackle surgical waiting lists and ease pressures across the region.

Risk 1048 - There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan 2021/22 (risk score 16: extreme)

This is caused by the impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. The health board has a comprehensive management system in place to manage planned care risks daily; implemented a risk stratification model for prioritising the review of patients; implemented a 'green' pathway on the four acute sites; escalation plans for acute and community hospitals; and an outpatient transformation programme which has a continuing focus on alternatives to face-to-face delivery of outpatient care to enable increases in care volumes delivered.

Risk 1350 - There is a risk of the health board not being able to meet the 75% target for waiting times in the Ministerial Measures for 2022/26 for the Single Cancer Pathway (SCP) (risk score 12: high)

The impact of COVID-19 has increased the risk of the health board being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board in line with the infection control guidance that remains in place. The main area of concern is radiology. As well as continuing to hold virtual appointments via digital solutions, some of the additional actions we have taken to reduce the risk include establishing a cancer tracking team to allow patients to be proactively tracked through their pathways; implementing a four-week follow up process for patients whose treatments have change or have been suspended (some through patient choice) as a result of COVID-19; and establishing a SCP Diagnostic Group to review the capacity and demand for diagnostic services including the capacity required for a seven-day turnaround diagnostic service.

Harm from wider societal actions/lockdown

In relation to reducing harm from the wider societal actions and lockdown, the health board has:

- implemented virtual consultations to enable care to be delivered whenever possible in lockdown/periods of restrictions using the Attend Anywhere platform;
- maintained telephone contact with service users and carers known to the mental health and learning disabilities services in place of face-to-face contact. Face-to-face contacts were resumed as soon as guidance allowed, with appropriate infection, prevention and control (IPC) procedures;
- provided the hospital wards with iPads to facilitate and maintain contact with family and friends in the absence of visiting;
- maintained a digital texting initiative, known as ChatHealth, to provide confidential health advice and support for issues such as emotional health including anxiety, low mood, bullying, physical health and sexual health by sending an anonymous text message;
- employed a significant number of temporary staff and volunteers from our communities to support our COVID-19 response, including the TTP and vaccination programmes;
- employed community outreach workers, thanks to funding from NHS Charities Together and in response to a Welsh Government report, to help tackle inequalities and the adverse effects of the COVID-19 pandemic experienced by Black, Asian and minority ethnic communities.
- Read more about how we have worked with partners and our communities to tackle health inequalities in our Director of Public Health's Annual Report

Risk 1307 - There is a risk that the health board will not meet its statutory duty to breakeven against its capital resource limit for 2021/22 (risk score 10: high)

Significant uncertainty lies in the delivery of the capital programme in 2021/22 due to a number of factors which lie outside of the health board's control, including:

- supply chain issues
- global shortage of key components including glass and steel

- greater delivery lead time for digital and medical equipment
- impact of COVID-19, for example, unable to complete programmes of work in live hospital environment, labour shortages due to self-isolation, and
- local supply issues of key construction materials such as concrete.

As well as ensuring that as key areas of concern emerge there is timely financial reporting to the Sustainable Resources Committee, the board and Welsh Government, we have prioritised replacement medical and digital equipment lists which have lead times for delivery included and regular meetings are held to monitor spend profiles with escalation measure put in place immediately, where required.

Risk 1032 - There is a risk that the length of time mental health and learning disability clients (specifically the Specialist Child and Adolescent Mental Health Service (S-CAMHS), Autism Spectrum Disorder (ASD), memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during 2021/22 (risk score 16: extreme)

This is 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. As well as continuing to hold virtual appointments via digital solutions, providing information regarding community support, well-being at home and guidance, and clinical prioritisation regarding assessment and treatment of service users, we have provided additional funding for recruitment; strengthening interdepartmental working between the Mental Health and Learning Disability Directorate and Women and Children's Directorate; and processes in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.

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

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

Regional response to Test Trace Protect

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 causes COVID-19, to protect our communities, and provide advice and support.

Three county-specific Incident Management Teams (IMTs) and a Regional IMT, set up at the beginning of the pandemic, continued to operate. These enabled excellent continuous engagement and partnership working to respond to increases in transmission in a collaborative and co-ordinated way.

Throughout 2021/22 our Command Centre continued to provide 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 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.

Contact tracing

We have continued to work closely with our 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.

In partnership with the local Public Heath Wales team, we established the Regional Response Cell (RRC) within the Command Centre. This team brings together consultants in public health, operational managers and nurses who provide support to the local tracing teams and directly deal with healthcare settings. The team works to support complex settings (care homes and hospitals) as well as co-ordinating partnership working across the region.

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.

Redesign of primary care services to provide COVID-19 care

GP practices

All GP practices within Hywel Dda maintained the delivery of essential services throughout 2021/22.

GP practices continued to support the vaccination programme, with the majority of practices providing second doses across our communities by the end of June 2021. Booster clinics were supported in the latter part of 2021, where practices played a key role in vaccinating care home residents and housebound patients. At the same time, practices were making inroads into their flu campaigns, with weekend and evening clinics in some practices.

Individual GP practices started to report increases in workload early in 2021/22. By the end of summer, there was widespread reporting of increasing pressures and demands on services, exacerbated by challenges in the wider system. Pressures continued into the autumn and winter, with increases in COVID-19 positive cases and isolation due to household contacts. All practices remained open throughout 2021/22.

A shortage in blood bottle supplies impacted on disease management monitoring in practices in the latter part of 2021. A number of reset and recovery schemes (such as learning disabilities annual reviews, blood test reviews and secondary care generated phlebotomy) were introduced to help address the backlogs identified.

Our aim for 2021/22 was to tender expressions of interest in returning the health board managed practices back to independent contractor status, however, this work continued to be stalled due to the pandemic.

The Physician's Assistant (PA) Development Programme was originally funded through Pacesetter funding and, whilst due to the pandemic it was difficult to get early traction on the development of this programme, the appointment of a development manager in 2021 has led to an agreed programme of development and education being developed with the first intake of GP-PAs being brought in as part of the original programme in November 2021. It is anticipated that, following an evaluation of the first cohort, additional recruitment will happen in 2022/23 and in subsequent years as the programme develops, and seen as an exemplar for GP-PA training and development.

With the national focus considering contract reform across all professional groups, it is hoped that this will lead to greater parity and transparency of contractual arrangements across all four contractor professions.

A plan to provide primary care services for Ukrainian refugees residing within the welcome centre and the community was put in place at the end of the year.

Pharmacy services

Following on from the challenging time in 2020/21 for community pharmacies, the last year has seen a return to more normal levels and frequency of dispensing. However, maintaining pharmacy services has been more problematic due to a much higher number of the workforce testing positive for COVID-19. This resulted in 2021/22 being a year with the highest number of temporary closures of pharmacies since records were maintained.

Most of the closures have impacted areas within Pembrokeshire and are a mix of vacancies and COVID-19 related. This looks set to continue into 2022/23.

Levels of national enhanced service provision within community pharmacies have increased during 2021/22 and for some services, for examples, common ailments have been higher than pre-COVID. During 2020/21, the first year of the pandemic, 9,309 patients accessed the common ailments service. During 2021/22 this increased to 12,529 for the period April 2021 to January 2022 and represents only 10 months activity so far.

We have also worked to re-establish the local triage and treat service which offers a first-aid service for people with minor injuries. This service, while not suspended during 2020/21 was left to the discretion of individual pharmacy teams. During 2021/22 there has been renewed interest in offering this service.

A new local enhanced service was developed during the latter half of the year to enable urinary tract infection testing and treatment, if indicated, for women aged 16-64. This has been taken up by 63 pharmacies out of the 98 pharmacies within Hywel Dda.

Independent prescribing within pharmacies was first commissioned in June 2020 at four pharmacies and utilised the skill of trained professionals to deliver consultations for acute conditions and contraceptive services. During its first year of operation just over 1,200 consultations were carried out. The COVID-19 pandemic interrupted the training and completion of independent prescribing courses for pharmacists which delayed the expansion of this service. During 2021/22 the four existing sites have become established and a further four sites have been added. A total of 2,822 consultations have been provided in 2021/22 and these have offered a first point of access for patients in the localities where the service is commissioned.

General dental services

The health board has continued to work with dental practices to support them with contract reform plans and resetting of services following the pandemic. Dental practices continued to experience difficulties with staff shortages and the provision of services due to the ongoing COVID-19 infection control requirements, this did result in reduced access to routine dental care. In line with Welsh Government guidance priority was given to urgent care and the

health board commissioned additional urgent care sessions. Additional funding was received from Welsh Government to reduce the waiting time for orthodontic care, a waiting list initiative was undertaken which resulted in a significant number of patients accessing treatment. The Dental Services Team worked closely with practices to ensure they were supported to demonstrate and deliver continuous improvement in access.

Community dental service

The community dental service (CDS) is a referral only service for vulnerable adults and children, and as part of the service, provides dental care under conscious sedation, which is available at all community sites.

During the COVID-19 pandemic, changes were put in place to ensure that dental services were able to comply with the national infection control procedures introduced to ensure patient and staff safety. Through the CDS, we established an urgent dental centre in each county to provide urgent dental procedures to patients and aerosol generating procedures (AGPs). From March 2020 the CDS has provided urgent dental services in addition to providing care to their regular vulnerable patients. For an interim period, the CDS service at Withybush Hospital was stood down to reduce patient footfall at the acute site; this service was transferred to Winch Lane Health Centre to ensure continued access for patients and has since been reinstated.

One of the biggest challenges to resetting services during this period was the need to ensure enough air changes per hour in each dental surgery to undertake AGPs. Without measurement of the air changes, it meant that fallow times between patients could be in excess 90 minutes. To improve this situation Welsh Government provided funding to support dental practices to install air change systems and the health board match-funded this grant. In addition, we invested £140,000 in an air change system for seven of the CDS clinic sites. As part of reset the service re-introduced the paediatric general anaesthetic assessment service to ensure that children's dental needs are reviewed to ensure that treatment under general anaesthetic is provided after all other sedation options have been reviewed.

The CDS continued to support residents in care homes with the domiciliary dental service.

Optometry

During 2021/22, optometric services in Wales continued to work in amber phase in line with national guidance, which meant that all services had to be offered to those with the highest clinical need. Despite the continued pressure as a result of the pandemic, all optometry practices in Hywel Dda continued to provide all services, including urgent and routine eye care, to patients within primary care. A number of additional eye care pathways were also developed and implemented. These pathways were designed to allow patients to be seen in their local optometric practice for the treatment and monitoring of a range of eye care conditions, rather than attending their GP or local hospital. An example of this is the Independent Prescribing Optometric Service, which allows optometrists with the independent prescribing qualification to manage and treat a range of conditions within their practice, that would have previously required a referral to the nearest eye casualty service.

This service proved to be a success in the earlier part of 2021/22, and so was expanded towards the end of the year to allow more patients to benefit from the service.

Redesign of community services to provide COVID-19 care

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 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.

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. See the Delivering in Partnership section from page 75).

Our focus is on strengthening community and primary care services so that, where appropriate, people can receive care closer to home rather than in hospital, while ensuring they can access the services they need, such as diagnostics and same day assessments.

We have strengthened our 'care closer to home' approach with social care colleagues to reduce conveyance and admission rates and implementing 'discharge to recover' and 'assess' pathways.

The health board successfully secured funding from Macmillan Cancer Support for the 'Right by You' programme of work on:

- co-producing with a range of stakeholders (including people in our local communities with cancer and our partner organisations) an improved way of working that focuses on individual and community well-being through an asset based approach;
- working towards the ambitions of improved local access to information, advice and assistance through the development of a model based on local and national best practice that meets the specific needs of our local communities;
- better supporting people with cancer as well as the wider health and social care economy;
- adopting an approach from the start which facilitates improvements in current working models, links with the strategic transformation agenda and embeds good practice models in existing services.

The project is fixed term and whilst based in Cardigan, has a catchment area of 20 miles, therefore covers parts of each of the three counties.

We have also been successful in securing Macmillan Cancer Support funding for a virtual reality pilot for palliative and end of life patients. The pilot is aiming to improve the quality of life and well-being for people who are living with a life-threatening illness and facing physical, psychological, social and spiritual challenges, and their families. Due to the pandemic patients are reporting greater levels of isolation and vulnerability. Whilst the use of virtual reality equipment in the clinical setting has proved to be incredibly valuable, less research has so far been undertaken in the community or home setting. We want to work with patients and their families and carers to explore the value in these settings, especially for those living in isolated rural areas. This could potentially reduce the risk of admission to acute site due to social isolation and loneliness; reduce the need for analgesia and anxiolytics due to increased feeling of well-being; and improve well-being and quality of life for patients and their carers.

Community pharmacy staff from across Carmarthenshire Ceredigion and Pembrokeshire took part in mental health first aid training to support their patients and own mental health, as well as that of their colleagues. Pharmacists, pharmacy technicians and dispensers from across 35 pharmacies attended online training to equip them with the tools to support their own mental health and that of their colleagues and encourage them to access timely support when needed. In addition, the training provides the participants with the knowledge to identify suspected mental health conditions in patients, and the skills to start a conversation surrounding mental health.

District nursing

We have updated a draft of our three county-wide district nursing service specification. It highlights the need for consistent, equitable and standardised working practices across all three counties, aligning to the national strategic programme of work around the Neighbourhood District Nursing Model.

Funding from Welsh Government is enabling us to further develop the Neighbourhood District Nursing Model to establish several new roles, including:

- a senior peer nurse advocate to work closely with senior nurses and district nurse team leaders to enhance integrated working across localities;
- a practice and professional development nurse focused on supporting and developing the community health care support worker workforce; and
- recurrent funding to increase both health care support worker and assistant practitioner roles across the three county community nursing teams.

We have put in place patient experience feedback processes across the three counties through CIVICA, so that we can continue to learn from feedback and inform service delivery.

An e-scheduling system, Malinko, has now been fully implemented across Carmarthenshire, Ceredigion and Pembrokeshire, with national work continuing to agree standardised reporting and metrics deliverable from the system. Malinko is demonstrating opportunities for improving service efficiency and maximising use of resources, reducing duplication of care where possible and improving the patient experience.

Our district nursing service continues to comply with the Chief Nursing Officer's interim district nursing principles, as well as participating in the national work around the Welsh levels of care acuity and dependency tool, quality indicators in district nursing and professional judgement.

We will be publishing our community nursing annual report in August 2022 highlighting all key achievements and new initiatives, including ear micro suctioning clinics, trial without catheter clinics and collaborative leg ulcer and lymphoedema pathway developments, all of which are in the early stages of implementation.

Health visiting

Our health visiting service works with children aged 0-5 years and their families with the focus on early intervention and prevention along with school readiness. The primary function of the health visiting service is to assess and support the child and family in the early years (0-5 years). The key priority of the service is to deliver the Healthy Child Wales Programme (HCWP) to all children living in Carmarthenshire, Ceredigion and Pembrokeshire. The HCWP is a standardised approach to service delivery throughout Wales and was implemented in 2016. This is a universal programme for all children in Wales and includes a family resilience assessment (FRAIT) and an assessment of child and family needs. The assessment determines the level of intervention for the family and child, whether it be universal, enhanced or intensive. All health visiting interventions are underpinned by key public health messages, targeting health inequalities and aim to improve health outcomes for all children.

Children's public health nursing has been pivotal throughout the pandemic in making a difference to children, families and the communities despite many challenges. This includes the continued delivery of support to children and families by the health visiting service using a blended approach, often when other services had totally reduced delivery. The service is committed to safeguarding the health and welfare of all children aged 0-5 years and aims to achieve key priorities that also include supporting families to make long term health enhancing choices; to ensure secure emotional attachment for children through supporting positive parent child relationships; promote positive maternal and family emotional health and resilience; assist children to meet growth and developmental milestones enabling them to achieve school readiness; to support the transition from home into the school environment and to mitigate the effects of poverty on early childhood and adverse childhood experiences (ACES).

The main challenge during the pandemic was to try and maintain a level of service and ensure children were safeguarded. In the initial stages, the health visiting service had to cease from home visits and innovative ways had to be sought in how to reach families, to include the setting up of central hubs in the communities along with central telephone lines for ease of access for families and virtual contacts to families, eventually including the use of 'Attend Anywhere'. Throughout, due to the staffing deficits and pandemic the emotional well-being of staff was paramount, weekly virtual communication and support meetings were set up plus the continued publication of the bi-monthly newsletter which celebrates achievements, shares good practice was essential in keeping morale high and the service to families being delivered.

Some examples of locality-based developments across our three counties include:

Carmarthenshire

We have scaled up our urgent primary care provision in the last year to provide a multi-disciplinary rapid response to patients in the community within two to eight hours. Additional care and support provision is available for people who are vulnerable and frail at home. These patients are cared for on our 'virtual ward' in their own homes until they recover and can live independently. Where 24/7 care oversight is needed, we have commissioned additional community beds in a care home in Llanelli to provide 'step up' and 'step down' (from acute hospital) care. We have increased our bed capacity in Amman Valley Hospital, and assessment beds are available in nursing and residential homes when an individual requires it, for a period of up to six weeks.

Technology Enabled Care (TEC) provide digital solutions to monitoring health and care needs of our patients remotely. Telecare is already well established in the provision of care and support while Telehealth monitoring of chronic conditions such as respiratory and heart disease is an opportunity that we are embedding into our health care provision.

We are also exploring the use of ARMED technology in frail adults particularly to provide early warning of increased risk of falls for our frail elderly. This allows us to better anticipate patients' needs, avoid hospital admission and injury, and also maximise our district nurse capacity knowing that patients can be monitored digitally.

Social prescribers in each of our cluster areas have demonstrated improved health outcomes for the population that they have supported. We now have six social prescriber posts (two for each cluster area) in the county who signpost individuals to services that meet their felt and expressed health needs. Working with the Public Services Board partners, Carmarthenshire Association of Voluntary Services, rural and town councils, we aspire to create a network of providers in developing resilient and stronger communities.

As part of considering and modernising our community infrastructure, our outline business case for a health and well-being centre in Cross Hands was reviewed by stakeholders to ensure that it remains fit for purpose following the COVID-19 pandemic. We anticipate submitting this to Welsh Government for approval in June 2022.

Earlier this year, a submission to UK Government Levelling Up Fund made by Carmarthenshire County Council was successful. This will allow the development of a 'Well-being Hwb' and provision of accommodation for health services in the town centre with the health board as a key partner.

The 'Pentre Awel' development progresses at pace with construction due for completion in 2024. This will provide Llanelli and surrounding areas with a 'state of the art' leisure complex co-designed with our physiotherapy team to ensure a seamless care pathway between therapy and exercise provision (including a hydrotherapy suite). Working in partnership with the local authority and universities, the Pentre Awel development will also accommodate our research facilities and provide much needed space for training and education to support future workforce sustainability.

Ceredigion

We have expanded Tregaron Community Hospital to a 20-bedded facility on a temporary basis through Welsh Government COVID-19 funding. This is helping patient flow from acute hospitals for those with complex discharge needs.

Our interim placement scheme in Ceredigion (part funded by the Integrated Care Fund) helped patients requiring 24-hour nursing monitoring to be placed in an independent nursing home for a period of up to six weeks. The scheme has enabled timely assessment (in line with the discharge to assess model) as well as preventing hospital admission. We have seen a significant increase in its use during 2021-22 (an increase of 30% from pre-pandemic levels) improving patient flow through the wider system and delivering appropriate care close to home.

In late 2021, we introduced the Same Day Urgent Care service in Cardigan Integrated Care Centre in a phased way. The service has been designed to prevent unnecessary demand on our acute sites by delivering appropriate diagnostic and treatment in the community.

The time critical ophthalmology clinics have expanded and continued to be delivered out of Aberaeron and Cardigan integrated care centres throughout the pandemic.

Pembrokeshire

The Falls Team has seen a significant increase in demand with their 500th referral in September. The team provide monthly education sessions for care home staff and deliver an important pathway for the Welsh Ambulance Services NHS Trust (WAST) to use for those people who fall without serious injury.

Working with the primary care clusters has been important and several beneficial new schemes have been introduced, for example, respiratory care and education in schools for young people, increasing first contact physiotherapists in GP practices, Dance to Health and increasing the Community Connectors.

We have worked with Pembrokeshire County Council and Pembrokeshire Association of Voluntary Services to build community connectedness in our communities through the new communities hub. This recognises the isolating impact COVID-19 has in our communities and provides a co-ordinated mechanism to connect people in communities, working together to meet needs and reduce the harmful impacts of isolation. Specialist connectors have also been introduced for young people, those living with dementia and to enable better digital connections and use of technology.

The community teams, third sector, social care and primary care have continued to work together to identify those people who need a more co-ordinated approach to care, planning and supporting to meet needs collectively. Care co-ordinators have been put in place to support this process and in South Pembrokeshire the cluster has commenced with a scheme focusing on identifying those who may be at risk of further health deterioration and potential admission to hospital.

Our Intermediate Care Team seeks to rapidly respond to people experiencing a significant increase in their needs, either to enable them to stay at home rather than go into hospital, or to support them home safely after an admission. We have brought together doctors,

nurses, therapists, social workers and support workers to first assess needs that might be complex and then put in place a short-term response until independence is recovered or long-term care is available. At the end of the year this team was supporting an average of 60 people in a community 'ward' each day and we hope this can continue to grow.

Therapy services

The COVID-19 pandemic impacted therapy services significantly in several ways: in the way services evolved to continue to support patients across our care settings and within their own homes; and also responding to the increased acuity and complexity of patients presenting for care following periods of lockdown and service interruption.

In the acute stages of the pandemic and during successive waves, therapy services needed to respond, not only to the urgent clinical needs of COVID-19 patients, but also to requests for therapists' redeployment to urgent services. To ensure that our service users continued to be able to access effective support and rehabilitation, therapy services continued to use virtual and digital solutions such as Attend Anywhere to provide individual and group session support and have been capturing patient outcome and experience data using online platforms.

Therapy services have also been increasingly required to respond to a new and growing cohort of individuals with post-COVID-19 syndrome (known as Long COVID), and in September 2021 a dedicated community based Long Covid Syndrome Service was established to provide specialist multi-disciplinary support for individuals suffering from Long COVID. The service aims to enable patients to take control and responsibility for their ongoing health and well-being and equips them with skills and knowledge to manage their ongoing rehabilitation needs. With support from multi-professional rehabilitation professionals, including therapy assistant practitioners, occupational therapists, physiotherapists, dietitians, psychologists and advanced nurse practitioners, the service provides a comprehensive individualised person-centred assessment utilising National Institute for Health and Clinical Excellence (NICE) recommended Long COVID assessment tools.

Design and implementation of testing and immunisation for COVID-19

COVID-19 testing

We first commenced community testing for COVID-19 in March 2020. Since that time, the demands for testing, national strategy and testing infrastructure have changed frequently and quite dramatically. We developed a robust testing infrastructure, which has been responsive to the changing expectations from Welsh Government, as the national testing strategy developed. We continue to provide COVID-19 testing to anyone who needs it.

Over the past year the provision of testing has included:

- those with COVID-19 symptoms in the community
- identified contacts of COVID-19 positive individuals

- patients prior to surgery and chemotherapy
- all patients on admission to hospital
- all inpatients routinely every five days
- inpatients when they become symptomatic
- patients prior to discharge to or admission to a care home, or home with domiciliary care support
- residents within care homes
- all care home and ward residents/patients and staff in response to outbreaks
- our population as appropriate in response to outbreaks or the identification of a new variant of concern
- routine asymptomatic testing of health and social care staff, teaching staff and students with lateral flow devices (LFDs)
- public access to LFDs for routine asymptomatic testing.

From 1 April 2021 to 31 March 2022, 700,000 real time polymerase chain reaction (RT-PCR) tests were carried out within the health board region.

The rates of COVID-19 infection across Carmarthenshire, Ceredigion and Pembrokeshire, and the positivity rates of RT-PCR testing, have fluctuated dramatically across the year. In April 2021, our region saw rates of 7.7 cases per 100,000 population and a positivity rate of 1% for around 3,000 RT-PCR tests per week. At the highest peak in January 2022 these rates increased to around 1,900 cases per 100,000 population and 48% positivity for around 15,000 tests per week.

We are currently using a range of testing methodologies, including RT-PCR and point of care testing (POCT). Previously, we also provided antibody testing, which has now been discontinued on a national basis.

The national strategy for testing over the past year included:

- supporting NHS clinical care – diagnosing those who are infected so that clinical judgments can be made to ensure the best care;
- protecting our NHS and social care services and individuals who are our most vulnerable;
- targeting outbreaks and enhancing community surveillance to prevent the spread of the disease amongst our population;
- supporting our education system and the health and well-being of our children and young people, enabling them to realise their potential;
- identifying contacts of positive cases to prevent them from potentially spreading the infection if they were to become infected and infectious, and maintaining key services;
- promoting economic, social, cultural and environmental well-being and recovery.

Symptomatic community testing, including critical workers

During the past year, the vast majority of our symptomatic community testing, including critical workers, has been delivered via the UK testing system. Tests were booked through the UK government portal or 119 and swabs were analysed in the UK Lighthouse Laboratories. Testing via this route was also offered to identified contacts of COVID-19 positive cases.

At times of high demand, or where issues relating to the UK system adversely affected access to testing or longer than acceptable turnaround times for results, we stepped up our own delivery of testing via the community testing units (CTUs). This allowed us to deliver testing to health and social care workers to support the availability of our workforce, enabling them to return to work as quickly as possible to help maintain critical service delivery.

We continued to provide testing to symptomatic individuals who could not attend a testing site, for example, the housebound and international travellers with a suspected variant of concern. This was delivered through a home visit by our CTU staff.

Modelling work was frequently reviewed to maximise daily community RT-PCR testing throughout the year in response to changing demand. Additional mobile testing units were located across Carmarthenshire, Ceredigion and Pembrokeshire in line with local increased demand and allowed us to respond effectively to clusters or outbreaks in specific areas.

We continually worked with our partners and other health boards in relation to mutual aid and supporting testing for people who live or work across our boundaries or travel into our communities, such as students and visitors/tourists.

We continually communicated with our local community throughout the pandemic on the criteria for testing and its importance in keeping people safe. We also provided practical information on how to access testing and the need for self-isolation while waiting for results or following a positive result. We used a combination of updates through traditional media and 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.

Access to RT-PCR testing for the public ceased on 31 March 2022, at present replaced with the use of LFDs for symptomatic testing. Going forward into 2022-23, we will continue to provide RT-PCR testing for symptomatic health and social care staff.

Care home testing

We have continued to offer both symptomatic and asymptomatic testing in outbreak and incident management scenarios across the care home sector. This testing was delivered in conjunction with the weekly asymptomatic testing of staff via the UK government portal and was central to identifying infection cases in individual homes that founded the basis of all decision making in declaring outbreaks and incidents.

During 2021/22, we carried out testing for 859 care home staff and 14,873 care home residents via the Public Health Wales (PHW) laboratories. In addition, the UK government portal provided 255,373 RT-PCR tests for regular staff testing.

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).

Inpatient testing

We have continued to test patients on admission to hospital and routinely during their stay in line with Welsh Government requirements. This has been mostly via RT-PCR tests, however, in November 2021 we introduced a rapid point of care test (POCT) (Roche Cobas Liat) into our admitting units for paediatric services to support grouping of patients with viral respiratory illnesses. This test is used to identify respiratory syncytial virus (RSV) and COVID-19.

Similarly, in January 2022, rapid SARS-CoV-2 antigen testing was expanded to unscheduled adult admissions at the four acute hospitals using the Abbott ID NOW POCT.

Whilst admission testing will continue into 2022-23, routine repeat inpatient testing has now ceased. We will, however, continue to test where patients develop symptoms, or where indicated in the case of a hospital outbreak.

Asymptomatic testing

We have always directed all asymptomatic testing of pre-operative and pre-chemotherapy patients via the health board CTUs and PHW laboratories to ensure rapid turnaround times for results. This testing will continue into 2022-23.

These facilities are supporting one-stop clinics for pre-chemotherapy RT-PCR testing and phlebotomy. They are also being utilised as COVID-19 vaccinations centres, maximising facilities and staffing resources. Consideration is being given regarding the longer-term continuation of phlebotomy at such community sites, rather than returning fully to hospital-based phlebotomy services post-COVID-19.

Health board testing staff based at these sites are also supporting testing within care homes for symptomatic residents, mass home testing in response to outbreaks and domiciliary testing where required.

In February 2021, we began offering LFDs to health board staff and students for routine asymptomatic testing. This testing is not mandatory, and staff can reserve the right to decline the offer. The offer of twice-weekly LFD testing is also being made to all primary care contractors.

Over the past year, routine asymptomatic LFD testing was rolled out across a wide range of workplaces including education, public services and private companies and businesses. LFD tests were latterly made available for the public via community pharmacies and LFD Direct, with tests ordered on the UK government portal and delivered to their home.

Routine availability of LFD kits for asymptomatic testing ceased on 31 March 2022, however, we will continue to provide LFDs to health and social care staff during 2022-23 in line with Welsh Government policy.

COVID-19 vaccination programme

Our COVID-19 vaccination programme for the three counties continues to support 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 remains 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 continue to strive to offer everyone eligible their primary or booster vaccinations.

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.

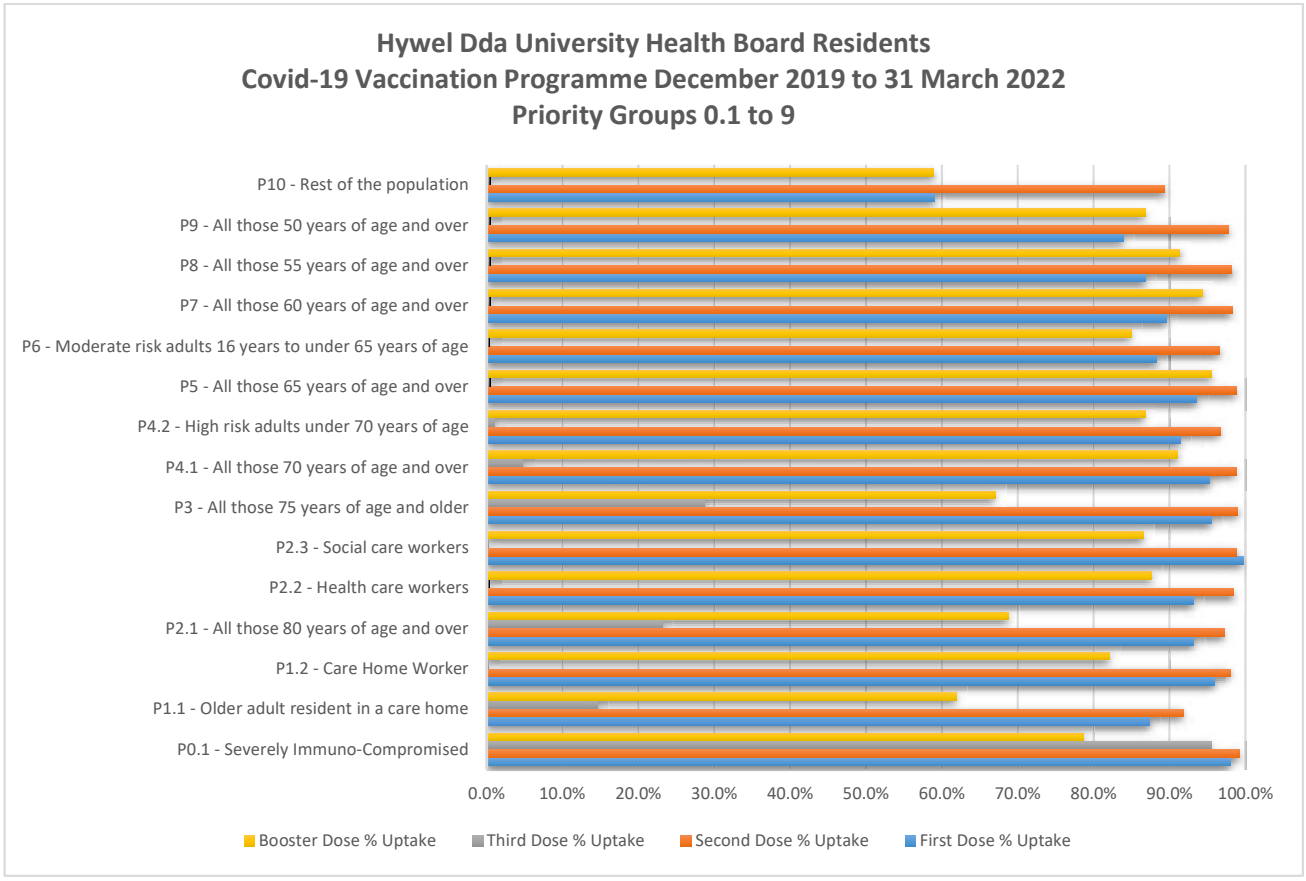
This means some people have or will receive their vaccinations through their GP surgery or community pharmacy, whilst others will be invited to their nearest mass vaccination centre, where vaccine is delivered by health board staff.

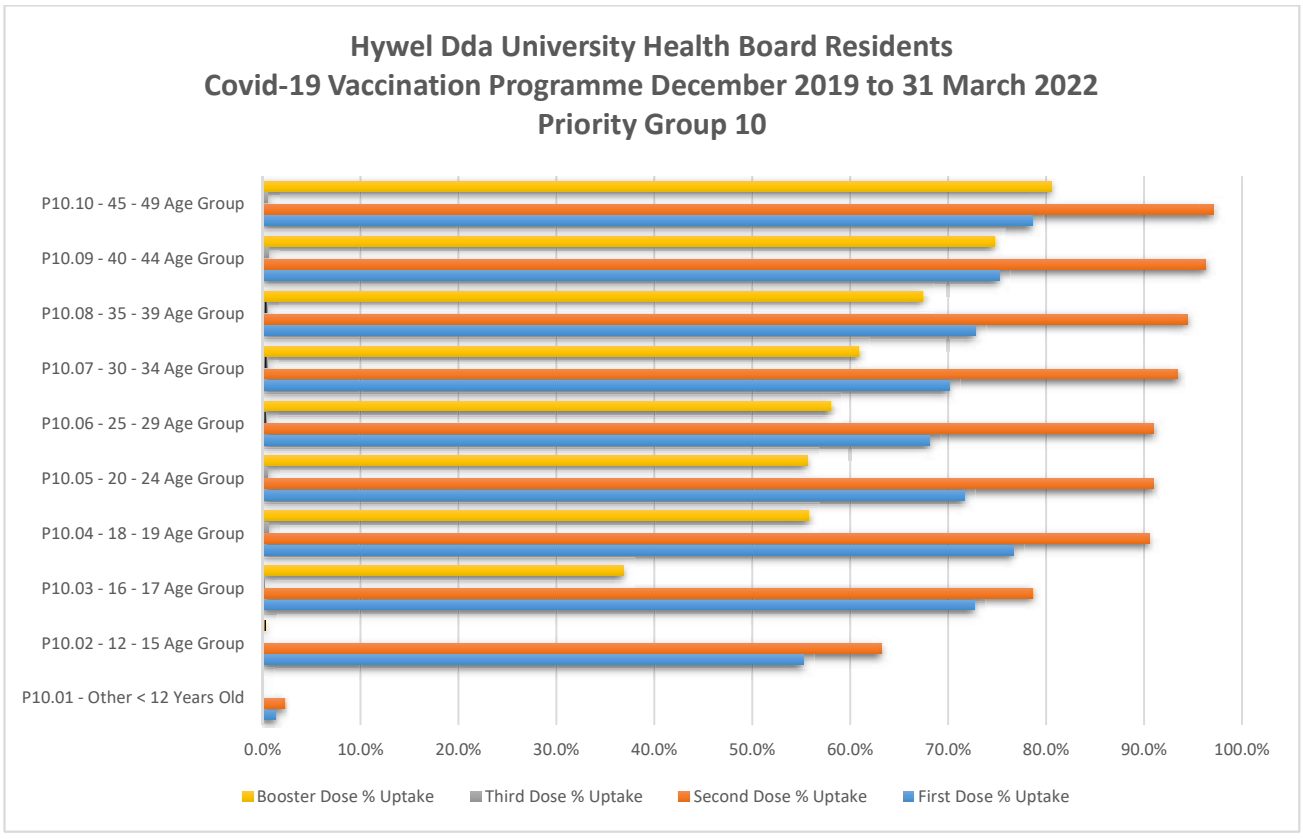
We also vaccinate target groups in other ways where necessary, for example, we have undertaken vaccination in the hospital to care for long term patients or service users. We have also held 'pop-up' clinics for certain communities, such as travellers, unpaid carers and those people who are homeless.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

Flexibility of delivery is crucial to meeting the guidance of eligibility as set out by the JCVI and on occasions 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. As the programme has now reached our younger population, we aim to support our younger children through clinics in our mass vaccination centres or additional 'pop up' clinics setting that are suitable for this younger group. We aim to ensure the environment is adapted for the needs of this younger group to prevent any distress and support a positive experience.

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

As of 31 March 2022, 867,173 COVID-19 vaccinations had been delivered to our residents and staff – 315,323 first doses, 300,306 second doses, 19,806 third doses (severely immunosuppressed only) and 231,738 first boosters. The detail as per JCVI priority group is shown in the image below:


Hywel Dda University Health Board Residents
Covid-19 Vaccination Programme December 2019 to 31 March 2022
Priority Groups 0.1 to 9
P10 - Rest of the population
P9 - All those 50 years of age and over
P8 - All those 55 years of age and over
P7 - All those 60 years of age and over
P6 - Moderate risk adults 16 years to under 65 years of age
P5 - All those 65 years of age and over
P4.2 - High risk adults under 70 years of age
P4.1 - All those 70 years of age and over
P3 - All those 75 years of age and older
P2.3 - Social care workers
P2.2 - Health care workers
P2.1 - All those 80 years of age and over
P1.2 - Care Home Worker
P1.1 - Older adult resident in a care home
P0.1 - Severely Immuno-Compromised
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%
Booster Dose % Uptake
Third Dose % Uptake
Second Dose % Uptake
First Dose % Uptake


Hywel Dda University Health Board Residents
Covid-19 Vaccination Programme December 2019 to 31 March 2022
Priority Group 10
P10.10 - 45 - 49 Age Group
P10.09 - 40 - 44 Age Group
P10.08 - 35 - 39 Age Group
P10.07 - 30 - 34 Age Group
P10.06 - 25 - 29 Age Group
P10.05 - 20 - 24 Age Group
P10.04 - 18 - 19 Age Group
P10.03 - 16 - 17 Age Group
P10.02 - 12 - 15 Age Group
P10.01 - Other < 12 Years Old
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%
Booster Dose % Uptake
Third Dose % Uptake
Second Dose % Uptake
First Dose % Uptake

We are 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. Their response across all our delivery settings to the acceleration of the booster roll out during the autumn period in response to the Omicron outbreak and the need to vaccinate our eligible population to a reduced interval timescale, was outstanding.

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 maintained 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 aim was to explore the opportunity for administration of flu vaccine and COVID-19 booster vaccination at the same time. Due to the timescale of the availability of both vaccines the opportunities were limited for this flu season, however, it remains an aspiration for future programmes.

The contribution of the health board's School Nursing Service resulted in the programme for primary school children being delivered alongside the addition of a programme for secondary school children. Despite challenges due to the circulating COVID-19 infection due to the Omicron variant, they successfully delivered the enhanced school programmes with very good uptake across all ages.

This was complemented by an external communications and public relations exercise that aligned with Welsh Government's vaccination strategy. Part of this campaign included a significant investment to reach the non-digital audience, such as newspaper adverts across the three counties to replicate the success received the previous year, along with radio adverts. Meanwhile, all schools were provided with flu promotion materials to issue directly to parents.

The table below illustrates the uptake of flu vaccination in our communities for all eligible groups (note the 2021/22 data is provisional at the time of preparing this report):

Cohort	2021/22 Uptake (%)	2020/21 Uptake (%)	% Change	Wales uptake 2021-22
Over 65s	75.9%	73.6%	2.3%	78.0%
Under 65s with chronic conditions	47.4%	49.8%	-2.4%	48.2%
2-3 year olds	47.0%	55.1%	-8.1%	41.0%
School aged children (4-10 year olds)	68.46%	87.1%	-18.64%	
School aged children (11-15 year olds) Note: excludes vaccinations in GP surgeries and home-schooled children	64.6%	n/a	n/a	59.8%
Hywel Dda staff (direct patient contact) Note: staff denominator has increased, even though the number staff immunised has increased this is not reflected in % uptake rate	53.9%	55.1%	-1.2%	

Through this combined effort we:

- vaccinated a cohort of people in our communities aged between 50-64 years old following confirmation from Welsh Government this group was to continue as a priority;
- 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 and an increasing wave of the Omicron variant was managed through exceptional partnership working and the need to be as flexible and responsive as possible.

The programme was supported by a communications and staff engagement campaign, which highlighted available clinics and how to access vaccines. The flu vaccination programme ran between September 2021 and 31 March 22; uptake was 54% with 6,880 staff vaccinated against flu, higher than previous years.

Redesign of acute services to provide COVID-19 care

Critical care

Going into year two of the COVID-19 response, the number of available critical care ventilated beds remained within funded capacity of 22. This was due to the challenges related to the availability of suitably skilled staff, including agency, and a recurrent vacancy factor which saw a flow out of skilled staff and recruitment of novices. In addition, as many external services continued their provision in year two, the staff pool trained up in year one to assist in the critical care bed base expansion were not available.

All critical care locations did feel the challenge across the peak of the third wave of COVID-19. With twice daily cross-site meetings, patient cohorts and staffing were discussed; and risks were assessed resulting in patient or staff moves to assure safety concerns could be mitigated and addressed. It should be noted that, when able, many nursing staff moved at short notice to other locations in support of optimising staff numbers in locations of higher patient acuity need.

The inability to safely segregate COVID-19 patients noted in year one, has continued across year two. This has placed significant pressures on all staff disciplines on making decisions on best options for patient flow and placement. The funding for installing side rooms into existing bed base across all four sites has been obtained and installation commenced. This will improve site ability to appropriately segregate patients in the future.

The launch and availability of the Acute Critical Care Transfer Service (ACCTS Cymru) has been a significant asset to the critical care service from its launch in August 2021; facilitating transfers across the health board and beyond in support of assessed patient need.

Field hospitals

Our 2020/21 annual report described how the health board's field hospital arrangements were set up and commissioned to the point of being brought into a state of operational readiness. This was made possible through collaborative working with local authority and town council partners along with the private sector. The arrangements included providing nine field hospital sites offering 915 inpatient beds distributed across Carmarthenshire, Ceredigion and Pembrokeshire as a precautionary measure to tackle the impact of increased acute and community hospital site admissions. Three of these field hospital sites experienced inpatient activity namely:

- Ysbyty Enfys Caerfyrddin (Carmarthen Leisure Centre) June 2020 – August 2020: activity 32 patients
- Ysbyty Enfys Selwyn Samuel (Selwyn Samuel Centre) November 2020 – June 2021: activity 263 patients
- Ysbyty Enfys Carreg Las (Bluestone) December 2020 – March 2021: activity 86 patients.

Other sites were used to support vaccination demands and broader local health needs, such as accommodation for training and development and associated clinical back office functions.

The most recent waves of coronavirus did not increase demand to the point where field hospital support was needed. All premises that were adapted for field hospital purposes have now been returned to their owners except for Selwyn Samuel Centre in Llanelli; work is in progress to return the building to its former use and is scheduled to complete in April 2022.

Overall, the health board's field hospital provision is considered a successful venture with a high degree of patient satisfaction for the care received, with no complaints received. Positive remarks from Health Inspectorate Wales, low levels of incidents and a total of

5,367 bed days saved which otherwise would have created further pressures on acute and community hospital beds.

Emergency care

Our urgent and emergency care (UEC) model has been reviewed and redesigned reflecting those priorities outlined in the six national policy goals.

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 and 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.

These recognise the need for us to strengthen community services and care for people at home not in hospital, but to also ensure timely access to diagnostics and assessment in same day emergency care (SDEC) facilities that allows patients to return home to their own bed.

Our UEC model and resource investment has therefore focused on strengthening urgent primary care services, SDEC and 'wrap around' care so that frail people who require a level of support receive this at home rather than in hospital.

Examples of how we are strengthening community and urgent primary care services are available from page 23.

In September a new project was commenced to rapidly expand the wrap-around care that is provided in each county to deliver additional 'bridging' care at home. This with the intention of growing the whole home-based care workforce to meet the needs of those people in hospital unable to get home safely without it. 24 new healthcare support workers were recruited and trained and deployed into community settings across the region. In Carmarthenshire, they enabled the earlier opening of additional beds in Amman Valley Hospital; in Ceredigion, they supported gaps in fragile community teams at the peak of the third wave; and in Pembrokeshire, they supported an additional run being opened in the existing bridging service. Although the numbers recruited were less than sought, there were important lessons learnt and feedback from patients and staff to support future recruitment and workforce development.

Temporary paediatric service change

In September 2021, we agreed to extend a temporary service change to ensure the safe treatment of seriously unwell children in the south of the Hywel Dda area.

In spring 2020, the children's daytime unit and its specialist staff at Withybush Hospital, Haverfordwest (called a Paediatric Ambulatory Care Unit or Puffin Ward locally), were moved to Glangwili Hospital, Carmarthen. This was due to the necessity to use the area for the hospital's COVID-19 response.

It has meant that children under 16 with serious illnesses or injuries have been treated at Glangwili Hospital, where there is a co-located Emergency Department and specialist children's services staff including an overnight children's ward, and children's high dependency unit (which are not available at Withybush Hospital).

The extension of this service change was agreed in a board meeting in the context of the continuation of the pandemic response, but also due to the expected increase in the number of children likely to have respiratory viruses in the winter of 2021/22. In anticipation of more children becoming unwell from respiratory viruses, we invested in more equipment and high dependency beds at Glangwili Hospital. This has enabled children to have their definitive treatment more quickly and has also allowed for children to be monitored by specialists if they deteriorate.

In the interim period, Withybush Hospital treats children with minor injuries, via the minor injury unit and Emergency and Unscheduled Care Unit, and provides booked outpatient appointments. A communication campaign to advise parents in Pembrokeshire and the south of Ceredigion of where they can access children's hospital care has been undertaken and included radio advertisements and a household leaflet drop.

A review of the temporary service change is ongoing and will report back to the health board later in 2022. We are working closely with Hywel Dda Community Health Council to ensure the review has the appropriate scrutiny and that we measure outcomes for children and young people, as well as patient experiences, and the views of our communities.

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

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

Despite the challenging year, there have been many significant achievements across the health board this year in areas of care beyond COVID-19. Here are some examples:

- **Opening of the Special Care Baby Unit at Glangwili Hospital** as part of a £25.2m Welsh Government investment. The new obstetric and neonatal facilities provide five standard birthing rooms with en-suite; one birthing room with a fixed pool; one birthing room equipped to deal with multiple or complex births; and a six bedded enhanced monitoring unit. The unit will also improve the working environment for staff, with an appropriate area for teaching and multi-disciplinary working.
- **New CT scanner at Glangwili Hospital and replacement MRI scanner at Withybush Hospital.** These state-of-the-art scanners will greatly improve the patient experience with increased resolution and faster scan times.
- **Stonewall silver employer award** in recognition of our commitment to inclusion of lesbian, gay, bi, trans and queer people in the workplace. Initiatives include an LGBTQ+ Staff Network, for LGBTQ+ staff and allies, staff training sessions, and delivering LGBT inclusive services, and celebrating key annual events, such as LGBT History Month, Pride, and Trans Visibility Day.
- Developing with partners the **Carmarthen Hwb** and advancing the **Pentre Awel** development bringing together a range of health, well-being, learning and cultural services to support people of all ages to access key services all under one roof.
- The submission of our outline business case to Welsh Government for our **Cross Hands Well-being Centre**. The centre will provide an integrated health and social care network of services for the Amman Gwendraeth area, accommodating two local GP practices (Tumble and Penygroes), a library, family centre, community pharmacy and also community police support officers and voluntary sector groups.
- **New online access to information** for our population through platforms such as DrDoctor and Patient Knows Best to improve your patient experience and access to NHS services and information.
- A brand-new **clinical research centre** opened at Glangwili Hospital, providing access to new research opportunities to patients in west Wales. This new dedicated space will reduce the pressures on other departments within the hospital and makes Carmarthenshire a more attractive site to conduct potentially life-changing research. This centre will offer patients the opportunity to participate in clinical trials that offer earlier access to the very latest treatments and therapies. The £250,000 investment has seen the development of bespoke clinical rooms to treat and monitor patients and a

multifunctional lab space with state-of-the-art facilities to enable sample processing independently from other busy departments.

- **Quality Data Provider award for elective surgery at Bronglais Hospital.** The hospital was named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits. The hospital's orthopaedic team received the award for elective surgery. The NJR monitors the performance of hip, knee, ankle, elbow, and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients, clinicians, and industry. The registry collects high quality orthopaedic data to provide evidence to support patient safety, standards in quality of care, and overall cost effectiveness in joint replacement surgery.
- **Mental health support schemes.** Across mid and west Wales, GP practices have commissioned a range of schemes to help patients with low level mental health, isolation, and loneliness. These non-clinical interventions deliver a different approach to supporting patients and are designed to improve patients' mental health and well-being. Other innovative mental health projects include the appointment of mental health practitioners; mental health first aid in pharmacies; working with mental health agencies; and charities to provide counselling, resources, and support to people across all age groups with mental health issues.
- **Specialist endometriosis nurses** have been appointed in each health board in Wales to improve services for the chronic condition, which affects one in 10 women.
- **Miracle spray saves life.** A miracle spray saved the life of an overdose victim in Carmarthenshire as a result of a joint trial with Dyfed Powys Police. The trial, which began in January 2022, involves police officers carrying the nasal spray Nyxoid to help reduce deaths from drug overdoses and to refer people to the Dyfed Drug and Alcohol Service (DDAS) for support. The trial is operating in Llanelli, Aberystwyth, Pembroke Dock, and Llandrindod Wells for six months.

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

Management of safe personal protective equipment

The management of personal protective equipment (PPE) has been driven through a dedicated PPE Cell, chaired by the health board's Director of Nursing, Quality and Patient Experience. Once systems were established and there was confidence in supply chains, which have been consistent throughout the year, the cell reduced its meeting frequency. Training in the use of PPE has been provided by the Infection Prevention and Control (IPC) Team in multiple formats, including posters, videos and in person where needed. The Health and Safety Team has supported with 'train the trainer' sessions for fit-testing specialist respiratory masks and hoods. Both teams supported the testing and procurement of additional and specialised PPE.

Redesign of local estate to deliver safe services during COVID-19 (outpatients, theatres, diagnostics)

Our IPC Team worked with health services throughout the pandemic to review patient flow and ensure patient and staff safety is maintained. Services were supported through expert advice on mitigation and risk assessments where appropriate. Pathways of care in our hospitals have been reviewed and developed throughout the pandemic, in response to COVID-19 modelling information, emerging new variants of concern and new or updated national guidance.

Significant work and investment have been made to improve the capacity of isolation facilities, maintain social distancing requirements and improve ventilation in our closed settings. Capital investment has been secured for screens, Bioquell Pods, Redirooms, air humidifiers and for the conversion of isolation suites to negative pressure suites.

We deliver a number of outpatient services across our community hospitals and other settings, where community nursing staff support consultant and nurse led clinics. A standard operating procedure for delivering outpatient services from community facilities during COVID-19 was adopted across the health board having initially been led by Ceredigion county.

Arrangements were also in place across community settings and services, such as outpatient clinics, to ensure these were safe and accessible for our population. For example, in Ceredigion, additional domestic support was put in place to enhance cleaning and meet and greet functions; and a process put in place to ensuring patients were familiar with the COVID-19 arrangements on site and reassuring patients that it was safe for them to attend their appointments.

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

The health board's Communications Team continually communicated relevant and timely messaging, supported by the IPC Team, to inform and reassure local communities on national and local requirements and how to stay safe during the pandemic. This included messaging around attending GP practices, pharmacies, and self-care. The IPC Team has continued to support the Regional Response Cell and local authorities in mitigating risks associated with COVID-19 and other infections in care homes across our three counties. The assessments, action plans and support across these premises have played a significant part in care home outbreaks across the health board. The IPC Team has also supported all community services including community hospitals, health board community clinics, managed GP practices, out-of-hours GPs, primary care, integrated care centres, community nursing, children's community services, dental and therapies on COVID-19 measures, processes, and risk assessments.

The implications from this additional requirement

The last year has, again, tested the resilience of the health board's IPC Team, stretching resources across multiple areas of healthcare and into the community, supporting education, the fire service and private companies in their pandemic response. While

endeavouring to continue services, face-to-face training was suspended, and some locality meetings were cancelled.

The IPC Team is a small, specialist team. The recruitment of additional resource has helped to support the team's specialist practitioners and sustain the routine work around infection prevention and reduction. During this time, the health board recruited a substantive consultant practitioner in infection prevention. This role provides additional expert clinical care, senior leadership, and strategic delivery of the infection prevention service, while further developing an integrated preventative approach to infection prevention and control across the health board (including community settings such as care homes). A seven-day-a-week service has been successfully piloted and is continuing currently.

An integrated infection prevention nursing role has also been designed and evaluated in partnership with, and funded by, Carmarthenshire County Council. This is a substantive, jointly managed, post provides ongoing support to our communities. Our hospital and community IPC teams have, throughout the pandemic, visited wards, care homes and GP practices to assess IPC measures for COVID-19 and outbreaks; support staff and residents; deliver training; provide mitigating actions to prevent onward transmission of COVID-19; and to protect vulnerable residents and staff. These on the ground assessments, action plans and support have played a significant part in care home outbreaks across the health board.

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 of 31 March 2022 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 and 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 service

- The number of consultations closed as telephone advice during 2021-2022 rose to approximately 75-80% of total contacts. More recently this level has reduced and there is a slow move back to pre-COVID-19 management of patients with approximately 60% of current levels of calls closed as telephone advice with no further contact or follow-up required. During quarter four of 2021-2022, there was an average monthly demand of 3,364 calls. Over this same period calls have been managed across the following distribution:
  - Treatment centre 18%
  - Home visits 5%
  - Referred to Welsh Ambulance Services NHS Trust (WAST) 7%
  - Referred to emergency department 6%
  - Referred to secondary care 4%
- Individual call complexity has also shown signs of change over time with the average time per call taking double from the previous pre-COVID-19 average of 11 minutes. If this pattern were to continue the impact would be a reduction in calls dispersed per hour per GP to a maximum of three.
- The 111 service has consistently dispersed additional calls before they impact the local out-of-hours service and this amounts to an additional third of calls. In line with previous patterns of referral into out-of-hours, the Carmarthenshire centres continue to see the greatest demand, and Pembrokeshire continues to disperse more via home visiting.
- The service has seen success in recruiting eight additional salaried GPs, however, the net positive impact has not been as significant as was hoped due to some being recruited from the locum resource. A more settled position was seen over the latter part of the year although this was not a consistent picture across the three counties.

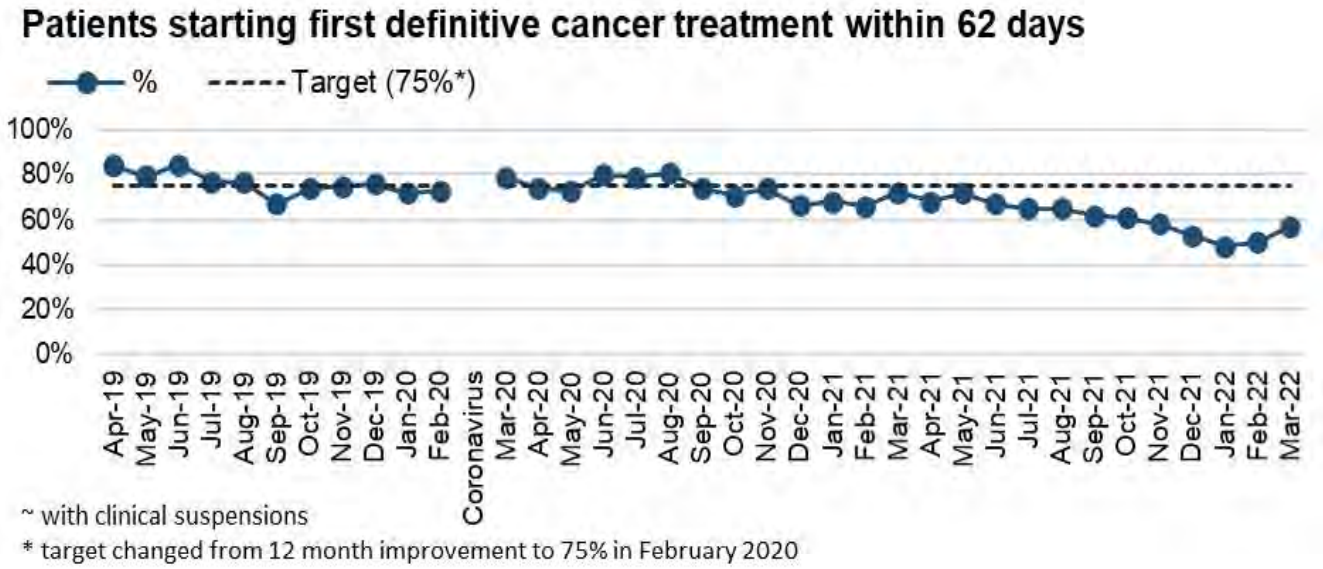
- Overall availability of locum GPs support has continued to reduce, however, the transfer of some into salaried positions should not strictly be considered a capacity loss. Daytime practice and out-of-hours continue to draw on the same pool of human resource and work continues to balance out this position. Weekend shift fill remains the greatest service challenge with a level three (70-79%) being on average the best sustained achieved levels of fill rate over the past twelve months. Weekdays (not including bank holidays) have an average shift fill at level one (>90%).
- The recent departure of some advanced nurse practitioner resource due to taking up work elsewhere is a further loss to note and, although this has limited bearing on weekday shifts, it is beginning to have some impact on weekend resilience. The advanced paramedic practitioner pilot in partnership with WAST continues and remains an important resource contribution to the overall service. All the advanced practitioners available to the out-of-hours service have been key in allowing the needs of patients across the health board to be managed in the most appropriate and timely way.
- The temporary reduction in services at Prince Philip Hospital, Llanelli and Llynyfran Surgery in Llandysul, has remained in place due to persistently fragile rotas across the entirety of the out-of-hours service and the limited ability to safely increase the provision of clinicians at these two centres without destabilising the remaining three bases continues to pose challenges.
- A new clinical and non-clinical rostering system will go live in May 2022 and will make shifts available and individuals' wishes to commit administratively more efficient to manage and communicate with the team. This is expected to improve clinical service resilience long with capacity within the administrative team.

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;
- maintain all cancer services.

We did not meet the 75% target for cancer patients commencing treatment within 62 days from point of suspicion during 2021/22. This is due to several factors including diagnostic capacity issues due to infection control guidance, particularly in radiology. COVID-19 related sickness, staff vacancies and planned annual leave has further impacted performance. Performance for quarter three has been declining due to the increase in COVID-19 related sickness, management of COVID-19 related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short-term planned and unplanned step down of activity within outpatients and planned surgery.



Impact on our patients

We need to ensure a continued effective response to COVID-19, whilst providing essential services within the outpatient services and to adhere to Welsh Government guidance on social distancing and to avoid unnecessary visits to the hospital setting. Therefore, the introduction of face-to-face clinic consultations has required careful consideration. Most of the face-to-face outpatient appointments (in breast, head and neck, skin and gynaecology) required physical examinations or procedures. Virtual appointments are being undertaken via digital solutions such as Attend Anywhere.

We have implemented a Cancer Pathway Review Panel to identify any risk for those patients who have not received their treatment within 146 days from their point of suspicion. To date, no harm has been identified.

Outpatient appointment oncology clinics are being held via telephone consultation and virtually where needed; supported by the Oncology Clinical Nurse Specialist (CNS) Team. Chemotherapy/systematic anti-cancer therapy (SACT) is still being administered on all four hospital sites. All six levels of SACT continue to be administered. The current waiting time for chemotherapy is 15 days across the health board sites.

At the beginning of the pandemic, a non-clinical cancer helpline was set up for patients, relatives, and professionals to access advice and support from external agencies and charities. This has strong links with the local authority. This is now a substantive service.

During the last year, visiting was restricted as per Welsh Government guidance. Currently, family and friends can attend Hywel Dda hospitals on a limited basis, with prior agreement with hospital staff and in line with current Welsh Government guidance. Patient Support Services remain in place for patients or visitors to contact with any questions and concerns.

Key issues and risks

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

- The impact of COVID-19 has increased the risk of being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board in line with the infection control guidance that remains in place. The main area of concern is radiology.
- A decrease in capacity for appointments and results reporting within radiology, due to COVID-19 related sickness, current vacancies and planned annual leave within two of the four health board sites. Patients have been offered alternative appointments on other sites, however, some patients have not agreed to attend and have requested an appointment close to home.
- Cancer performance has been on a downward course due to the increase in COVID-19 related sickness, management of COVID-19 related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. Clinics and elective cancer surgery with green pathway and green intensive care unit (ITU) / high dependency unit (HDU) have now been reinstated on all four acute hospital sites.
- At the beginning of March 2021, we saw a 38% increase in urgent suspected cancer referrals when compared with the same period in 2020. By the end of September 2021, the number of referrals had increased by a further 10%.
- We have strived to ensure that our elective cancer surgery with green pathway and green ITU/HDU remains in place. There have been occasions during the peak of the pandemic when surgery has been relocated to Prince Philip Hospital, except for head and neck surgery, which remained in Glangwili Hospital. This was mainly due to limited availability of critical care beds and staffing issues.
- All tertiary (specialist) cancer surgery was resumed.
- At the start of the pandemic, endoscopy was centralised in Glangwili Hospital. Following the first lockdown in 2020, Endoscopy services were reinstated on all four hospital sites, with capacity increasing to 53%. With the introduction of a green pathway in endoscopy in June 2021, capacity has increased and is now at 87%.
- 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. This helpline remains in place.
- A Single Cancer Pathway (SCP) Diagnostic Group with all the relevant service managers is in place to look at the capacity and demand for diagnostic services, looking at what capacity is required for a seven-day turnaround diagnostic service.
- A Rapid Diagnosis Clinic (RDC) was launched within the health board in October 2021. Currently one clinic per week is being held in Prince Philip Hospital. Plans are being looked at to roll this service out across all three counties.
- As per the Wales Bowel Cancer Initiative, a successful faecal immunochemical test (FIT10) screening in the management of urgent suspected cancer (USC) patients on a colorectal pathway was implemented in June 2020. This initiative is due to be rolled out to primary care by the endoscopy service in early 2022.

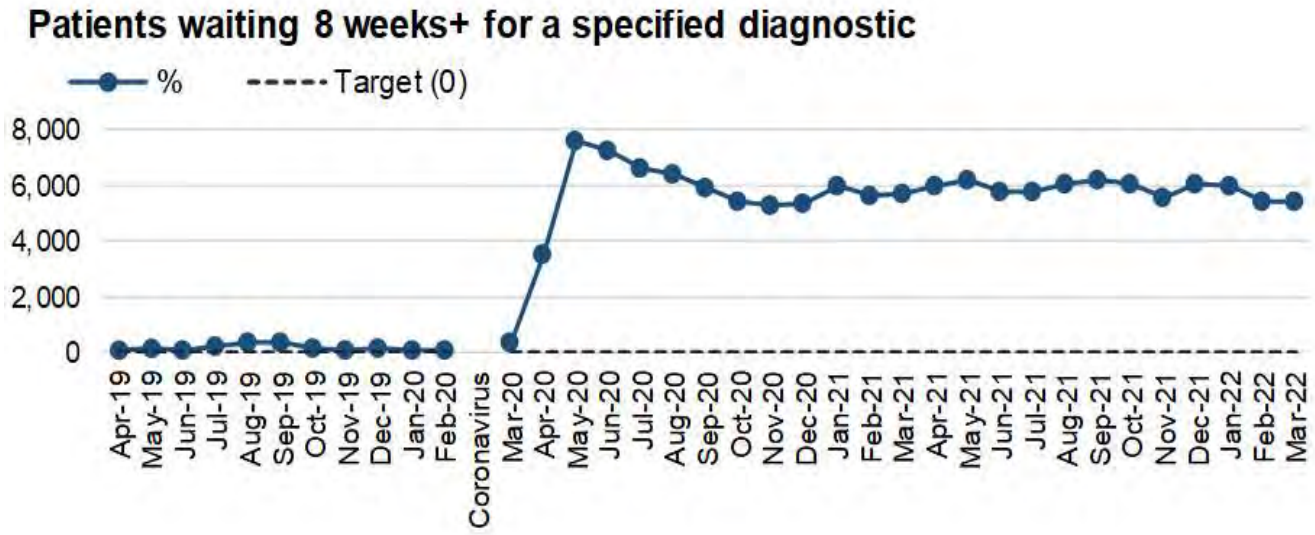
- Digital delivery of care was implemented during the first wave of the pandemic, resulting in two-thirds of patients receiving virtual appointments and only a third requiring face to face appointments.
- We have implemented a Cancer Pathway Review Panel.

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.

In April 2021, there were 5,989 patients waiting over eight weeks for a specified diagnostic. The number of breaches has remained at a relatively consistent level over the last 12 months, in March 2022 there were 5,403 breaches. Waits for radiology, endoscopy and neurophysiology show the highest number of patients waiting across diagnostics services in Hywel Dda.



Impact on our patients

- The restrictions in capacity have limited endoscopy to being able to undertake priority one (P1) and priority two (P2) patients only. The P1 patients are all dated within the ten working days. P2 patients are currently waiting five months to be dated where the guidance is four weeks. Priorities three, four and surveillance patients are not currently being dated within the health board unless they are expedited due to changing symptoms. Where patients' symptoms change, they are given an urgent review and the endoscopy procedure is undertaken if deemed necessary. Work is continuing to validate the patients waiting and we are sending out letters explaining to patients what to do in the case of changing symptoms.

- Rapid recovery from the pandemic has been constrained within radiology due to staff shortages and continued absences related to COVID-19. Across the four main hospital radiology departments, additional sessions have been held where possible during evenings and weekends to create additional appointment slots which have been more convenient for some of our patients and has shown a reduction in the number of patients waiting eight weeks plus for a radiology diagnostic examination.
- Radiology has continued with equipment replacement which will ensure that equipment breakdowns are minimised, and the latest technology is utilised within our departments leading to improved performance.
- Longer waits for cardiac diagnostics has resulted in delays in clinical diagnosis and a longer than typical/desired whole pathway for patients. This will have also had the associated consequence of patients re-presenting with symptoms at primary care, accident and emergency and acute hospital admission.
- COVID-19 backlog and recovery work has involved the outsourcing a proportion of cardiac computerised tomography (CCT) and cardiac magnetic resonance imaging (MRI) activity to St Joseph's Hospital, Newport which has required patients to travel further for this diagnostic. Despite this, feedback from a patient experience perspective has been positive and complimentary.
- There has been an increase in the number of patients contacting the cardiology service with concerns and anxiety related to delays in diagnostics.

Key issues and risks

As seen in the chart above, the COVID-19 pandemic continues to significantly impact on our performance for the delivery of diagnostic services:

- Capacity has significantly reduced due to the required infection control measures and reduction in services during the Omicron variant.
- Staffing shortages due to COVID-19 isolation and vacancies have affected our capacity to address backlogs and reduce waiting times.
- Continued capacity pressures, equipment failure and COVID-19 precautions are all potential risks that could impact our ability to meet target.
- There has been a sustained increase in cardiology referrals during 2021/22 due to COVID-19 backlog and recovery, as well as the cardiology follow-up recovery initiative.
- Trans-oesophageal Echocardiogram (ECHO) or dobutamine stress ECHO test capacity has been recovered to near pre-COVID-19 level during 2021/22.

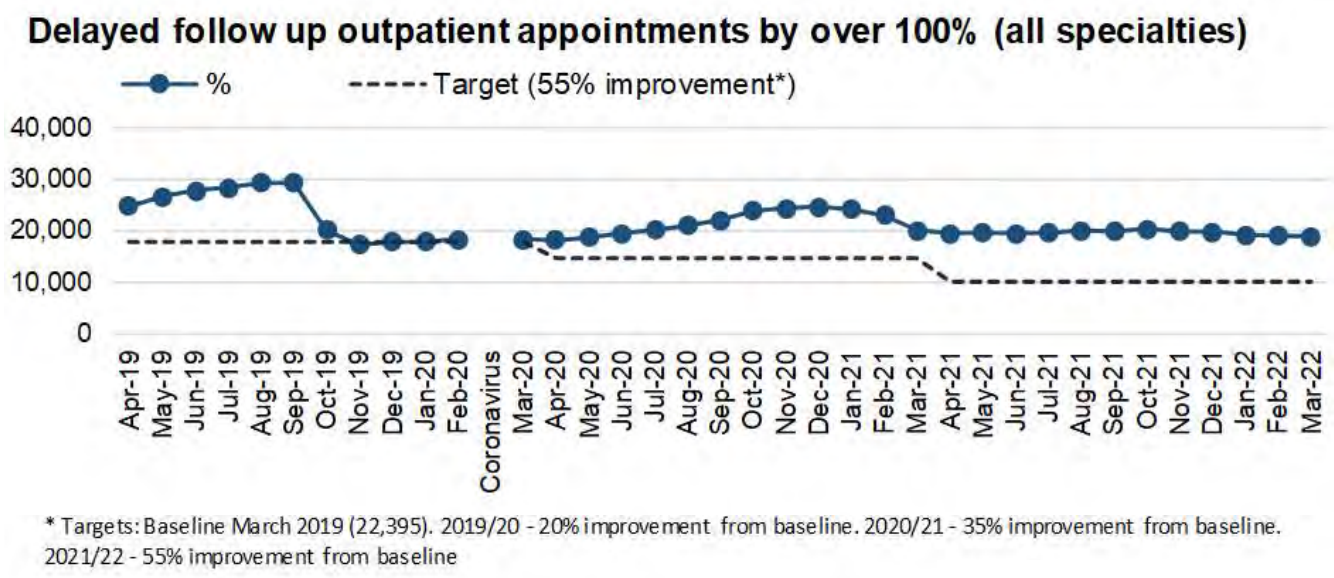
Key actions taken to ensure continued delivery of essential diagnostic services

- Continuous demand and capacity optimisation, investigation of outsourcing options, clinical validation and 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.
- Waiting list validation and robust triage of referrals.

- Six-day working established at Glangwili Hospital to maintain social distancing and increase the number of cardiology diagnostic tests undertaken.
- Some cardiology services were moved off-site to facilitate social distancing.
- COVID-19 recovery funded outsourced capacity for computerised tomography coronary angiography (CTCA) and cardiac MRI at St Joseph's Hospital, Newport during 2021/22.
- COVID-19 recovery funded enhanced and double-time rate payment to internal staff has assisted in addressing ECHO and cardiac monitor capacity shortfalls during 2021/22.
- Cardiac physiology demand and capacity exercise has identified historic and chronic workforce deficit which will continue to drive challenges in undertaking timely cardiac diagnostics.
- Cardiac physiology workforce deficits are identified as a key service risk and investment need in 2022/25 Integrated Medium Term Plan (IMTP).
- A capsule endoscopy service was introduced in 2022 to further reduce demand for scoping capacity.
- Screens continue to be used in our endoscopy waiting and recovery areas to help increase capacity safely. A green pathway was established allowing endoscopy capacity to increase back to 87%.
- Additional lists in-house to be established to further reduce P2 waiting times.
- All priority one endoscopy patients were dated within two weeks.
- Faecal immunochemical tests continued in line with national programme guidelines.

Outpatients

In March 2022, 66,418 patients were waiting on a follow-up list and 18,941 (28.5%) were delayed by over 100% of their target date for a follow appointment, which is an improvement of 1,153 compared to March 2021.



* Targets: Baseline March 2019 (22,395). 2019/20 - 20% improvement from baseline. 2020/21 - 35% improvement from baseline. 2021/22 - 55% improvement from baseline

We have had to look at more flexible solutions to safely maximise capacity. These objectives align with the three-year Welsh Government Outpatient Transformation Strategy. Examples of more flexible and innovative solutions include advances in digital platforms such as Attend Anywhere and Consultant Connect. Both applications have had a positive

effect on patients waiting for their appointment with 30% of all outpatient activity during 21/22 being undertaken virtually.

The service continues to roll out See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) pathways for both new and follow-up patients. In 2021/22, 6,461 follow ups (3.9%) were allocated an outcome of either SOS/PIFU, which has reduced demand for follow-up appointments.

Impact on our patients

The national guidance for outpatient services during the COVID-19 pandemic has required us to minimise the risks associated with COVID-19 transmission for patients. This has been achieved by reducing the number of patients in each clinical session. Additionally, the outpatient nursing teams have continued to provide high standards of cleanliness in maintaining infection prevention and control measures across the four acute sites. COVID-19 screens have been purchased and installed across all sites. Feedback from patients on the screens has been very positive including how safe, protected, and reassured they feel when attending all outpatient departments.

Outpatient nursing teams have adjusted and strengthened throughout the pandemic and maintain a positive approach to new ways of working to ensure we provide the best patient-centric care. The nursing teams across the four sites are prepared for future challenges in relation to reset and recovery plans and continue to prioritise patient safety, quality, and patient experience for all. The teams have continued to achieve positive feedback from individual compliments, and via the Feel Good Friday initiative. The service also enjoys regular appraisal via Envoy. The nursing teams engage in projects to enhance patient care/service provision and the senior nurse is currently engaged in an EQIiP (Enabling Quality Improvement in Practice) project to improve services for patients with sensory deficits.

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. Throughput is less than before the pandemic due to these 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 which includes undertaking virtual activity as an alternative to face-to-face.
- A virtual hub in Glangwili Hospital has been created so that medical staff have a dedicated area to undertake virtual appointments with patients.
- All patients waiting for either their first or follow-up appointment have been validated by internal or external validators to ensure appointments are kept for those who need it most and unnecessary referrals or appointments are removed. Validation is targeted at those follow-ups delayed by over 100%.
- Face-to-face contact has continued where necessary for urgent patients.
- Building on the success of our patient waiting list support team, we are working to establish a single point of contact for patients to enable timely responses and advice.

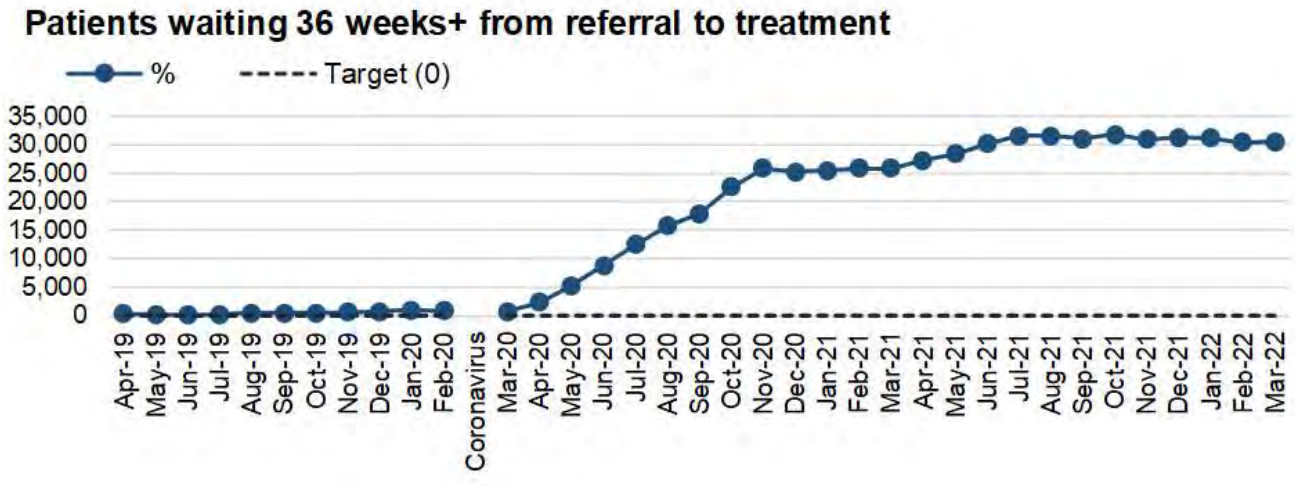
- Continued use of SOS and PIFU pathways in two ways as part of validation and after a patient has had a follow-up appointment.
- Innovative transformation pathways are being developed utilising the Welsh Government Outpatient Department (OPD) transformation fund. These include:
  - maximising optometry services in primary care for a number of eye conditions;
  - developing pre-habilitation programmes for patients waiting a long time for treatment;
  - developing virtual group consultations with a dedicated co-ordinator.

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 assess patients and prioritise accordingly so those at higher clinical risk or risk of harm are treated first.

While we have been working hard to steadily increase capacity to see and treat patients where possible in 2021/22, the pandemic has continued to impact upon planned care activity while we adhere to related government restrictions to keep us safe. There has been additional impact during the various waves of COVID-19 cases throughout the period, where planned care activity had to be scaled back with only emergency and urgent cancer care continuing. As a result, the number of patients waiting 36 weeks or more from referral to treatment (all stages) increased from 25,868 in March 2021 to 30,542 in March 2022. However, performance in 2021/22 has steadied when compared to the impact on performance during the first year of the pandemic.



Impact on our patients

We are working hard to minimise the impact the pandemic has had on our patients.

- Urgent and emergency care pressures have continued to impact upon elective bed capacity; however, the health board will benefit in the new financial year with protected areas at Prince Philip, Withybush and Bronglais hospitals. This, along with the investment and development of the demountable unit at Prince Philip Hospital, will increase day surgery capacity for the health board and access to treatment for patients.
- We are actively working with experienced focus teams via Waiting List Support Services (WLSS) to both contact and support our long waiting patients. This includes developing rehabilitation and pre-habilitation programmes to both aid stability while waiting an optimal health pre-surgery. This service is working alongside operational teams to gain valuable patient feedback whilst also utilising positive feedback via our Patient Advice and Liaison Service (PALS) and communications teams. Supportive resources are provided for people awaiting surgery. This information can be found on our website (https://hduhb.nhs.wales/healthcare/covid-19-information/) by selecting 'restarting services' or 'preparing for treatment'.
- Patients who have accessed external services through the outsourcing route have been communicated with and patient experience data has been collected. Regular patient experience reports are received from our outsource partners, with feedback from patients generally very positive.
- The planned care directorate have a robust governance process where all incidents, reviews and safeguarding are discussed, action plans developed, and teams are encouraged to work collaboratively to improve processes to give the highest quality patient care.

Key issues and risks

- Capacity in clinics and theatres continues to be reduced when compared to pre-pandemic levels; this is primarily due to social distancing and stringent infection control measures to keep us safe. This is constantly reviewed in line with national guidance.
- Exceptional levels of pressure continue to impact; predominantly upon activity levels, staffing levels through sickness and self-isolation, and the requirement to maintain adequate flow within acute sites to treat both COVID-19 and non-COVID-19 patients.
- Temporary pauses to planned operations have been necessary during 2021/22. This has added to the backlogs and put pressure on recovery plans.
- Significant pressures have been felt in the private sector, limiting our ability to outsource planned care activity. However, extensive work has been undertaken to increase outsourced activity throughout the year wherever possible.
- 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.
- There is still public concern about attending acute hospitals. To allay this apprehension, the current Welsh Government advice is that appropriate face coverings are worn in all healthcare settings. This continues to be endorsed within the health board.
- There continues to be significant risk regarding staff vacancies to ensure safe staffing levels to support planned operations. Operational teams work with the medical and nursing workforce teams to remedy this.

In line with national guidelines, our clinical staff are working to risk assess every patient waiting for an inpatient or day case procedure. As of 31 March 2022, we had risk assessed

76% of patients on the waiting list, of which 6% (1,035 patients) were assessed as needing their operation within four 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 of 31 March 2022.

Specialty	P1* Operation needed within 72 hours	P2 Surgery can be delayed up to 4 weeks	P3 Surgery can be delayed up to 3 months	P4 Surgery can be delayed >3 months	Waiting to be risk assessed	Total patients waiting
Trauma & Orthopaedics		404	1727	3305	107	5543
Urology		297	448	886	1188	2819
Ophthalmology		37	394	1842	16	2289
General Surgery		102	220	922	620	1864
Gastroenterology		2	2		1158	1162
Gynaecology		82	312	499	117	1010
Colorectal		57	84	90	339	570
Pain Management			164	379	6	549
ENT		35	120	301	20	476
Breast		18	4	18	78	118
Other specialties		1	9	14	399	423
All specialties		1035	3484	8256	4048	16823

*P1 covers urgent cancer and emergency which is prioritised

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

- We continue to plan our recovery. Planned surgery has continued at Bronglais Hospital, restarted at Prince Philip Hospital for orthopaedics, and Ward 9 in Withybush Hospital has reopened and started to treat patients. Cancer continues to be treated across all sites with a focused centre at Prince Philip Hospital. Specialty based cancer continues at Glangwili Hospital. Plans to reinstate further capacity during 2022/23 include:
  - repurposing Amman Valley Day Surgery Unit to deliver five days per week cataract surgery. This will involve the relocation of the age-related macular degeneration (AMD) service to the outpatients area;
  - a demountable unit at Prince Philip Hospital to provide additional day surgery access for the health board with an opening date of May 2022;
  - developing an enhanced care unit (PACU) at Prince Philip Hospital and Withybush Hospital to reduce critical care demand for elective patients.

- Where possible, patients are offered appointments/procedures in the private sector, with 6,849 appointments/procedures delivered in this way in 2021/22. Further outsourcing will be delivered in 2022/23.
- Virtual appointments are provided as an alternative to face-to-face appointments where possible to mitigate the reduction in outpatient capacity. A virtual hub has been established at Glangwili Hospital to facilitate virtual appointments, with others to follow in 2022/23. We are now urgently scoping returning outpatient activity to pre-pandemic levels using virtual and face-to-face appointments.
- The initial aim is to reduce the number of patients waiting over 104 weeks to zero by March 2023, as part of phase one of the ministerial measures to provide access to timely planned care.
- We have developed a revised post-COVID-19 watchtower planned care monitoring programme where we will monitor progress.
- We have implemented pre-assessment and screening pathways, including social isolation pre- and post-operatively with COVID-19 screens 72 hours pre-operation.
- Validation of all waiting lists has continued throughout the pandemic, both internally and through an external technical validation service.
- The health board has engaged with an external agency, Lightfoot, which has been working closely with key specialties on recovery plans. There is also an internal reset and recovery process, which is currently led operationally at watchtower. Key numerical messaging and lengths of time to recover is revised and reported to the executive team which will then inform the board.

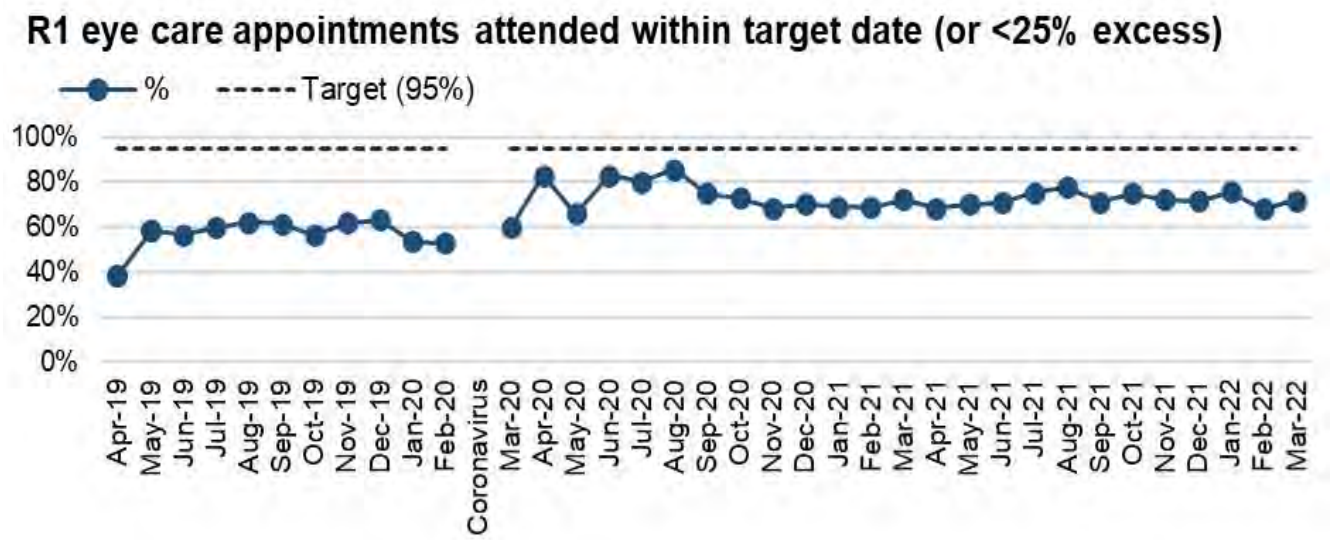
Eye care

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 2021/22, the NHS delivery framework definition of this measure was revised from recording R1 patients (those at risk of irreversible harm or significant patient adverse outcome if the target date is missed) waiting within their clinical target date for care and treatment to R1 appointments attended within their clinical target date or 25% beyond their clinical target date.

This revised definition illustrates that since the onset of the pandemic, performance for R1 appointments attended improved when compared to pre-pandemic. This can be attributed to the severe lack of capacity available during the early stages of the pandemic, where only the very most urgent/emergency R1 patients were able to be seen. Following an initial improvement to near the 95% target, performance has steadied from September 2020 at lower levels following the re-opening of more general ophthalmology clinics.



Impact on our patients

- Overall positive feedback has been received from patients seen in the independent sector for their operation as part of outsourcing arrangements. Feedback shows that patients are very grateful for having an appointment despite the current pressures being faced.
- The Eye Care Liaison Officer (ECLO) provides patient feedback directly to the service regarding patient experiences, both positive and negative, with ophthalmology services across the health board.
- As part of quarterly Eye Care Collaborative Group (ECCG) meetings, we can receive patient feedback through third sector organisations and we use this to inform service changes and improvements to ensure patients are satisfied with the care they receive.
- The service team is proactively meeting with patient groups, such as Wales Council of the Blind (WCB), to listen to experiences and feedback from patients and use this as a learning tool. This has been delayed during the pandemic, however, is due to restart during the first quarter of 2022/23.
- Audit and governance meetings (bimonthly) have recommenced, which provide tools for further learning.
- Following the independent review into eye care in Wales (Pyott report), an action plan has been developed and progress will be monitored through both the ECCG and ARCH (A Regional Collaboration for Health).
- During 2022/23, the service aims to establish a patient feedback mechanism that will allow for patient feedback to be shared in future reports.

Key issues and risks

The COVID-19 pandemic continues to impact on our performance for the delivery of essential eye care services:

- Due to the nature of examinations and tests required for ophthalmology appointments, the service is heavily reliant on face-to-face activity, which is still limited. Use of virtual appointments as an alternative is not suitable for the vast majority of ophthalmology patients.

- Routine surgery and face-to-face outpatient capacity continues to be reduced when compared to pre-pandemic levels. This is due to factors such as infection prevention and control measures restricting patient flow and staff shortages through sickness and periods of isolation.
- Reduction in availability of outsourcing for cataract appointments/procedures throughout the pandemic due to extreme levels of pressure in the independent sector.
- New patients experienced longer waits due to the combined impact of pandemic related restrictions, an increased backlog of patients created by the pandemic, lack of clinical space and a shortage of consultant ophthalmologists and experienced non-medical ophthalmic staff.

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

Ophthalmology services have been reconfigured to meet essential urgent care where required:

- We have maintained treatments and reviews for imminently sight threatening or life-threatening conditions throughout the pandemic (prioritising those patients most at risk):
  - Every referral received is triaged and allocated a clinically determined health risk factor.
  - Glaucoma patients currently waiting are being re-prioritised by the clinical team to determine the level of risk on a case-by-case basis. These cases will fall into one of six new categories of R1 patients to ensure those most at risk are seen first.
  - Services continue to be provided 24-hours-a-day, via an on-call consultant rota for emergencies.
- The telephone triage of emergency eye casualties by a senior clinician has reduced attendance, with patients being managed via other routes, including independent prescribers in optometric practices.
- We are continuing to re-establish outpatient clinics and theatres across the health board where possible with the ambition to increase our internal capacity beyond the levels available pre-pandemic.
- We have recommenced ARCH workshops and we continue to work closely with Swansea Bay University Health Board (SBUHB) to develop a regional response and solutions for the short, mid and long term. This includes:
  - regional plans for the recovery of cataract surgery. This involves the repurpose of Amman Valley Hospital Day Surgery Unit for cataract surgery, relocating the AMD service to the outpatients area. This will provide five days per week cataract operating capacity;
  - South West Wales Glaucoma Service has commenced, supported by the SBUHB clinical lead. It will support the reduction in waits for glaucoma follow up appointments by developing a service within Hywel Dda on our acute sites and in community optometric practices.
- The intravitreal injection therapy service has continued for all patients throughout the pandemic, however, increased non-medical injectors and clinic space is required to meet the demand on the service, which is growing by 13% per year.
- Outsourcing arrangements to the independent sector began during 21/22 with 2,388 cases delivered to date.

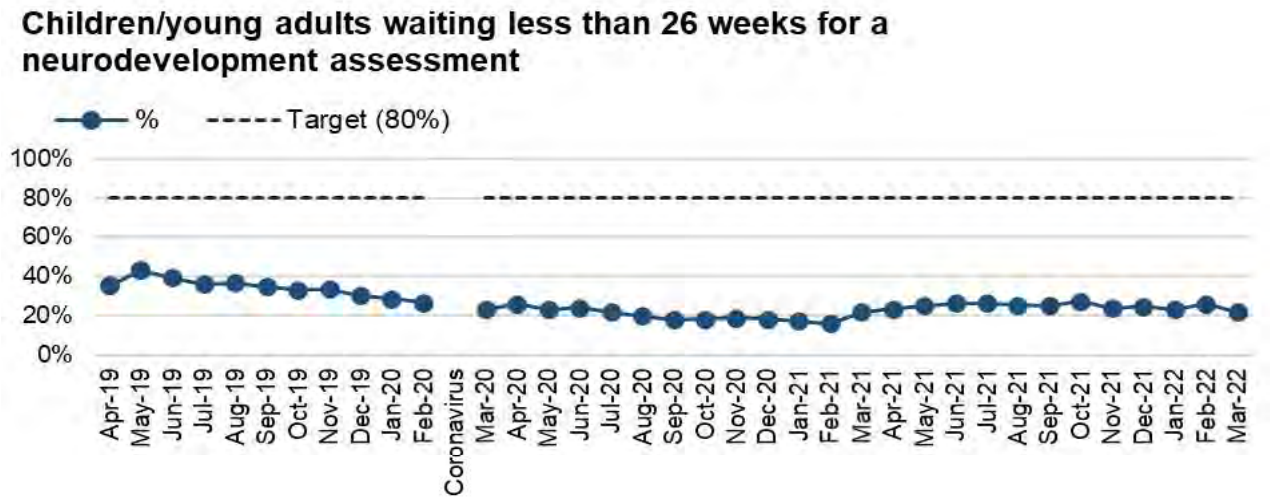
- Where possible, virtual activity is delivered, including:
  - virtual diabetic retinopathy clinics using Consultant Connect, which commenced in February 2022;
  - a research study is underway allowing stable AMD patients to be followed up in optometric practices with virtual consultant oversight.

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. This includes medical, nursing and therapeutic interventions delivered by the multi-disciplinary team, to promote recovery and ensure patient safety;
- undertake mental health examinations 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;
- work jointly across mental health and specialist eating disorders teams to deliver monitoring, support and treatment in community and home settings.

We did not meet the target throughout 2021/22 for children and young people requiring a neurodevelopmental assessment and adults waiting for a psychological therapy.



Our Mental Health and Learning Disabilities Directorate has been working with local authority partners and the third sector to ensure that there is broad provision of services available at the point when they are required. To enable this, we have strengthened Tier 0 services so that our population can more readily get help and support and safeguard the more specialist services so that these are available 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.

Impact on our patients

- In 2021/22 we have maintained visiting where reasonably practicable, the main constraint being where we have had COVID-19 outbreaks.
- All clients waiting over 26 weeks for an intervention receive a keeping in contact letter to reassure clients that they are important to us. Within this we provide signposting options for third sector help, SilverCloud online counselling service and links to the health board's website.
- To ensure regular and up-to-date feedback is received from service users and inpatients, the Mental Health and Learning Disabilities Directorate has launched its own QR code and feedback form to ascertain the patient's view of the service provided both in the inpatient areas and in the community.
- To ensure the directorate learns from all incidents within the directorate (not just serious incidents), a monthly governance report is compiled which outlines trends, themes, increases and decreases in self harm, falls, unexpected deaths, and suspected suicides. The governance report, alongside feedback from Her Majesty's coroners, is shared and circulated with all staff within the directorate. Over the last 12 months a discharge audit has been completed to ensure adequate discharge planning takes place from inpatient areas. The outcomes of this audit were positive with only a few action points required to be addressed.
- A suicide prevention officer has been appointed to ensure that guidance and themes from the National Confidential Inquiry into Suicide and Safety (NCISH) is shared widely and staff are aware of a changing picture of needs within mental health services. This information is also available to all staff via the Quality Assurance and Professional Development (QAPD) SharePoint site.

- Incident investigations that are completed under 'Putting Things Right' guidance are shared widely with the teams involved in the patient care and on the finalisation of the internal review. All staff are made aware of the recommendations and improvement plans are completed and operational services lead on the implementation of the actions.

Key issues and risks

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

- We have witnessed social impacts of the pandemic have an 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. This has been evident in the increased acuity of patients being seen. 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 as there is a recognition that the pandemic will have a far-reaching impact on people's resilience and mental well-being. We have also been working with local authority and third sector colleagues locally to strengthen Tier 0 provision. 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 across the directorate, with 17% of all posts currently vacant. This includes professional and administrative roles. Additionally, there can be difficulty retaining staff, worsened by a national shortage of registered mental health practitioners.
- Accommodation pressures across the directorate are impacting upon capacity, both in terms of providing appointments as well as providing workspace for clinical and administrative staff. Increased year on year additional funding from Welsh Government to further develop and enhance services has worsened this situation.
- Use of digital platforms have been accelerated throughout the year to provide virtual opportunities where appropriate. There continue to be challenges sourcing appropriate equipment to extend the use of this facility.
- Staff sickness rates in mental health services are above health board averages, although have been in line with other mental health services in Wales.
- We continue to receive a steady 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.
- Higher patient ‘did not attend’ (DNA) rates experienced in mental health services than the health board average.

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

- After the first wave of the pandemic, due to competing priorities, work to develop a mental health and learning disabilities single point of contact had halted. We are now working to implement the mental health 111 service which will be 24/7.

- 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 seven day a week mental health services.
- Third sector commissioned services have adapted throughout the pandemic to offer telephone/online services on a three-county basis where possible. They continually update local directories of services.
- We are working 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. Additionally:
    - a recruitment campaign is underway in disciplines including medical and psychology;
    - use of bank, agency and locum staff wherever possible to backfill vacancies and sickness.
- Seven-day-a-week working is in place in a number of areas.
- The directorate is prioritising the repurpose and reuse of accommodation across the health board to increase capacity.
- Opportunities to provide additional capacity within the independent sector are continually explored, with child and adolescent ASD looking to commence some appointments with an independent provider in the new financial year.
- Use of virtual platforms to deliver more capacity as an alternative to face-to-face where possible.
- Implementation of therapeutic groups has been scoped and will be piloted.
- Development and integration of the Welsh Patient Administration System (WPAS) into the whole of the directorate will assist with monitoring waiting lists and demand and capacity planning. WPAS is being rolled out in a phased approach.

Dignified care

The past year has been challenging with the ongoing demands from the pandemic and maintaining the provision of dignified care to all our patients has been a priority for all staff. Due to the second wave of COVID-19 (27 July 2020 to 16 May 2021) our services experienced extreme pressure which impacted on our population and inpatient services. A similar position was experienced during the third wave (17 May 2021 to 19 December 2021) and during the peak of Omicron, which impacted on our population and inpatient services. Primary care and community services maintained regular clinical reviews for our patients, which included, where appropriate, end-of-life-care plans for COVID-19 patients.

There are representatives from our clinical teams on the National Dementia Hospital Charter which will be launched in April 2022 following which there will be workstreams set up to support implementation of the charter and will be a priority for the coming year.

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 during the year, including sessions on British Sign Language. Information on the ways in which staff can support service users, including pre-arranging interpreters, using digital interpretation and telephone options, using communication aids, and providing information in accessible formats are set out in the recently updated Interpretation and Translation Policy.

In line with all health boards across 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.

Within mental health and learning disabilities services measures were put in place to maintain patients' dignity during COVID-19 restrictions. During this difficult time mental health ward staff responded by facilitating 'virtual visits' using electronic devices such as iPads and laptops to provide contact with patients' loved ones. Patients also made use of the RITA systems on a regular basis. Patients who were hard of hearing used an amplified hearing device provided by the wards to a good effect so that they could communicate effectively; speakers for these devices were also provided by the health board. It was plainly apparent that both patients and families felt reassured following the virtual contact. Relatives were also encouraged to continue to bring treats for their loved ones enjoy on the wards. They also brought other property to the wards with the continued support and guidance from the health board's Infection Control Team.

Clinical reviews were also carried out on a regular basis. These were either face-to-face or virtual consultations throughout all the restrictions; in addition, staff updated each family/carer by telephone on a weekly basis. It was distressing for families and carers not to be able to have face-to face contact with their loved ones, so staff provided emotional support and compassion for families, particularly for spouses. The older adults mental health wards' Twitter account was used to show the therapeutic activities carried out on the ward, obviously always adhering to confidentiality and ensuring the patients' dignity was upheld. Relatives were informed about this and were encouraged to look at the account for reassurance.

Due to the restrictions that were implemented because of COVID-19 pandemic, patients in clinical areas were unable to see their relatives face-to-face because of the high risk of infection. After advice from Infection Control Team and following strict PPE protocols, measures were introduced to support those patients whose mental state was compromised

by lack of contact with family. For example, some patients' nutritional intake was reduced by the stress and distress caused by the separation from their loved ones. These patients' relatives were then afforded private visits in such a way to reduce the chance of introducing any infections on the wards. The effect of this face-to-face contact made discernible improvements to the patients' well-being and mental state, at the same time as maintaining dignity and a high level of person-centred care.

Putting things right

Putting things right

Putting people at the heart of everything we do

As a health board, we manage concerns is in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Read more here about 'Putting Things Right: Raising your concerns about the NHS'

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.

Concerns (complaints)

During the period 1 April 2021 to 31 March 2022, we received 2,244 concerns (complaints) which were managed in accordance with the Putting Things Right regulations.

We are fully committed to resolving complaints in a timely way and most of our concerns can be managed within 30 working days.

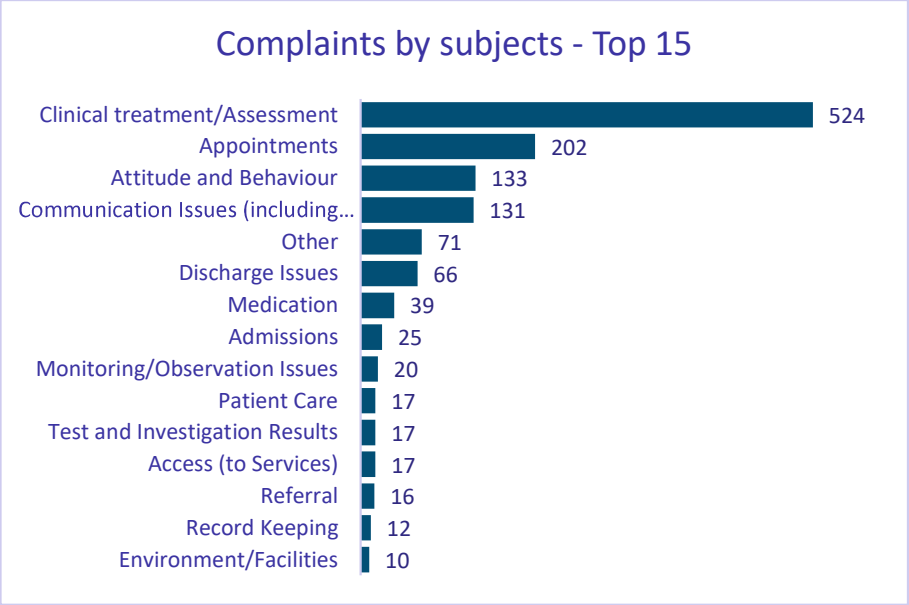
When this is not possible (such as when complaints involve multiple agencies, or when a complaint is about a very serious event), our aim is to resolve complex matters within six months. Improving the timeliness and outcomes of the concerns process is a priority for us to ensure any remedial actions can be addressed as quickly as possible. During the year, we responded to 62% of concerns received, within 30 working days. Of those exceeding this target 26% were responded to within six months and 12% exceeded six months. Meanwhile, 20 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 were our A&E departments, medicine, 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 as well as the additional pressures the services experienced because of the COVID-19 pandemic.

For general practice, there are currently 49 practices (four of which are health board managed practices). The number above represents the total number of concerns received across general practice.

The main reason people raise complaints is because of clinical treatment and assessment, appointment waiting times, attitude and behaviour and communication issues. The table below shows the top 15 themes of complaints.



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 understandably caused concern for 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. Throughout the year we have tried to resume as full a range of services as possible, providing that patient and visitor safety could be maintained.

Public Services Ombudsman for Wales

During the period 2021/22 a total of 76 complaints were referred to the Public Services Ombudsman for Wales (PSOW). Of these, 37 resulted in an investigation, of which four settlement agreements were reached, one upheld, 10 partly upheld, two not upheld and 20 are ongoing.

Of the remaining 39, 30 were recorded as queries; comprising of 10 early resolutions, nine not investigated, four investigations commenced and seven awaiting further instruction. Nine complaints were rejected outright by the PSOW.

Of the complaints that resulted in an investigation, 11 of all complaints were relating to unscheduled care, a further 10 related to scheduled, nine were within primary care, five within women and children, and two within mental health and learning disabilities.

Core themes recorded within the findings of ombudsman reports relate to:

- Communication, including communications with patient, families, and other health boards;
- Delays, including delays in assessments, reviews and diagnostics;
- Records, including poor record keeping, inaccuracies, omissions and discrepancies;
- Complaint handling, including delays in completion of investigations, missed opportunities for reflective learning, failures to consider breach of duty.

Patient experience and learning from complaints

We are highly committed to improving patient experience through the feedback we receive, whether these are positive experiences, or instances where concerns and complaints are raised. When people tell us that their experience could have been better, we use this to direct our own learning and improvement as a health board.

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.

We are currently implementing a new electronic patient experience system, which will be available across all our services, including community services.

Our board receives details of the feedback received from service users at each of its meetings and is informed of what is being done to improve patient experience. The patient experience reports, which include patient stories about a range of experiences can be found at https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/

Last year we told you about our Improving Experience Charter which sets out what our service users can expect when using our services. It sets out several pledges that we call ‘always experiences’. We continue to implement the charter and 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, we 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
You need us to keep working on communication. While pressures on the ward are recognised, the ability to get meaningful updates on the well-being of relatives and loved ones is important.	Last year, a new role – the Family Liaison Officer - was introduced onto wards and in some community facilities. The main purpose of the role during the pandemic was to support communication between patients, their families and ward staff, as well as enhancing patient experience. Owing to the positive feedback received by patients, this role is going to continue and will focus on enhancing patient and family experience in a hospital setting. This will be fully evaluated throughout the year as the role develops. We will also be delivering additional training to all staff on the importance of effective communication.
As a health board, we need to be better prepared to receive people with sensory impairments at our emergency departments and for outpatient appointments.	Reception and screening staff will be better prepared to receive people with sensory loss. Staff will be equipped with British Sign Language charts to help with communication, which have been translated into Welsh and issued across the health board.
After the opportunity to identify a diabetic patient was missed when attending a minor injuries unit, you said we need to ensure that staff are adequately trained and equipped to recognise diabetes in our younger patients.	We have equipped our minor injuries unit with a machine used to measure blood glucose measurements, and triage nurses have been asked to consider its use when young people present with certain symptoms. This has been supported with the use of online diabetic learning resources to support staff knowledge.
Having the opportunity to visit people in hospital when they are at the end of life can have a profound effect on the patient, their family, and our staff. We need to keep this at the forefront of our planning around visiting arrangements.	We have reviewed the arrangements for visiting end of life patients. Staff have been provided with training opportunities relevant to end of life care, and compliance is being monitored by senior nurses on the wards. We continue to reiterate the need for good communication with family members when they are facing the difficulty of losing a loved one.
While delays can be expected, the experience of waiting in A&E was made more difficult by the physical environment. Seating within	We have recognised the physical environment within A&E at Glangwili Hospital as a challenge and needing improvement. We have purchased new seating and screening to help improve the experience.

waiting areas could be better, particularly in Glangwili Hospital.	
Staff in A&E need more training on mental health and learning disabilities.	All staff within the A&E Department are aware of the need for reasonable adjustments when assessing patients with mental health or learning disabilities. There is a teaching regime in place for our doctors working in the emergency departments, and there will be a wider training plan for nurses and health care support workers, so that they act as advocates and are equipped with the knowledge to support this specific patient group.

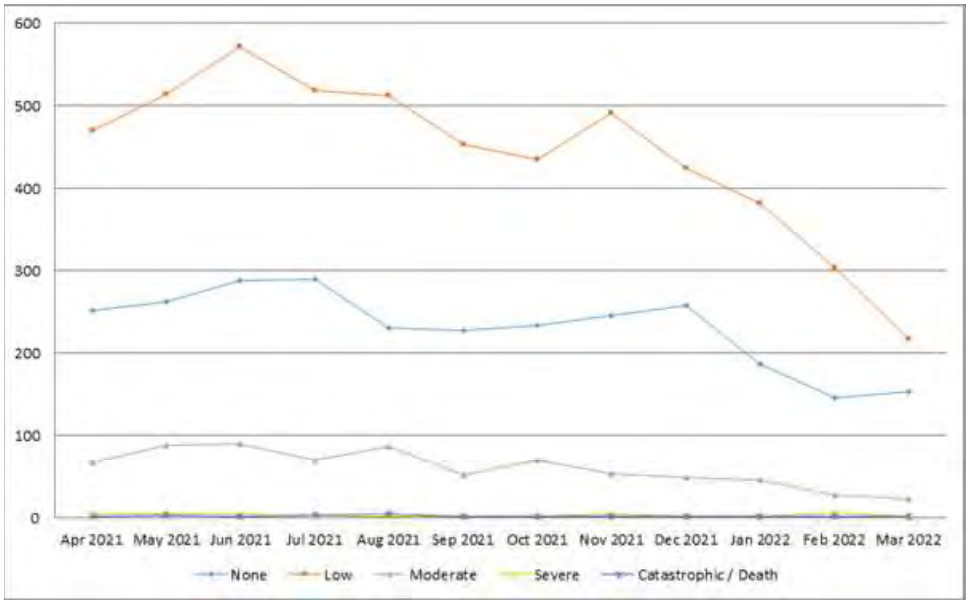
Concerns (incidents)

On 1 April 2021, we introduced the Once for Wales Concerns Management System, DatixCymru. The system is designed to specifically meet the needs of NHS Wales organisations and allows for a consistent approach across Wales for recording concerns. The health board was the first organisation in Wales to go live with DatixCymru.

During the period 1 April 2021 to 31 March 2022, 14,165 patient safety concerns (incidents) were reported.

The introduction of DatixCymru has altered the way in which severity of harm is recorded. The new system allows the reporter to give an initial indication of the harm to the person affected. Following investigation, the investigating officer confirms the level of harm (this is recorded separately, and the initial rating given on reporting is unchanged).

The run chart below shows the severity harm following investigation of the patient safety incident:



Of the 14,165 patient safety incidents reported, 7,173 have been investigated and closed. 3,254 incidents have had the severity amended; 2233 incidents were downgraded whilst 901 incidents were upgraded.

Pressure damage and moisture damage incidents continue to be the highest reported incident (3,178 pressure damage and 3,387 moisture damage incidents), followed by accident, injury and behaviour (including violence and aggression).

Of the 3,178 incidents reporting pressure damage, 1,696 were present before admission to the clinical area.

For each pressure damage incident a focused review is undertaken. In 43 cases, where the focused review has been completed, the pressure damage (which had developed or worsened during care) was deemed to be avoidable. Of these cases, 15 incidents are grade three, four or unstageable pressure damage.

Pressure damage incident scrutiny panels are held by heads of nursing with their teams. The panel consider the findings of the focused review, consider the wider learning, and approve the incident record for closure if appropriate.

The Quality Assurance and Safety Team and the Tissue Viability Nursing Team have introduced a corporate scrutiny panel to review and reduce the duplicate pressure damage incident reports and ensure consistency of grading of pressure damage in the incident report forms.

Quality improvement work is also underway to consider the appropriate management of incidents where pressure damage is reported as being present on admission. Most cases are not known to district nursing services or other health board services and it is these incidents where there may be potential learning.

Nosocomial COVID-19 infections

We are undertaking reviews of suspected nosocomial infections, in line with the all-Wales Protocol for the Review of Patient Hospital Onset COVID-19 Infections. On conclusion of the initial review using the all-Wales toolkit, and where it is assessed or suspected that an action or inaction has or is likely to have caused or contributed to the patient's unexpected or avoidable death, or caused or contributed to severe harm to the patient, a proportionate investigation is also undertaken in line with Putting Things Right. Read further information regarding the learning from these reviews is provided to the Quality, Safety and Experience Committee.

Nationally reportable incidents

A patient safety incident is nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected that an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm. Read further information about the requirement to report incidents to the NHS Wales Delivery Unit.

Between 1 April 2021 and 31 March 2022, 24 reportable incidents were reported to the NHS Wales Delivery Unit.

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Behaviour (including violence and aggression)	0	1	1	0	2
Infection Prevention and Control	0	1	0	0	1
Maternity adverse occurrence	1	0	1	0	2
Medication, IV Fluids	0	0	0	1	1
Patient/service user death	0	0	4	7	11
Pressure Damage, Moisture Damage	1	2	2	0	5
Treatment, Procedure	0	0	0	2	2
Total	2	4	8	10	24

Delivering in partnership

Delivering in partnership

Working together to be the best we can be

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

We have a shared vision with our communities for us to live healthy, joyful lives.

We published our long-term health and care strategy, A Healthier Mid and West Wales: Our Future Generations Living Well in 2018. The strategy sets out our ambition to shift from a service that just treats illness to one that keeps people well, prevents ill-health or worsening of ill health, and provides help people need early on. We have taken significant steps towards our strategy during 2021/22.

Engagement with our communities and land selection process

Between May and June 2021, we held a six-week engagement exercise, called Building a Healthier Future after COVID-19, with staff, patients and their families, and the wider public. The purpose of this was to find out how the pandemic had affected people's health and care, and access to it, and to understand the implications of these experiences in relation to our health and care strategy.

You can read the feedback report here: https:/www.haveyoursay.hduhb.wales.nhs.uk/building-a-healthier-future-after-covid-19

This information is now being used to inform the delivery of our services.

An example of this is the process and land selection for a new hospital in the south of the Hywel Dda UHB area. In our engagement exercise, we asked people for nominations of possible sites between the zone of St Clears and Narberth; and also to tell us what was important to them in the selection of a site.

Some sites were suggested as part of the engagement exercise and there was significant feedback about the areas of importance in site selection. Common concerns were around the potential distance to the hospital for communities furthest away, public transport links, parking, the importance of attracting and retaining staff, and cost of a new hospital.

As a result of the engagement exercise, sites suggested by members of the public were assessed against criteria, including areas of importance to the public, as part of technical review of the 'long list' by the health board in October 2021.

As part of the next phase, and to ensure continued engagement from the public, we have invited groups and individuals across the three counties of Carmarthenshire, Ceredigion and Pembrokeshire, to submit an expression of interest to be part of the process to further assess and evaluate shortlisted sites. This will result in a recommendation on the best location for the new hospital to the health board later in 2022.

We are receiving support and advice on the process from the Consultation Institute - a not-for-profit, independent body, which provides guidance on best practice for engaging with communities.

Submission of programme business plan

Additionally, as part of business planning for programmes of this type in Wales, we submitted a Programme Business Case (PBC) to the Welsh Government in February 2022. Read the full PBC here.

This is the first, high level document, to try and secure Welsh Government endorsement for the programme and support the funding for more detailed work (outline business cases).

We hope this will eventually lead to Welsh Government investment of up to £1.3billion in the buildings and infrastructure we need to deliver our long-term strategy.

This is a long-term programme which will take more than a decade to deliver. For example, we expect the new urgent and planned care hospital will take until at least the end of 2029 to open.

We intend to continue regular engagement, and possibly consult on parts of the programme, with patients, public, staff, and partners during this process.

Partnership approach to health and care

The pandemic has demonstrated how communities can work together to support the most vulnerable. The pandemic has caused a decrease of personal resilience for some individuals as they have had very limited social opportunities. With support from the Welsh Government Transformation Fund (Programme 7), engagement with local communities to enable community resilience has continued.

We have an integrated management structure in Carmarthenshire which is jointly responsible for the planning, delivery and evaluation of care of our population. The regional Integrated Executive Group (IEG) membership includes directors of social services and health board executive directors. The IEG has been instrumental in directing integrated strategy to enhance integrated service provision for the population including discharge arrangements for our inpatient population. Risks and issues for urgent and emergency care are brought to the attention of the IEG to consideration and action as appropriate.

Cwtch service

The Cwtch service in Ceredigion delivers low level domiciliary care to prevent or delay the requirement for long term assessment and provision. Funded by the Integrated Care Fund and delivered by the British Red Cross, the service receives an average of 100 referrals per quarter with approximately a 50:50 split between support for hospital discharges and support to prevent hospital admissions; on average only one person per quarter is referred to the local authority for ongoing support following provision from Cwtch. The service delivers assistance and support for meal preparation and personal care; medication prompting; domestic tasks and shopping, but more importantly encourages confidence to maintain self-care.

Trial without catheter clinic

Building on the success of the community catheter clinic for patients, we developed a clinical pathway for a ‘trial without catheter’ (TWOC) for ambulatory patients in Pembrokeshire. With over 400 people with long-term indwelling catheters in

Pembrokeshire, a specialist, nurse-led community TWOC pilot clinic was introduced to help reduce waiting times. The impact of COVID-19 resulted in delays of between eight to 12 months to access a TWOC appointment (prior to the pandemic, the average wait for an appointment was six to eight months). Since the first clinic on in May 2021 in Tenby Cottage Hospital, nine new patients have attended clinic, four with successful outcomes. This new initiative will be adapted following lessons learned during its pilot phase so it can be rolled out across Ceredigion and Carmarthenshire. Initial feedback on the TWOC approach is extremely positive, with praise for the professionalism and knowledge of the clinical team, as well as the clinical environment and surroundings. The clinic is running extremely well and has been nominated for a Royal College of Nursing community award.

Advanced heart failure supportive care project (Bevan Commission) pilot

Following a pilot completed and evaluated at the end of March 2021, we have developed a successful collaboration bringing the heart failure palliative care multi-disciplinary team (comprising the heart failure clinical nurse specialist, occupational therapist, cardiologist and palliative care consultant) into normal working hours. This has created an opportunity to work more closely with the Paul Sartori Foundation, Shalom House and the wider palliative care support. The planned clinic-based approach with visiting third sector support did not materialise due to COVID-19 restrictions, so most have been seen at home or accommodated in the re-established face-to-face clinics.

Remote cardiac monitoring

We have introduced remote cardiac monitoring for people in Pembrokeshire who are able to undertake some physical measures at home. Providing blood pressure monitors helps patients to monitor themselves without needing face-to-face contact. This has led to the development of a telehealth system enabling patients who have heart failure and chronic obstructive pulmonary disease (COPD) to self-monitor their conditions, supported by a professional monitoring platform, before having a virtual or online appointment). Investment has also been made in other technology enabled care equipment specifically to deliver pre-habilitation for patients waiting for musculoskeletal surgery.

Palliative care respite

Working with Shalom in St Davids, Pembrokeshire, we supported the trial of three respite periods for people with a palliative diagnosis to support them and their families to continue to cope with their care at home. The trial ran between January and March for one period of four days each month, and the feedback from those attending and their families has been very positive.

Supporting social care and ensuring safe discharge

During 2020-21, each of our three counties have increased their intermediate care offer through Transformation Programme 3 funding. This includes collaborative interventions such as the recruitment of additional health and social care workers, increasing home-based care and reablement to support people to return or stay at home.

Working with and supporting nursing homes

We continue to work collaboratively as a system, with regular and effective joint care meetings with care home communications which have significantly reduced the risk care home patients being admitted into hospital.

A health board-wide Care Home Risk and Escalation Policy is in place and outlines our approach to supporting compromised care homes to ensure sustainability of care when faced with risk.

West Wales Regional Dementia Strategy

The West Wales Regional Partnership have co-produced a dementia strategy highlighting what matters to people living with dementia and their families. It outlines the priority areas needed to deliver this expressed need. A regional programme manager has been appointed to implement the strategy and its associated plan.

Palliative and End of Life Care Strategy

We have developed a robust strategy to ensure everyone at the end of life is able to access the specialist care and holistic support they need. The Palliative and End of Life Care Strategy, approved by our board in March 2022, considers the estimates of palliative care need and sets out a sustainable workforce plan to meet these increasing needs. It sets out in detail the background to its development, a summary of the population needs analysis carried out, best practice, the service model pathway and the approach to and ambitions for implementing the service model.

Working with our partners on research opportunities

We established two exciting new partnerships with Aberystwyth University and the University of Wales Trinity Saint David (UWTSD) providing us with greater opportunities for education, research and innovation in transforming healthcare across Carmarthenshire, Ceredigion and Pembrokeshire. A new clinical research facility opened at Aberystwyth University as part of the new collaboration, offering a day-to-day focal point for staff to collaborate on education, research and innovation. UWTSD and the health board already work in collaboration on a number of initiatives and the new arrangement will enable greater opportunity for collaboration in relation to workforce development, research, enterprise and innovation, particularly post-COVID-19.

The developments are part of a Memorandum of Understanding (MoU) between the health board and each of the two universities, designed to transform healthcare and support the delivery of the health board's 'A Healthier Mid and West Wales' strategy.

Initiatives to improve the health and well-being of people in Wales are in progress thanks to a new collaboration between the health board and the Welsh Wound Innovation Centre. An MoU between the organisations will see innovative solutions being developed to promote opportunities across wound care technology research. The health board's role will be delivered by the Tritech Institute to provide specific services in innovative healthcare solutions.

Digital nursing documentation

Nursing staff within the health board were the first in Wales to go live with the new national Welsh Nursing Clinical Record (WNCR). The health board was also the first in Wales to implement the programme across the whole organisation.

The aim of the WNCR is to provide one standard set of digital nursing records to enhance the safety and effectiveness of care for the population of Wales irrespective of location, and improve patient, carer and staff experience. WNCR forms part of a national vision to ultimately have consistent information standards within all patient populations and healthcare settings across Wales.

Phase one of the WNCR project features the adult inpatient assessment, six core risk assessments, patient notes and discharge checklist. Nationally, Digital Health Care Wales, digital and specialist nursing leaders continue the application and data standards development. Within Hywel Dda, we have seen an extensive WNCR rollout across all adult inpatient wards and supporting departments in acute and community hospitals during the last 12 months, despite pressures from the ongoing pandemic.

Detailed project planning, recurrent Welsh Government funding and effective communication and training for teams prior to WNCR rollout have proved critical to the successful implementation. The WNCR project team have engaged and communicated regularly with corporate and operational nursing and multi-disciplinary teams. This engagement has extended to local universities to ensure that WNCR and informatics are integral to future nursing careers within pre-and post-registration nurse education.

The role of our Stakeholder Reference Group

The Stakeholder Reference Group (SRG) provides a forum for engagement and input among 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.

Four meetings of Hywel Dda SRG took place during 2021/22, which provided SRG members 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:

- Healthier West Wales Transformation Programme/Funding (Integrated Care Fund)
- Engagement/Engagement HQ
- Charter for Young People/Early Adopter
- Building a Healthier Future after COVID-19
- Regional Partnership Board Population Assessment and Public Services Boards Well-being Assessment
- Role and Remit of HDdUHB Ethics Panel
- Draft Integrated Medium Term Plan 2022/25 and the Planning Objectives for 2022/23
- Best Approach to Reflect the Populations ‘Lived Experience’ of the Health Board

- Draft Regional Dementia Strategy
- Community Development Outreach Team (CDOT)
- Improving Patient Experience/Improving Experience Charter (IEC)

Dyfed Powys Local Resilience Forum

Dyfed Powys Local Resilience Forum (LRF) is a multi-agency partnership made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The LRF is supported by other organisations, known as Category 2 responders, such as the Highways Agency and public utility companies. They have a responsibility to co-operate with Category 1 organisations and to share relevant information with the LRF. The geographical area the forum covers is based on Dyfed Powys Police area.

The LRF also works with other partners in the military and voluntary sectors who provide a valuable contribution to LRF work in emergency preparedness. The LRF aims to plan and prepare for localised incidents and catastrophic emergencies. It works to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Dyfed Powys LRF supported planning for an increase in deaths during the pandemic and co-ordinated the development of additional facilities during the peak of the pandemic to support existing NHS facilities and funeral director/crematoria sectors. As the excess deaths and hospital admissions reduced, then these additional facilities were stood down. Processes for reactivation if required in future are being detailed in updated pandemic response arrangements. A number of tactical and operational sub groups were also set up to support the regional response and facilitate requests from partner agencies.

Workforce management and well-being

Workforce management and well-being

Culture and workforce experience

We want every day in Hywel Dda University Health Board to be a good day in work'. We are on a culture change journey and our staff have set out for us the aspiration for the culture they want in Hywel Dda.

2021/22 saw a real period of listening to what is important to our staff to ensure the next steps we take on our journey are the right ones. Our Discovery Report gave us the opportunity to understand our staff experiences through COVID-19 and we have shaped a framework for culture change through Our People Culture Plan. We co-created this with our trade unions and ensured it reflects what our staff say are important to them.

Organisation development relationship managers

We recruited a team of new roles to help enable more good days at work across the health board. Our new organisation development relationship managers and assistant managers started to work with our leadership teams, staff and staff side, in developing new ways of working together to help us see things differently across our organisation. We began work in some key areas, based on risk and opportunity.

Staff well-being

Staff Psychological Well-being Service

The Staff Psychological Well-being Service continued to ensure easy and rapid access to resources and support for staff, teams, and managers. Provision evolved in response to changing circumstances and focused on maintaining rapid access, assuring the quality of well-being resources, managing the weight of well-being related messages to avoid overwhelm and finding ways to reach all our staff groups. Our staff psychological well-being intranet site launched in 2021, providing information and signposting to a range of guides, resources, and services to support the mental health and resilience of individuals and teams.

A number of initiatives covering a range of mental health topics were made available to staff, including a series of Well-being@Work Webinars, bespoke 'rest and recovery' sessions, and workshops covering the themes of well-being in nature. A new 'Spaces for Listening' Facilitators Network provides support and a safe learning environment for facilitators.

An innovative programme of Recovery in Nature: Ecotherapy Retreats for staff was funded by NHS Charities Together. This programme was designed for staff who are on sick leave, or at risk of sickness absence due to work related stress or burnout. We continue to support the green health agenda in Hywel Dda, contributing to the improvement of green spaces inside and out, with a focus on how the natural environment supports psychological well-being.

Access for staff to an online mindfulness training programme was funded with support offered by a mindfulness lead.

There was a steady increase in the number of staff accessing one-to-one psychological support service, with an increase in the level of distress and risk at first contact. Care pathways were clarified to ensure that an appropriate response, including signposting elsewhere when necessary. We have built and maintained our links with primary and secondary mental health service teams to expedite access for staff where needed. Access to the Employee Assistance Programme, Care First, continued with the majority of contacts being for one-off appointments. Evaluation remains a key aspect of service improvement and a range of measures are used including service user satisfaction surveys, clinical outcomes measures and longitudinal measures for specific programmes.

Support was provided to programmes such as the Nurse Preceptorship Programme and Medical Education Programme for Doctors continues, with a focus on sustaining mental health in challenging times.

There was an increase in the number of requests for team support around well-being at work and these are now discussed as part of the wider commissioning process to ensure a co-ordinated approach and the best use of resources.

Well-being Champions Network

In August 2021, we launched our Well-being Champions Network to provide a supportive forum for staff to share ideas and link up with services and other support that promote staff well-being. The aim of our champions is to:

- promote health and well-being within the workplace;
- publicise health and well-being initiatives, awareness days and calendar events;
- advise and direct staff to appropriate support services;
- share the needs of staff to help shape our staff health and well-being agenda.

125 staff registered to undertake the role and over 50 champions are already fully trained, with further sessions planned.

Occupational health

The Occupational Health Service introduced key performance indicators to measure demand and waiting times to deliver core activities. Data is now used to evaluate the effectiveness and efficiency of the service to support capacity planning so that peaks in activity can be managed.

The main priority for the service during 2020/21 was to ensure employees and managers had access to advice when they needed it. There was a sharp increase in demand for occupational health advice due to COVID-19 which created significant waiting times.

Reducing the waiting list, while continuing to provide an occupational health service which met the needs of employees, managers and the health board, was a significant challenge. We simplified the waiting list by prioritising and checking in with managers to confirm if appointments were still required, which proved to be an effective solution. The

Occupational Health Service continued to accept both self and manager referrals to ensure staff were given a choice on how to access.

The service worked closely with recruitment to ensure clearance times were reduced, optimising turnaround times to allow employees to start work. This relieved pressures related to vacancies.

Occupational health clinicians linked in regularly with the public health and infection control teams to ensure all COVID-19 advice was consistent and based upon the evidence available at the time. Managers were supported to manage risk to staff with underlying health conditions and/or with clinically extremely vulnerable status by the provision of individual occupational health advice. COVID-19 advice requests were prioritised on arrival to ensure advice was timely and attendance optimal wherever possible.

All Wales networking increased within occupational health, ensuring that occupational health staff were aware of all health and well-being support options available to staff as demand was high and waiting times increased accordingly. Networking via Health Education and Improvement Wales continued to share good practice and ensured equal availability of support services throughout Wales.

The All-Wales COVID-19 Risk Assessment Tool was used to assess the level of risk for staff in developing more serious symptoms throughout the year. No periods of shielding were advised in 2021/22; however, those who remained on the shielding list were advised to take extra precautions to keep themselves safe, as well as following latest guidance. Most staff who were shielding returned to work, either to their substantive role or redeployed to a different role where risk remain an issue.

The flu vaccination programme between September 2021 and 31 March 22 saw an uptake of 54% (6,880 staff) vaccinated against flu. Our organisation was the only health board or trust in Wales to increase the numbers of staff vaccinated against flu during this season.

Menopause cafes

Virtual menopause cafes were established in response to staff interest. Menopause cafes offer a safe environment for any staff to meet, chat, learn, share experiences and gain support on menopause related issues.

Reflection Book

During 2021, staff in the workforce and organisational development directorate produced a book of memories of their experiences moving into and supporting staff through the global pandemic. Individuals from the directorate contributed articles, messages, photos and poems which together created a keepsake of sentiments and memories of the united effort of the team during such a challenging and unique time.

Staff benefits

Following its relaunch in June 2021, we saw a significant increase in the number of staff signing up to our ‘Hapi’ benefits app, with just under 50% of the workforce benefiting. The relaunch was supported by a comprehensive communication strategy including developing posters, promoting at induction and organisational development events, social media posts

and including a signpost in staff email signatures. The improvements and continued evolution of 'Hapi' saw staff saving £3,500 in discounted high street vouchers alone. Looking ahead, we anticipate that 'Hapi' will become an important support mechanism putting benefits and well-being in one easily accessible app for staff.

Ensuring safe staffing levels

Recruitment activity in response to the pandemic continued into 2021/22, with staff appointed into COVID-19 specific positions since the start of the pandemic, including to support the mass vaccination programme and the Test Trace Protect service.

Our overall workforce increased by 213 whole time equivalent as of March 2022 and we appointed over 1,577 (1,303 whole time equivalent) staff through our continued recruitment efforts during 2021/22. This included many appointments to our contingent workforce supply of bank and fixed term contracts under our mass resourcing efforts for COVID-19.

It is the health board's strategic intent to support economic local recovery via the provision of permanent employment for our local population. Recognising that many individuals came forward to apply for roles that supported the work of the pandemic, we initiated a number of 'internal only' recruitment campaigns to recognise the commitment of those individuals, with security of permanent employment in the health sector.

Significant shifts in stabilising and developing our workforce in 2021/22 have been progressed, including our systems and approaches that support the wider health and social care workforce. We have:

- continued to develop our workforce intelligence to demonstrate and monitor the changes through performance dashboards;
- strengthened our approaches to workforce planning for the health and social care system developing forums and tools;
- invested in cultural change through a number of initiatives including organisational development relationship manager roles;
- continued to develop integrated partnership working with local authorities/social care, for example, shared staff induction programmes, integrated roles and piloted the 'bridging service' for domiciliary care options.

Identifying and training staff to undertake new roles

We have started to create new roles to support the ethos and concept of the 'team around the patient/family/child', such as the family liaison officer role. Key to our workforce strategy and development is to explore new support roles and to create a pipeline of future health and social care professionals. We have used the means available to us, through governance frameworks and training contracts, to develop new roles with extended and advanced skills. We have seen the success of this approach in the development and expansion of the Apprenticeship Academy and this will continue to evolve as we put in place new pilot development pathways, such as the therapy assistant practitioner.

In addition, we have supported a number of staff to access training and development opportunities, including:

- helping 268 staff to undertake Diploma/NVQ work-based courses supplied through either personal learning account funding, apprenticeships, or further education funding. Courses range from the Institute of Management qualifications, project management, cookery, and medical administration;
- securing funding to support 92 staff to undertake their Level 4 Higher Education Certificate in Health Care Studies through Swansea University. This qualification is aimed at growing our existing healthcare support workers so they can progress into assistant practitioner roles or progress to their nursing degree;
- supporting 202 staff to access our internal higher awards/study leave process to start or continue their study at a higher education level and undertake PhDs, higher education certificates and masters qualifications. In addition, staff have been given the opportunity to undertake bespoke training specific to their role, with 766 study leave applications approved to support staff training needs;
- supporting 82 non-registered allied healthcare professional staff to work towards various Level 3 Therapies qualifications as part of our internal Agored Training Centre. Assessors and quality assurance networks have been developed along with a robust internal quality assurance process. The last three virtual external quality assurance audits by Agored Cymru were positively received.

Level 4 therapies pilot

As part of the career pathway development for therapies staff, the health board is leading a pilot with Swansea Bay University Health Board, Health Education and Improvement Wales and University of Wales Trinity Saint David to deliver the first Level 4 in Therapies qualification in Wales. In 2021/22, 23 staff from our organisation signed up to complete the qualification. Service leads and subject matter experts supported development of the curriculum and a joint assessment process agreed. The first programme will be delivered over 18 months. There is interest across the rest of Wales to deliver the same programme.

Joint induction programme

Working in partnership with social care, the Clinical Education Team supported the development of a bespoke joint health and social care induction. This new induction is the first in Wales to deliver induction training jointly for care support workers from community care, care homes and domiciliary care, learning disabilities, mental health, and children's settings. The programme has demonstrated increased confidence and competence, improvements in practice and better care outcomes. 216 people across health and social care attended the programme and 134 people will undertake the All-Wales Induction Framework Qualification.

Partnership working across the health board and Carmarthenshire, Ceredigion and Pembrokeshire local authorities increased, with the appointment of the first integrated learning and development training advisor, the first step to increasing core care skills for all care support worker roles. Read the evaluation report here.

Clinical induction programme

A three-day bespoke clinical induction programme, during the mass recruitment programme, was attended by 476 staff. The Clinical Induction Team adapted the education and training programme to a blended approach consisting of three face-to-face days, and three virtual days. Several additional services undertook elements of the programme, including pharmacy, Delta Well-being, and the Welsh Ambulance Service NHS Trust. The first primary care staff member undertook the programme and evaluated well. Places will continue to be offered to primary care staff in 2022/23. The All-Wales Primary Care Group have sought evaluation and feedback to undertake a similar process across Wales.

Enhanced care unit

A training programme was developed with service, theatre staff, critical care staff, ward managers and specialist nurses in preparation for the opening of the enhanced care units in Prince Philip Hospital. A self-assessment and competency document was devised and offered to relevant staff.

Training and use of retired staff

During 2021/22, 132 individuals retired and returned to work for the health board. The health board is to be represented at the new All-Wales Task and Finish Group established to review the retire and return policy across Wales. A review of the health board's retirement policy is underway as we recognise that retention of staff considering retirement, albeit in reduced hours or alternative roles, is critical.

Role of employee/professional advisory groups

We continued to work closely with our staff-side and trade union partners throughout the pandemic and in relation to the recovery agenda. The Director of Workforce and Organisational Development met regularly with staff-side chairs from each county and these focused weekly meetings have continued with members of the workforce team and trade union partners.

Partnership Forum and Local Negotiation Committee meetings continued to be held on a remote basis. Frequently asked questions were regularly updated in conjunction with all Wales links and mechanisms remained in place to address staff concerns and deal with queries as they arose. Specific task and finish groups involving trade union partners were held throughout the year to implement pay enhancements and help with initiatives relating to carrying over annual leave.

BAME advisory group

The Black, Asian and Minority Ethnic (BAME) Advisory Group took forward a range of actions to address inequality for minority ethnic staff, covering a number of key themes:

- Raising awareness of diversity and inclusion
- Supporting our staff
- Reviewing our organisational data

- Strengthening management awareness, capacity and capability about diversity and inclusion issues.

As a step towards celebrating and understanding each other more, and to gain inspiration and strength from all our beliefs, the Advisory Group produced a calendar of religious festivals and events in 2021. The aim of the calendar was to support timetabling, work scheduling and event planning to help provide an inclusive environment, enabling participation from all our staff and visitors. The calendar was distributed to all staff and volunteers and highlights key diversity days, the main faith days observed and celebrated and awareness raising dates.

A wide range of dates were formally acknowledged and celebrated using social media and global emails to raise awareness amongst the staff and our population. In August 2021, a week-long programme of activities celebrated 20 years since the arrival of our first group of Filipino staff. In November 2021, to celebrate Diwali, staff helped to create a video which was shared on our health board's Twitter and Facebook accounts.

The BAME staff network was launched in September 2021. The network has over 70 members who are part of a Microsoft Teams channel which is used to share information and share opportunities with staff.

A key achievement of the Advisory Group was its success in raising awareness of the lived experiences of existing minority ethnic staff and ensuring that the concerns and lived experiences of members are acted upon. A Bullying and Harassment Task and Finish Group was created which led to regular meetings, allowing staff to discuss concerns regarding dignity at work, grievance procedures, exit interviews and many other issues experienced.

The Advisory Group also commissioned a review of BAME staff dismissals over a 10-year period to identify any indication of disproportionate impact on staff from minority ethnic groups. The report provided assurance that no evidence of disproportionate impact had been found, however, a number of recommendations were made to ensure that more positive action can be taken to support staff going through the disciplinary process.

We are proud that our progress and achievements have been recognised in this year's National BAME Health and Care Awards. Eleven incredible finalists have been shortlisted in the categories for clinical champion (2), community initiative of the year (4), digital champion (1), inspiring diversity and inclusion lead (1), mental health initiative (1), outstanding achievement (1) and outstanding corporate achievement of the year (1). Winners will be announced on 9 June 2022.

Review of Covid-19 staff deaths

Sadly, the health board reported one staff death as a result of COVID-19. Guidance and support were provided to the family and work colleagues.

Future Workforce

Apprenticeship Academy 2021/2022

Following the success of the 2019 apprentice programme, the 2021 intake of 72 apprentices provided a greater scope of opportunities including digital services, patient experience, mechanical engineering, electrical engineering, plumbing, workforce development, corporate governance, and the healthcare apprentice programme.

The healthcare apprenticeship is one of the biggest programmes we currently offer, creating a career pathway to becoming an adult general nurse and supporting workforce shortages. A further 55 apprentices joined our clinical teams throughout the health board in September 2021. Our apprenticeship completion rates were consistently higher than the national average for Wales.

Apprentices support our future workforce and make a difference to the resilience of our workforce every day. During winter pressures 2021, our newest healthcare apprentices were given additional training, increased their competencies and were deployed to reinforce the testing and vaccination programme in our response to COVID-19.

Volunteers supporting mass vaccination centres

Mass vaccination centres were supported by 434 volunteers, and 277 remained deployed in March 2022.

We have been overwhelmed with the number of people who came forward to offer their support to one of the largest vaccination programmes in NHS history. While the pandemic brought with it many challenges, the vaccination programme, together with all the volunteers from varied walks of life, has been a heart-warming silver lining.

With the acceleration of the MVC programme in December 2021, we received another 292 enquiries about helping with the programme, which further demonstrated its popularity and true community spirit coming into its own.

New volunteer roles / volunteers moving into health board employment

A new suite of volunteering opportunities was developed during COVID-19, including field hospital volunteers, MVC programme volunteers and gardening. With agreement that volunteers could re-enter all areas post COVID-19 restrictions, with appropriate control measures, the interest in volunteering soared with greater interest than ever before. Many volunteers moved onto paid work within the health board and was the first step in the workforce for many, having gathered invaluable skills through volunteering.

University research pilot scheme

Our Future Workforce and Research, Innovation and Improvement departments, together with the University of Wales Trinity Saint David and Aberystwyth University, worked collaboratively on the development of an academic engagement programme during 2021/22. The programme aimed to provide work-based learning for students, related to their academic courses, developing their employability skills through engagement with the programme. It provided an opportunity to support student studies, informing their career

pathway, supporting their development in preparing for the field of work, and enhancing our partnership working with these universities.

We also developed a summer university engagement programme, as a four-week pilot in July and August 2021, in collaboration with University of Wales Trinity Saint David and Aberystwyth University. Applications were open to second and third year undergraduate or postgraduate students studying in west Wales.

Students were required to work virtually in multi-disciplinary groups looking at a particular health needs from different disciplinary perspectives. The four-week programme resulted in a presentation of findings to senior members of the health board, offering mentoring and training for skills required in the workplace.

Partnership working with local county voluntary councils

Throughout the year, we worked with our strategic partners in the local county voluntary councils (CVCs) across Carmarthenshire Association of Voluntary Services (CAVS), Ceredigion Association of Voluntary Organisations (CAVO) and Pembrokeshire Association of Voluntary Services (PAVS). All CVCs were instrumental in the success of the vaccination programme within Hywel Dda, ensuring that we had a constant supply of volunteers readily available to support. Within Pembrokeshire, we worked with PAVS to bring Volunteering Matters into Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) as part of that multi-agency approach to supporting people at the time of increased need.

Work experience

In 2021/22, 19 participants were placed following the reintroduction of Future Workforce work experience placements.

Traineeship programme: supporting into employment

We developed a traineeship programme, working with local training providers to expand our traineeship offer.

Careers Wales, schools and educational establishments

We worked with Careers Wales, schools, colleges, and further education providers throughout 2021/22 keeping them informed about developments and COVID-19 restrictions. We delivered several sessions to schools promoting our Future Workforce function and the health board was represented at the Careers Wales virtual high impact event in March 2022.

The well-being of our future generations

The well-being of our future generations

The Well-being of Future Generations (Wales) Act 2015 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 have not made any changes to them as they continue to have strategic relevance to our vision and mission to become a population health focused organisation. Our well-being objectives align to more than one of the national well-being goals but broadly fall into four themes: environment and climate change; workforce planning and development; early intervention and prevention; collaboration, involvement and engagement. Our well-being objectives are to:

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 2021/22 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. Within this section of our Annual Report we have provided some examples of our how we have made progress to meet our well-being objectives through the lens of the five ways of working set out in the Act.

Integration

We continue to work with our partner organisations to find ways of accelerating partnership arrangements. For example, as part of the health board's commitment to reduce its carbon footprint and contribute towards the Welsh NHS aspirational target to be 'net zero' on emissions by 2030 a Transport and Sustainable Travel Group has been created. The group includes personnel from different departments in the health board such as finance,

transport, estates, workforce and communications, as well as Knowles Fleet, an external vehicle provider for the health board. The purpose of this group is to develop projects and initiatives to help us tackle climate change and key activities have included promoting awareness and educating staff on the benefits of electric vehicles. As a result of this engagement campaign there has been a 227% increase in the number of electric vehicles secured or ordered by the health board in a six-month period. This brings the total number of electric vehicles across the whole health board fleet; including business use only, salary sacrifice and salary deduction lease car schemes to 128, with 66 fully electric vehicles currently in use, and 62 fully electric vehicles on order. This figure does not include hybrid electric vehicles, of which there are a total of 58 either in use or on order.

Involvement

During the year we have sought to engage with the public in a range of conversations including in the development of the Public Services Board (PSB) Assessment of Local Well-being. Each county had a separate well-being survey to find out what matters most for people and communities. Listening and understanding as well as analysing the feedback has been essential and using our knowledge of the languages used in our local communities the health board's Community Development Outreach Team was able to promote involvement from minority ethnic communities and provide access to surveys in Arabic, Polish and Romanian. This work has been essential to encouraging our diverse communities to have their voices heard.

The coronavirus pandemic has had a major impact on health and care services. As a result, the health board carried out an engagement exercise during the spring of 2021, to learn from the public about how the pandemic had affected their health and care, and access to healthcare services. The public were also asked for their feedback in relation to the health board's long-term strategy to develop and build a new hospital in the south of the Hywel Dda area and this represents our continued commitment to involvement and co-production.

Long term

Public bodies are facing the challenge of an ageing population and the impact that this has on our available workforce. The Apprenticeship Academy scheme is a key example of work we are doing to take a longer-term approach to contribute to 'A Prosperous Wales'. It supports us to invest in local wealth building and contributes to our own well-being objective to offer a diverse range of employment opportunities which support people to reach their full potential. The structured programme is open to anyone aged 16 and above and offers a variety of learning experiences in the workplace, as well as offering the opportunity to attend college or a training centre to gain qualifications. Of the places offered for apprentices in the 2021 cohort, 63 apprentices are still participating in the programme.

This year a pilot initiative was undertaken to fund and support a member of nursing staff to complete a postgraduate degree (MSc Social Research Methods) on a full-time basis over a 12-month period. This initiative demonstrates the health board's commitment to developing the research capability and capacity of our nursing staff, investing in our workforce by enabling a staff nurse to take dedicated time away from clinical duties to undertake the Swansea University programme. This initiative establishes a route to support

nurses to pursue postgraduate studies and build an academic career route, while developing research knowledge and skills within the health board.

Prevention

The health board's health and care strategy - A Healthier Mid and West Wales: Our future generations living well – sets out a strategic vision for services that are safe, sustainable, accessible and kind for current future generations. The strategy is based on the implementation of an integrated social model of health and well-being which signals a shift from our current focus on hospital-based care and treatment towards a focus on prevention and building the resilience of people and communities.

We established a Community Development Outreach Team (CDOT) to engage with our minority ethnic communities and their work has played a key role in supporting those who were reluctant to engage with the health board's COVID-19 vaccination programme. They were a key member of the Vaccine Equity Group which was formed by the health board to improve information and access to COVID-19 vaccinations for those groups who often struggle to access healthcare services or who already suffer inequalities in health. The team have also facilitated access to information in an individual's first language if this is not Welsh or English. This has resulted in public health messages and information being translated into 17 different languages and demonstrates the cultural diversity within Hywel Dda.

Collaboration

Our partnership arrangements with PSBs created a variety of opportunities for collaboration. One example is the work which has been ongoing in Pembrokeshire. PSB partners have come together with businesses and local community organisations, with an ambition to develop a five-year climate adaptation strategy. This work is about coping with future changes to the climate in Pembrokeshire and is focused on the following:

- Climate adaptation which helps to minimise risks from changes resulting from past emission, including unpredictable severe weather; sea level rise; changes in natural systems that we rely on.
- Climate risks: multiple risks likely to arise from changes to our climate: which may impact on the local economy; natural environment; infrastructure; communities; people's well-being both now and in the future.
- Climate resilience: ensuring that the county can deal with the risks from climate change and be prepared for the future.

Our work has also included action within our corporate areas and services. We are cognisant that we are a large anchor institution for west Wales and we can effect positive change on the economy and in our communities, including their wider determinants of health. We have several planning objectives aligned to this work in key areas such as workforce, procurement and decarbonisation. To support the work within those areas, the health board has been working with external partners and Public Health Wales to develop a deprivation mapping tool which enables the user to layer different data sets on top of various publicly available deprivation indices (for example, Welsh Index of Multiple Deprivation) and locations of key services (for example, GPs and pharmacies). Our system

will also add in additional data sets such as our estate, procurement spend and recruitment information. We have just finalised the deprivation map and work will commence to consider how the tool can be best used.

The potential outcome for our communities through using this tool within the established workstreams could be significant. For example:

- Recruitment: Workforce are already working with communities to understand the barriers faced by individuals with regards to employment. A programme is being developed which supports those from our most deprived or marginalised communities to gain employment within the health board. The mapping tool can be used to support with the identification of key communities.
- Procurement: Procurement are already considering how we best incorporate social value into our procurement processes. The aim is to use the skills, capabilities, supply chain and recruitment potential of our suppliers to positively impact our communities. The mapping tool can be used to visually show our suppliers where the highest areas of need are.
- Environment: We have a significant estates programme within the health board and can use the mapping tool to consider the location of our estate alongside the deprivation information to inform future location and estate strategies.

This section of the Annual Report has provided an overview of some of our work to deliver the ambition of the Well-being of Future Generations Act. We also publish a separate Well-being Objectives Annual Report 2021-22 on our website that will provide more detail about our progress to meet our well-being objectives and evidence of our contribution to the national well-being goals.

Read further information about our Well-being Statement and Objectives, the PSB Well-being Plans and our Well-being Objectives Annual Report here

Embracing our Welsh language

Welsh language

We want 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 embrace the spirit of our Welsh language as well as comply with the Welsh Language Standards.

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.

Our organisation is passionate about the Welsh language and we are ambitious to achieve and go beyond our statutory duties. We recognise that delivery is not always consistent across our sites and teams. Our culture needs to evolve for us to deliver a seamless bilingual service to people who use our 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 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.

We will report our progress on targets set to achieve our ambitions and statutory obligations for the Welsh language in our annual Welsh Language report, which will be published on our website.

Language skills of staff

The language skills of our staff, in accordance with Welsh Language Standards 116 and 117, are captured and recorded on the electronic staff record system (ESR). As of 31 March 2022 96% of staff have recorded their Welsh language skills as follows:

0 – No skills/Dim sgiliau – 3,935
1 – Entry/Mynediad – 2,632
2 – Foundation/Sylfaen – 992
3 – Intermediate/Canolradd – 857
4 – Higher/Uwch – 873
5 – Proficiency/Hyfedredd – 1,273
Not recorded on ESR – 430
Grand total – 10,992

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:

Total number of health board vacancies in 2021/2022 advertised as:	
Welsh language skills are essential	76
Welsh language skills are desirable	2855
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	26
Total number of vacancies advertised 01/04/2021 to 31/03/2022	2957

Welsh language related complaints

Two Welsh language service complaints were received by the health board during 2021/22. Both complaints were investigated by the Welsh Language Commissioner within the year.

Complaint 1: A complainant telephoned the health board's COVID-19 enquiries helpline (0300 303 8322) on various occasions over a period of six weeks and was unhappy with the lack of Welsh language services received. The health board reported on a series of action points from the Welsh Language Commissioner in March 2022.

Complaint 2: The second complaint related to one of the health board's mass vaccination centres. The complainant reported that after registering at the desk, and receiving a leaflet about the vaccine, they were directed to another desk to provide their contact details, along with other information. Following this, the complainant was given a form containing these details, which they allege was in English only. The health board is required to report on four action points from the Welsh Language Board by the end of April 2022.

Sustainability

Sustainability

While providing a separate sustainability report is not required as part of our 2021-22 Annual Report, the matter of sustainability remains a high priority for the organisation. Actions to ensure we work within and develop an improved sustainable environment are referred to below. The data used to provide the information has come from verified, invoiced data which is recorded and monitored via internal management systems.

*Waste Management

In 2021-22 the health board developed a waste strategy with targets to reduce 'total waste', increase recycling and divert waste from landfill in line with Government targets by 2030. A baseline year of 2018-19 has been used to reflect a 'normal' pre-COVID-19 year. Since the baseline year, we have increased recycling from 45% to 48% (prorated 2021-22). This has exceeded our waste strategy target to achieve 45% recycling by 2021-22. In 2021-22 the health board also rolled out source segregated recycling at Withybush Hospital and will continue to roll out source segregated recycling on the community and health centre sites in 2022-23. We expect this to increase recycling rates on a similar level to the increases seen from introducing source segregated recycling on the other acute sites (Bronglais and Prince Philip hospitals) in 2017/18 and 2018/19.

The total amount of waste recycled is now circa 750 tonnes. We managed to divert more landfill waste for recovery with an average of 50% of waste going to landfill in 2020-21 now being sent for recovery. This has exceeded our waste strategy target to recover 25% of waste being sent to landfill by 2022-23. These improvements have reduced the emissions produced from waste by circa 69% since the baseline year. There has been a small increase in overall waste costs primarily due to rate and landfill charge increases.

Warp It

In July 2018 we signed up to use Warp IT, an online furniture and equipment reuse platform. To date, over 1,122 staff have committed to reusing items no longer needed by others, avoiding waste disposal of nearly 63 tonnes, and preventing 226 tonnes of CO2e emissions.

ISO 14001

Our Environmental Team has continued to maintain the Environmental Management System in line with the ISO 14001 standard, including the production of annual objectives and targets and presenting a management review of performance via formal committee. Following a surveillance visit in November 2021, we have successfully maintained the accreditation with no major or minor non-conformances raised.

*Utilities

The total predicted consumption of all utilities for 2021/22 is estimated to be 96,359,293 KWhrs producing 19,185 TCO2. Actual consumption for 2020/21 was 96,737,462 KWhrs producing 19,640 TCO2. Subject to national pressure and current market influences there has been a significant increase in utility costs that the health board continues to monitor and report upon.

Electricity, oil and biomass consumptions are all marginally higher than last year although these increases were all more than offset by a 4% decrease in gas consumption.

This lower gas consumption over 2021/22 can be attributed to generally milder weather over the year. Electricity consumption was slightly higher (4%) than the previous year mainly due to the additional load at Glangwili Hospital attributed to the new women's and children's unit, and staff across the health board returning to work from COVID-19 home working. Increase in oil and biomass consumption can also be attributed to the commissioning and running of the new women's and children's unit at Glangwili Hospital. Combined heat and power (CHP) use was similar to the previous year with only a marginal increase of around 3%. The health board established a 10-year energy performance contract with Centrica in 2014/15 to deliver guaranteed financial and carbon savings. The energy performance contract (EPC) is anticipated to save around 1,040 TCO2 during 2021/22.

Gas, oil and electricity have all seen substantial unit rate increases throughout the year which combined are now on average 36% higher than last year. This is due to market influences outside the control of the health board. A decrease in the electricity CO2 conversion factor is the main contributory factor towards the overall lower CO2 produced over 2021/22.

Water consumption has seen an increase from a total of 269,931 M3 costing £739,747 in 2020/21 to an estimated 282,137 M3 costing £782,271 in 2021/22. This increase in consumption can be attributed to the extended period of tank flushing and the ongoing theatre building work, both at Prince Philip Hospital. We use a company to manage and monitor our water consumption in the health board. Estimated consumption and financial savings in 2021-22 are £65,000 and 44,162 M3 respectively. The consumption saving has saved 17.7 tCo2e.

***Note**: Actual consumption for the last two months of 2021-22 for waste and utilities has been estimated as a complete year of invoices are not received until the month of May.

Transport

We have been working hard to ensure that the actions set out within the NHS Wales decarbonisation strategy are implemented. This includes a number of initiatives:

- The promotion of electric vehicle use amongst departments and staff;
- Introduction of telematics tracking across a number of health board vehicles, with full rollout planned for 2022/23;

- The completion of reviews across our main site to assess the potential for installing electric vehicle charging infrastructure. We aim to begin the introduction of electric vehicle charging units across our sites in the 2022/23 financial year;
- The further development of onsite infrastructure to promote a greater us of active travel;
- Increased support provided to staff to enable a greater uptake of home and agile working.

As a result of the actions taken to date there has been considerable progress in our drive to reduce carbon emissions to meet those targets set out within the decarbonisation strategy. Key improvements include:

- As of 31 March 2021 we had a total of 35 electric vehicles in place across the health board's business use only and lease car scheme fleets. This number has now increased to 128 electric vehicles either in place or on order, representing an increase of 265% over the course of the last financial year. We expect this number to increase substantially over the course of the next financial year as we implement electric vehicle charging infrastructure on our sites and begin the transition of our business use only fleet to electric vehicles;
- There was a significant reduction in the total number of business miles travelled within the health board between 2018/19 and 2020/21. This saw mileage reduce from 10.2m to 6.5m, a reduction of 36% over the period. While we are still awaiting the final figures for 2021/22, it is anticipated that this positive trend will continue as the good practice relating to home working, agile working, telehealth and teleconferencing continues to be embedded as part of operational practices;
- The reduction in business mileage seen between 2018/19 and 2020/21 has also been reflected in the CO2e emissions seen over the period, with total emissions for the period reducing from 2,109 tonnes CO2e to 1,343 tonnes CO2e. We expect the level of CO2e emissions to decrease further in future years as the number of electric vehicles utilised by departments and staff as a proportion of total vehicles continues to increase.

Other initiatives

Decarbonisation/energy efficiency projects

Projects in the process of being completed or planned for delivery in 21/22 – 22/23 following secured government funding on existing assets include:

- Roof mounted photovoltaic (PV) installations at Bronglais, Withybush and South Pembrokeshire hospitals;
- Solar carports at South Pembrokeshire Hospital;
- LED lighting project at Bronglais Hospital;
- Ground mounted solar farm project at Hafan Derwen site – 0.45MW;
- Installation of four 7KW chargers at each acute hospital site and the purchase of seven electric fleet vans;
- Air source heat pump installation at Cardigan Integrated Care Centre.

Key benefits of all these schemes are carbon reduction, improved site resilience and revenue savings.

Carbon awareness programme

We are developing a carbon literacy programme, alongside wider public and staff engagement to support awareness and whole organisation change. The health board is part of the Circular Economy Innovations Programme, via Welsh Government funding, facilitated through Swansea University. Its aim is to raise decarbonisation awareness and public sector partnerships have developed within the Swansea Bay City Region Public Sector to jointly develop and deliver awareness. Our carbon literacy programme will deliver three layers of competency amongst our colleagues - awareness, practitioner and leader – and this will drive positive behaviour change, leading us towards our sustainable development ambitions. The health board is a member of the National Programme for Climate Change and Decarbonisation for Health and Social Care in Wales, and also of several environmental and climate change groups, which are all important contributors for us to capture best practice as part of our continuous improvement drive.

Green spaces

We have Green Health groups on all four acute hospital sites and at South Pembrokeshire Hospital. The more established groups at Withybush and Glangwili hospitals have a number of ongoing projects, with both sites having created miniature wildflower meadows as part of Plantlife's Magnificent Meadows project. Other projects at these sites include the development of a number of areas to enhance biodiversity and provide green spaces for patients, staff and visitors. Staff at Glangwili Hospital are currently working with Keep Wales Tidy to develop the large green space near Teilo, involving tree planting and the installation of two raised beds for native plants and wildflowers. The group at Withybush Hospital has been linking in with Pembrokeshire County Council as part of the Cleddau Reaches Project, involving a walkway from the hospital to a path along the River Cleddau. Around 200 native trees have been donated to Withybush Hospital and South Pembrokeshire Hospital as part of the NHS Forest project. Each site is to be given a tree to plant as part of The Queen's Green Canopy initiative to mark Her Majesty's Platinum Jubilee in 2022. With the support of our midwives, other NHS Wales staff we joined up with Pembrokeshire Nature Partnership to plant 3,810 trees in two years to celebrate the Queen's Green Canopy project. With each tree planted representing a baby born, they will soon have a flourishing woodland for families to enjoy for generations to come. This is a brilliant example of local project partnerships creating greener spaces and helping to benefit personal well-being. A short video was produced about the project here.

Our Green Health groups at Prince Philip and Bronglais hospitals are in the earlier stages of project development, with a growing interest across both sites. The Environment Team has recently had biodiversity surveys carried out on a number of sites which will provide the Green Health groups with further ideas for promoting green space.

Conclusion and forward look

Conclusion and forward look

In moving forward into 2022/23, we must not forget what we have learnt over the last 12 months, nor what we have continued to deliver and the advancements made during challenging times for our sector.

Throughout the past year we have seen increasing demand across our urgent and planned care systems, greater pressure on primary care services, substantial walk-in demand at our emergency departments, significant pressures in social care and high levels of sickness across our workforce. Despite continued constraints on capacity, we have sought to maintain services as best we can and restart many routine services.

We have worked hard to steadily increase capacity to see and treat patients where possible in 2021/22, the pandemic continued to have an impact while we adhered to related government restrictions to keep us safe. The various waves of COVID-19 cases meant we had to scale back some planned care with only emergency and urgent cancer care continuing. As a result, the number of patients waiting for treatment increased, although performance has steadied when compared to the impact on performance during the first year of the pandemic.

To proactively address some of the challenges faced, we worked flexibly and quickly adapted where we needed to – focusing on providing services for those at greatest need. With support from Welsh Government, we invested in modular theatres at Prince Philip Hospital to increase day surgery capacity. We also developed waiting list initiatives to contact and support our long waiting patients and worked on our community same day COVID-19 care. Significant work was done on admissions avoidance, working in partnership with our community and social care colleagues, aiming to reduce the pressures on our services.

Alongside this, we continued to manage our response to COVID-19. We worked with our multi-agency partners across the region to continue protecting our communities, local public services and the NHS as the pandemic continued. Our vaccination programme has been very successful, with an exceptionally high uptake of the vaccine to date. As our vaccine programme moves into the booster phases, we will continue to work to protect as many people as possible and ensure all residents can access a vaccine. The demands for testing, national strategy, and testing infrastructure have changed frequently and quite dramatically during the pandemic. As a result, we developed a robust testing infrastructure, which has been responsive to the Welsh Government's evolving national testing strategy. We continue to provide COVID-19 testing to anyone who needs it.

We are proud of all our staff and everything they have achieved in the last year - for their tireless efforts to deliver health care during unprecedented pressures and challenges. The impact of the past two years on our colleagues has been significant. We will continue to support our staff and their well-being as we begin to recover and recuperate from the impact of the pandemic by listening to their experiences and what is important to them. We want every day in Hywel Dda University Health Board to be 'a good day in work'- for both

our current and future workforce - and Our People Culture Plan will help us on our culture change journey.

Our three-year plan for 2022-2025 recognises that the strength of the health board lies in its people, both those who work in the health and care system and the communities we serve. It acknowledges the impact the pandemic has had on individuals, teams, families, and society. Consequently, our priorities and actions put our people at the heart of everything we do, recognising that the route out of the pandemic and towards our strategic vision will come from our people, in the same way it has through COVID-19.

Our strategy is ambitious and far-reaching, seeking to ensure mid and west Wales has a health and care system that will serve the population for decades into the future. It offers a truly once in a lifetime opportunity to reset the system and establish a sustainable, high-quality model for our future generations. We see our potential contribution to mid and west Wales in the broadest sense, not only in direct healthcare provision, as important as that is, but also the impact we can have as the largest employer and a significant contributor to the economy. We can, for example, play a major role in supporting our population to develop rewarding careers, support our local businesses and the regenerations of our towns, and provide leadership in the resetting of our society as we seek to address societal challenges like decarbonisation.

As a result, our three-year plan reflects the breadth of that ambition. Over the course of 2022 to 2025 we intend to take significant strides towards this vision, whilst at the same time continuing to respond to COVID-19 and addressing the legacy of the pandemic. Achieving our vision of a healthier mid and west Wales will require the organisation to have a clear focus (our six priorities for 2022/23), a route map to the strategic vision (our planning objectives), a way of measuring progress (our priority measures for 2022/23 and our strategic outcome measures) and robust oversight and risk management (our board assurance framework and revised committee structure). The key elements are now in place and our focus moves to delivery of the new models.

During 2022/23 we will:

- continue to be prepared for COVID-19 and any subsequent variants and surges in infections, so that we can be flexible in meeting any changes to demand in our system. This will include our vaccination programme, our testing programme; and understanding and responding to inpatient bed demand;
- focus on the recovery of our planned care activity and support patients whilst they wait – this will be aided by the opening of the new day surgery unit in Prince Philip Hospital and through increased efficiencies in our system, and through our programme of work centred on outpatient transformation;
- support our workforce and further develop our route map to workforce sustainability, including our overseas recruitment campaign;
- continue the redesign of our urgent and emergency care system, aligned to the six national policy goals;
- further strengthen our relationships with our neighbouring health boards through regional initiatives such as A Regional Collaboration for Health (ARCH) and Mid Wales Joint Committee for Health and Care;

- deliver savings resulting from our opportunities framework and work with Welsh Government on our route map to financial sustainability;
- continue work on our strategy 'A Healthier Mid and West Wales', with an emphasis in the coming year on our outline business case;
- build upon the work of our seven clusters, with a particular emphasis on our accelerated cluster design, and through our integrated locality planning;
- accelerate our work in the digital; value-based healthcare; research and innovation; foundational economy and quality management spheres; and
- continue to learn from our planning objectives.

We do not underestimate the challenges we face as an organisation as we go into 2022/23, but we are prepared for them and see the next period as an opportunity to reset the system to put us on course for making our strategic vision - a healthier mid and west Wales - a reality.

Chapter 2

Accountability Report

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Content

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Accountability Report

Introduction to the Accountability Report

The Accountability Report is one of the three 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 three 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 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.

Part 1 - Corporate Governance Report

Introduction

The Corporate Governance Report provides an overview of the governance arrangements and structures that were in place across the health board during 2021/22. It includes:

The Directors' Report: This provides details of the board 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 is fair, balanced, and understandable.

The 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

The health board has 11 Independent Members (including Chair and Vice-Chair) who are appointed by the Minister for Health and Social Services, and nine Executive Directors. All Independent Members and Executive Director Members have full voting rights. In addition, there are three 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. The health board also has appointed a Strategic Advisor who takes part in board meetings in public. Associate Members and the Strategic Advisor have no voting rights. There is also one Director and the Board Secretary on 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/public-services/health-and-health-services/local-health-boards.

Further details in relation to the composition of the Board can be found at pages 14 to 18 of the Governance Statement. This will include Board and Committee membership, including the Audit and Risk Assurance Committee, for 2021/22, 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: Register of interests, gifts, sponsorship and hospitality - Hywel Dda University Health Board (nhs.wales), 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 on page 47 of the Governance Statement.

Environmental, social and community issues

These are outlined in pages 46 of the Governance Statement.

Statement for Public Sector Information Holders

This is contained in the Parliamentary Accountability and Audit Report on page 91.

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: 9 June 2022**

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:	9 June 2022
Chief Executive:	…… Steve Moore	Date:	9 June 2022
Executive Director of Finance:	…… Huw Thomas	Date:	9 June 2022

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 significant challenges of planning and providing services during the COVID-19 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 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 Governance Statement."

This has been another unprecedented year across the NHS and for Hywel Dda University Health Board. We have continued to adapt our governance framework within the year to ensure we continue to operate in an open and transparent way whilst responding to each stage of the pandemic. Furthermore, in light of the ongoing learning through the pandemic, over the past year, we have reviewed our governance and assurance arrangements so they better support the delivery of our strategic and planning objectives as we look to the future to address pressures in our urgent and emergency care system, deal with the backlog of patients waiting for treatment and care and to help us get back on track with our financial roadmap whilst managing the exceptional economic challenges we face next year. Further detail on how we maintained good governance arrangements during 2021/22 are provided within this Governance Statement.

Escalation and intervention arrangements

The health board is held to account for its performance by the WG, which has established arrangements for escalation and intervention to support NHS bodies to address issues effectively and deliver the required improvement. Despite the unprecedented challenges we have faced in the last two years – exacerbated by our hospital configuration and relatively poor infrastructure – we have been able to consolidate our de-escalation from 'targeted intervention' to 'enhanced monitoring' status. The WG acknowledged the good leadership within the health board, however the following points were brought to our attention:

- There is a need to address the current financial position and financial strategy linked to future service and workforce plans;
- There is concern around the urgent and emergency care position across the health board, with all four acute sites often at high levels of escalation every day;
- The continued workforce challenges within the health board.

To realise our ambition to return to 'routine monitoring' status will depend on delivering an approvable Integrated Medium Term Plan (IMTP). We continue to work with WG as it remains our ambition to have an approved IMTP and to be de-escalated to routine monitoring status.

Our governance framework

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 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'.

The board approved the All Wales Model Standing Orders, Reservation and Delegation of Power for Standing Orders and the Standing Financial Instructions (SFI's) at the board meeting held on 27 May 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.

The only variations to Standing Orders during 2021/22 in response to the pandemic and the departure from Public Bodies (Admission to Meetings) Act is that the board has not been able to meet in public due to limitations on public gatherings. To ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

- Continued live broadcasting of board meetings;
- Published agendas and papers in advance of the meeting – 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, however a local variation has been made);
- A clear link to the health board's website pages and social media accounts signposting to further information and publication dates; and
- Amendment to the website (which constitutes the official notice of board meetings) and explain why the board is not meeting in public.

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 board

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.

During 2021/22, all board meetings in public were broadcast live, with a recording of the meeting uploaded to our website after each meeting.

During 2021/22, the board held:

- Eight meetings in public (all were quorate)
- One Annual General Meeting
- Seven seminar sessions (an additional Seminar was held in March 2022)

Attendance is formally recorded within the minutes, detailing where apologies have been received and where 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/.

The board has a programme of work, which was adapted during the year to respond to emerging events and circumstances. There is also 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.

Items considered by the board during 2021/22 included:

- Hywel Dda University Health Board Annual Recovery Plan 2021/22
- Programme Business Case – Implementing the Healthier Mid and West Wales Strategy
- Transforming Mental Health Services Update
- Three Year Draft Plan for Children's Services
- Bronglais Hospital Chemotherapy Day Unit Project – Approval to Develop with Revised Relocation Plans
- West Wales Care Partnership: Dementia Strategy
- Hywel Dda University Health Board Palliative & End of Life Care Strategy
- Paediatric Surge Plans for Respiratory Syncytial Virus (RSV)

- National Laboratory Information Management System (LIMS) Full Business Case
- Laundry Business Case
- South West Wales Glaucoma Service Business Case
- Modular Solution to Support Delivery of Elective Services - Procurement Outcome and Decision
- Haematology and Coagulation Managed Service Contract Award
- NHS Blood and Transplant (NHSBT) Organ Donation: Review of Actual and Potential Deceased Organ Donation
- Women & Children Phase II Project and Capital Governance Review Update
- An External Review of the Llwynhendy Tuberculosis Outbreak
- Pharmaceutical Needs Assessment
- Reducing Health Inequalities and Promoting Health Equity
- Integrated Winter Resilience Plan 2021/22
- Discovery Report: Understanding the Staff Experience in Hywel Dda University Health Board During 2020-21 COVID-19 Pandemic
- Making a Difference – Customer Service Programme
- Nurse Staffing Levels (Wales) Act:
    - Annual Assurance Report 2020/21
    - Three Yearly Assurance Report on Compliance 2018/21 Report for WG
    - Annual Presentation of Nurse Staffing Levels
- Revised Governance Structure and Arrangements
- Long Term Agreements - Contract Values and Approach in 2021/22
- Hywel Dda University Health Board Reset and Recovery Plan – Outsourcing Activities
- Virtual Pooled Fund Agreement for Adult Care Home Placements 2021/24
- Governance Arrangements to Manage Allocation of Recovery Funding
- Use of Consultancies to Support the Health Board
- Strategic Business Intelligence
- Regional Partnership Board – Population Assessment and Market Stability Report
- Major Incident Plan
- Hywel Dda University Health Board Well-being Objectives Annual Report 2020/21
- Improving Outcomes for Carers – Annual Update Report
- Strategic Equality Reports
    - Strategic Equality Plan Annual Report 2020/21
    - Annual Workforce Equality Report 2020/21
    - Gender Pay Gap Report 2020/21

Regular items throughout the year to the board included those listed above, as well as the following:

- Reports on COVID-19 and updates on delivery of the Annual Recovery Plan 2021/22
- Reports on the development of the IMTP 2022/25
- Reports on the financial performance and the related risks for discussion

- Reports on improving patient experience, providing feedback and activity, for assurance
- Integrated Performance Assurance Reports identifying areas of concern for discussion
- Board Assurance Framework Dashboard providing a visual representation of the health board's progress against each strategic objective for assurance
- Corporate risk reports providing assurance on the management of risks, and any variances to agreed tolerance levels
- Reports on the development of the IMTP 2022/25 for discussion
- 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, Board Committees, Joint Committees, Advisory Groups and Statutory Partnerships of the Board

Board committees

The board is supported by several committees, each chaired by an Independent Member. These committees have an important role in providing scrutiny and seeking assurance in relation to the achievement of our strategic and planning objectives, provision of safe and effective services, compliance with legislation and standards, learning from lessons, and oversight of performance and risk. Considering the learning through the pandemic, the board approved our revised committee structure, to align more closely to our strategic objectives, in July 2021. The term 'Assurance' was removed from Committee names (except for the Audit and Risk Assurance Committee) in recognition that the role of these committees is wider than providing assurance to the board. The health board now has the following committees in place, and these are set out in the diagram at Appendix 1.

- Audit and Risk Assurance Committee (ARAC)
- Health and Safety Committee (HSC)
- Charitable Funds Committee (CFC)
- Mental Health Legislation Committee (MHLC)
- Quality, Safety and Experience Committee (QSEC)
- People, Organisational Development and Culture Committee (PODCC) established to replace the 'people' element of the previous People, Planning and Performance Assurance Committee (PPPAC)
- Strategic Development and Operational Delivery Committee (SDODC) established to replace the 'planning' and 'performance' elements of the previous PPPAC
- Sustainable Resources Committee established to replace the former Finance Committee
- Remuneration and Terms of Service Committee

Terms of Reference for all Board Committees, listed above, can be found in the Revised Governance Structure and Arrangements Report that was presented to Board in July 2021.

The chair of each committee provides a written report to the board following each meeting outlining key risks and highlighting areas, which need to be brought to the board's attention to contribute to its assessment of assurance and provide scrutiny against the delivery of objectives or other matters. 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. As well as producing formal minutes, each committee maintains a table of actions that is monitored at meetings.

A further enhancement to the governance framework has been the introduction of a bi-monthly meeting of the committee chairs which supports the triangulation of information across the committee structure and the wider health board.

Throughout the year, each committee has undertaken a self-assessment and produced a meaningful development plan to ensure there is continual learning and improvement. Each committee chair is also responsible for providing the board with an annual report, setting out a helpful summary of its work throughout the year.

Each committee has an Executive Director lead who works closely with the chair of each committee in agenda setting, business cycle planning and to support good quality, timely information being relayed to the Committee. A summary of key items considered by Committees can be found in Appendix 2.

The following table outlines dates of board and committee meetings held during 2021/22, with all meetings being quorate:

Committee / Month	Board	Audit and Risk Assurance Committee	Charitable Funds Committee	Health and Safety Committee	Mental Health Legislation Committee	People, Planning and Performance Assurance Committee (until June 2021)	People, Organisational Development and Culture Committee (from July 2022)	Strategic Development and Operational Delivery Committee (from July2021)	Sustainable Resources Committee (Finance Committee until July 2022)	Quality, Safety and Experience Committee	Remuneration and Terms of Service Committee
Apr 2021						27.04.21			29.04.21	13.04.21	
May 2021	27.05.21	05.05.21		10.05.21					25.05.21		
Jun 2021	10.06.21 24.06.21	10.06.21 22.06.21	30.06.21		15.06.21	24.06.21			29.06.21	08.06.21	
Jul 2021	29.07.21			06.07.21							
Aug 2021		24.08.21					19.08.21	26.08.21	23.08.21	10.08.21	31.08.21

Sep 2021	30.09.21		27.09.21	13.09.21	02.09.21						30.09.21
Oct 2021		19.10.21					13.10.21	26.10.21	28.10.21	05.10.21	
Nov 2021	25.11.21		30.11.21	15.11.21	26.11.21						
Dec 2021		14.12.21					13.12.21	15.12.21	21.12.21	07.12.21	
Jan 2022	27.01.22			10.01.22							13.01.22
Feb 2022		22.02.22					03.02.22	24.02.22	23.02.22	08.02.22	
Mar 2022	31.03.22		15.03.22	14.03.22	01.03.22						

Board and Committee membership and attendance during 2021/22

The board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. The board consists of 20 voting members (11 Independent Members and nine Executive Directors). There are also three Associate Members and a Strategic Advisor that take part in board meetings in public, though 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, who attend its meetings but do not have voting rights.

We warmly welcomed three new Independent Members to the Board in 2021/22:

- Winston Weir, Independent Member (Finance) commenced duties on 1 April 2021
- Cllr Gareth John, Independent Member (Local Authority) commenced duties on 1 April 2021
- Iwan Thomas, Independent Member (Third Sector) commenced duties on 1 May 2021

These appointments dovetailed with the previous post holders therefore there were no Independent Member vacancies during the year.

The following Independent Members were also reappointed during 2021/22:

- Delyth Rainsford, Independent Member (Community)
- Maynard Davies, Independent Member (Information Technology)
- Ann Murphy, Independent Member (Trade Union)

Our new Executive Director of Strategic Development and Operational Planning, Lee Davies, took up post on 12 April 2021. This post was created following a review when the Executive Director of Planning, Performance and Commissioning, left the organisation in October 2020. 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.

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/.

In addition to responsibilities and accountabilities set out in terms and conditions of appointment, board members also fulfil a number of Champion roles where they act as ambassadors for these matters. The table below sets out the composition of the board in 2021/22 outlining the positions held, the area or expertise/ representation role, the board and committee membership and attendance, and the Champion roles.

Board and Committee Membership and the record of attendance for the period April 2021-March 2022

Name	Position & Area of Representation	Board Committee Membership & Record of Attendance	Champion Role
Maria Battle	Chair	• Board (Chair) 8/8 • RTSC (Chair) 3/3 • CFC 3/4	• Raising Concerns (Staff)
Judith Hardisty	Vice Chair (Mental Health, Learning Disabilities, Primary Care & Community Services)	• Board (Vice Chair) 8/8 • ARAC 8/8 • FC 3/3 • HSC (Chair) 6/6 • MHLC (Chair) 4/4 • PODCC (Vice-Chair) 4/4 • QSEC 6/6	• Mental Health
Anna Lewis	Independent Member (Community)	• Board 8/8 • CFC 3/4 • PPPAC 2/2 • QSEC (Chair) 6/6 • RTSC 2/3 • SDODC 4/4	
Prof John Gammon	Independent Member (University)	• Board 8/8 • ARAC 7/8 • PPPAC (Chair) 2/2 • PODCC (Chair) 4/4 • QSEC 5/6 • RTSC 6/6 • SDODC 2/4	• Infection prevention and control

Winston Weir from 1 April 2021	Independent Member (Finance)	• Board 7/8 • ARAC (Vice-Chair) 8/8 • FC 3/3 • MHLC 1/2 • PODCC 4/4 • QSEC 2/2 • SRC (Chair) 4/4	
Owen Burt to 30 April 2021	Independent Member (Third Sector)	• ARAC 1/1 • PPPAC (Vice-Chair) 1/1	
Iwan Thomas from 1 May 2021	Independent Member (Third Sector)	• Board 8/8 • CFC (Vice-Chair) 4/4 • HSC 2/2 • MHLC (Vice-Chair) 1/4 • PPPAC 1/1 • SDODC 4/4	• Equality
Maynard Davies	Independent Member (Information Technology)	• Board 8/8 • ARAC 8/8 • FC 3/3 • MHLC 4/4 • PPPAC 2/2 • SDODC (Chair) 4/4 • SRC (Vice-Chair) 4/4	• Older persons
Cllr Gareth John from 1 April 2021	Independent Member (Local Authority)	• Board 7/8 • FC 3/3 • SDODC (Vice-Chair) 4/4 • SRC 3/4	
Ann Murphy	Independent Member (Trade Union)	• Board 8/8 • CFC 4/4 • HSC (Vice-Chair) 6/6 • MHLC 3/3 • PPPAC 2/2 • PODCC 4/4 • QSEC 6/6	
Delyth Raynsford	Independent Member (Community)	• Board 8/8 • CFC (Chair) 4/4 • FC 3/3 • HSC 6/6 • MHLC 0/1 • PODCC 4/4	• Welsh Language • Armed Forces and Veterans • Children and Young People

		• QSEC (Vice-Chair) 5/6 • SRC 4/4	
Paul Newman	Independent Member (Community)	• Board 8/8 • ARAC (Chair) 8/8 • FC 3/3 • HSC 5/6 • QSEC 6/6 • RTSC (Vice-Chair) 3/3 • SRC 4/4	• Putting Things Right
Jonathan Griffiths	Associate Member	• Board 5/8	
Michael Hearty	Associate Member (until 30 June 2021)	• Board 3/3 • FC (Chair) 3/3	
Hazel Lloyd-Lubran	Associate Member	• Board 5/8 • SRG (Chair) 4/4	
Mo Nazemi	Associate Member	• Board 1/8 • HPF (Chair) 4/4	
Steve Moore	Chief Executive Officer	• Board 8/8 • RTSC 3/3	• Welsh Language
Phil Kloer	Executive Medical Director/Deputy Chief Executive	• Board 8/8 • QSEC 6/6 • HPF 4/4 • PODCC 4/4	• Caldicott Guardian
Huw Thomas	Executive Director of Finance	• Board 8/8 • ARAC 8/8 • CFC 4/4 • FC 3/3 • PPPAC 2/2 • SDODC 4/4 • SRC 4/4	
Mandy Rayani	Executive Director of Nursing, Quality & Patient Experience	• Board 8/8 • CFC 4/4 • HSC 6/6 • QSEC 6/6 • PODCC 4/4	• Violence & Aggression • Children & Young People
Alison Shakeshaft	Executive Director of	• Board 6/8 • QSEC 5/6	

	Therapies and Health Science		
Lisa Gostling	Executive Director of Workforce & Organisational Development	• Board 7/8 • PPPAC 2/2 • PODCC 4/4 • RTSC 3/3	• Raising Concerns (Staff)
Ros Jervis	Executive Director of Public Health	• Board 8/8 • PPPAC 2/2 • QSEC 5/6	• Emergency Planning
Andrew Carruthers	Executive Director of Operations	• Board 8/8 • HSC 4/6 • MHLC 4/4 • PPPAC 2/2 • SDODC 2/4 • QSEC 6/6	• Fire Safety
Lee Davies from 12 April 2021	Executive Director of Strategic Development and Operational Planning	• Board 8/8 • PPPAC 2/2 • SDODC 4/4	
Joanne Wilson	Board Secretary	• Board 8/8 • ARAC 8/8 • HSC 6/6 • PPPAC 2/2 • PODCC 4/4 • SDODC 4/4 • QSEC 6/6 • RTSC 3/3	• Counter Fraud
Jill Paterson	Director of Primary Care, Community & Long Term Care	• Board 8/8 • QSEC 5/6 • SDODC 4/4	

**Deputy representation for Executive Directors is included in figures above*

Command and Control

In March 2020, the health board established a Command and Control structure, i.e. Gold, Silver and Bronze Groups, to facilitate its planning and preparations for the emerging global COVID-19 pandemic. Whilst this structure was formally stood down in May 2021 due to

reduced COVID-19 transmissions, it was kept under review during 2021/22 and was reinstated in response to surges in community transmissions and hospital admissions, with Gold convening to make key decisions. All strategic actions are documented on a decision log to provide a clear audit trail and these are ratified by the board.

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 four Advisory Groups to the Board.

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 met four times during 2021/22.

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. SPF met six times during 2021/22.

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. HPF met four times during 2021/22.

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 reports to both PODCC and board, with the vice-chairs being invited to participate in board meetings as in-attendance members. BAME met six times during 2021/22.

Joint committees

Emergency Ambulance Services Committee (EASC)

EASC was established in 2014 to be a Joint Committee of the seven health boards, with the three NHS trusts as associate members. It has responsibility for the planning and commissioning of emergency ambulance services on an all-Wales basis. Hosted by Cwm Taf Morgannwg University Health Board, the health board is represented on the Joint Committee by the chief executive and regular reports are received by the board supported by a more in-depth discussion, on an annual basis, at the board seminar meeting.

Welsh Health Specialised Services Committee (WHSSC)

WHSSC was established in 2010 by the seven health boards to ensure the population has fair and equal access to the full range of specialised services. Hosted by Cwm Taf Morgannwg University Health Board, Hywel Dda is represented on the Joint Committee by the chief executive and regular reports are received by the board supported by a more in-depth discussion, on an annual basis, at the board seminar meeting and a joint executive-to-executive team meeting.

Partnership and collective working

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, 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, Audit Wales (AW), as well as designated local authority overview and scrutiny committees.

West Wales Regional Partnership Board

Regional Partnership Boards (RPB), based on Local Health Board footprints, became a legislative requirement under Part 9 of the Social Services and Well-being (Wales) Act 2014 (SSWBWA). Their core remit is to promote and drive the transformation and integration of health and social care within their areas. We are fully committed to integrating health and social care planning through a co-ordinated approach, and across West Wales we have a strong track record of joint planning between agencies, and the approach set out by WG this year builds upon the foundations already in place. During the year, we have been working together to produce a regional Market Stability Report (MSR) and a refreshed Population Needs Assessment (PNA). Together, the PNA and MSR are key instruments in the integrated planning and delivery of health and care services for the region will help to shape our Joint Areas Plans.

Regionally, we have been working collectively on our transformation plan and the delivery of projects funded through the Integrated Care Fund. Any funding that became available was targeted at our improvement planning. The WG Urgent and Emergency Care Funding and the Regional Transformation Scaling Fund were all utilised to invest in our Regional Plan. The health board supports the co-ordination of winter planning through the RPB.

Through our joint working with partners in the RPB, we have a programme of activity that is aligned to the WG Transformation Fund and Integrated Care Funding, for which the health board acts as the banker. This work is reported to board regularly and overseen by an Integrated Executive Group of directors from health, local authority and the third sector. From 1 April 2022, the Health and Social Care Regional Integration Fund will build from the excellent work undertaken through the Transformation Fund and Integrated Care Fund and generate a true partnership approach to investing in integrated services for the long term.

A statutory partnership update report is received by the board at every meeting.

Update reports from the Advisory Groups, Joint Committees and Statutory Partnerships can be found on our website within the board papers section via the following link https://hduhb.nhs.wales/about-us/your-health-board/.

NHS Wales Shared Services Partnership Committee

NWSSPC was established in 2012 and is hosted by Velindre NHS Trust. It is responsible for the shared services functions for the NHS, such as procurement, recruitment and legal services. Hywel Dda is represented by the Executive Director of Finance at this committee with regular reports received by the board following each meeting.

Board development

From autumn 2021, a new phase of development of the board began with members coming together periodically to participate and to get to know each other at a deeper level given the recent addition of new members to the board. This phase of the programme will run until July 2022. The board has already received sessions by Professor Michael West on Compassionate and Collective Leadership, and Associate Professor Stacy Johnson on Reverse Mentorship Cultural Learning. Further sessions are planned on Behaviours, Systems and Governance with Baroness Rennie Fritchie, and on Incivility: Reflections and Next Steps with Dr Chris Turner.

Over the last 12 months, the board has been participating in a Reverse Mentoring Programme, with both Independent Members and Executives mentored by staff members. Staff mentors are of Black, Asian and Minority Ethnic backgrounds, are Generation Z and under 25, or from front line staff delivering key services. The purpose of the programme was to allow our leaders to connect with our staff on a deeper level, listen and understand their individual perceptions and experiences and take systemic action in response. An evaluation of the programme commenced, and initial feedback was very positive. This programme is

providing powerful learning for all members of the board in relation to culture and diversity issues, as well as great insights into the experiences of working in Hywel Dda by front line staff.

IM engagement visits with our staff recommenced as soon as COVID-19 restrictions were eased to better understand the pressures our staff continue to face on a daily basis, with formal patient safety visits started in April 2022.

The board has regular professional updates on key issues as part of its ongoing bi-monthly seminar series. In addition, both the Executives and Independent Members participate in Development Programmes, with the Executives focusing on enhancing relationship building, trust and team dynamics to create space for strategic through reflection on complex organisational changes.

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:

- Joint Escalation and Intervention Arrangements Status as the health board consolidated its de-escalation of 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;
- AW Review of Quality Governance Arrangements;
- IA Reports received throughout 2021/22, including reviews of Financial Planning, Monitoring and Reporting and the Annual Recovery Plan/Planning Objectives;
- Work to achieve compliance with the Health and Safety Executive Improvement Notices; and
- Current progress on work to address the Fire Enforcement Notices.

Following due consideration of the sources of assurances and supporting documentation, the Board were asked to consider an overall level of maturity in respect of governance and board effectiveness, based on the following criteria:

Level 1	Level 2	Level 3	Level 4	Level 5
We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve.	We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	We are developing plans and processes and can demonstrate progress with some of our key areas for improvement.	We have well developed plans and processes and can demonstrate sustainable improvement throughout the service.	We can demonstrate sustained good practice and innovation that is shared throughout the organisation and which others can learn from.

The board concluded it maturity rating for board effectiveness and governance was 'Level 4' at its Board Seminar in April 2022.

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 2022 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 in Appendix 1 of this statement.

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, corporate 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.

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, which has the role to embed the risk management framework and process, and to facilitate a risk aware culture across the organisation through a business partnering arrangement.

The health board is working with colleagues across NHS Wales to develop a consistent Training Needs Analysis and risk training modules that will align to the new Once for Wales System for Risk Management, which is likely to be implemented within the health board in the latter part of 2022/23.

During 2022/23, we will be reviewing our Risk Management Framework and Strategy to ensure they support the achievement of our strategic 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.

As part of Internal Audit Plan for 2021/22, IA undertook a review of our risk management arrangements and the development of the Board Assurance Framework. This provided

substantial assurance overall concluding that the Health Board has an effective risk management process in place, incorporating a robust Board Assurance Framework aligned to strategic objectives.

AW reported in their Review of Quality Governance Arrangements that while corporate structures and resources provide effective support for quality governance and improvement, inconsistencies in operational arrangements and weaknesses in operational risk management limit the provision of assurance to the Board. Work is now underway to address these findings which has included an executive led review of each operational directorate's risk registers and included the Head of Assurance and Risk. These risk reviews will be followed up during 2022/23 as part of an ongoing programme.

Risk appetite

The health board's 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 board's committees.

The health board's risk appetite will be reviewed in 2022/23, to ensure it remains aligned to the health board's new strategic objectives and its capacity to manage risk. This is particularly important as we move into recovery, and along our roadmap to financial balance, whilst at the same time, managing some significant external challenges, such as increasing utility costs.

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 hoard. 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.

Risks are identified in a bottom-up and top-down approach throughout the health board. Each corporate and operational 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.

Communicating and consulting with internal and external stakeholders and partners is an important part of the risk management process. The frequency of the communication will vary depending upon the severity of the risk and is discussed and agreed with the stakeholders and partners. For example, our risk related to the delivery of integrated community and acute unscheduled care services requires a whole system approach, and the health board has been working with its partners in WAST and local authorities to take forward work to try to improve flow within our hospitals.

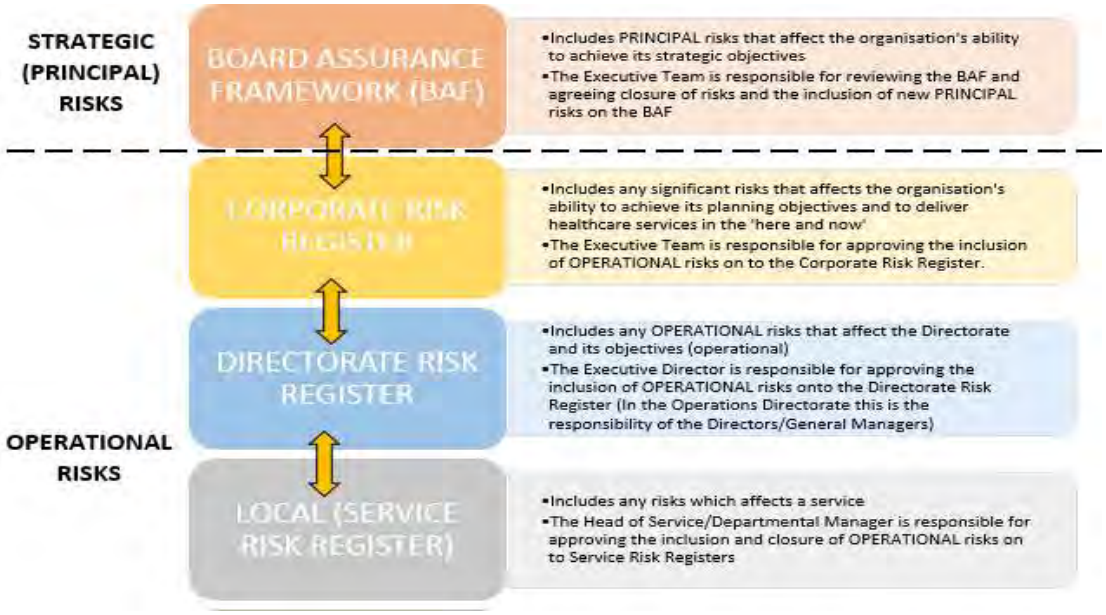
Engagement of stakeholders has also taken place through multi-agency partnership working. The Regional Partnership Board is part of the health board governance structure that helps to support the management of risk facing the organisation through collective dialogue.

In 2021/22, executive directors identified several principal risks, those that may affect the achievement of our strategic objectives, through a series of executive team workshops, before they were collectively agreed by the executive team. These principal risks now form part of our Board Assurance Framework (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.

Executive directors are also responsible for identifying significant operational risks for the Corporate Risk Register (CRR). These corporate risks can reflect new or emerging risks from

discussions or risks escalated by individual executive directors from their directorate to be collectively agreed by the executive team for entry onto the CRR.

This is how the CRR interacts with the principal risks on the BAF and the operational risks that are on Directorate and Service risk registers.



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.

Corporate and operational risks that are over the health board's agreed tolerance level, are aligned to the health board's committees, whose role it is to provide assurance to the board that risks are being managed appropriately.

The executive team review the BAF on a bi-monthly basis and hold a monthly risk session to review the CRR.

Risk profile

Delivering healthcare through the current clinical model in a large, rural geographical area presents significant quality, service, workforce, and financial challenges to the health board. The health and care system within Hywel Dda is facing intense challenges, which are being felt across Wales. A key challenge during 2021/22 and the winter period has been the significant uncertainty about how the COVID-19 pandemic would unfold. The emergence of the Omicron variant in early December 2021 led to unprecedented levels of community transmission. Our most significant operational risks are outlined in the CRR section below.

The health board's strategic and planning 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. The BAF section below outlines the risks and controls in place for achieving its objectives.

Board Assurance Framework (BAF)

During 2021/22, we refreshed our BAF to reflect the revised strategic and planning objectives and this was presented to every board since September 2021. The most recent BAF report can be accessed here and provides a link to our BAF Dashboard. AW identified the reinvigorated interactive BAF as a model of good practice in its Structured Assessment 2021. As well as identifying the principal risks to delivery of our objectives, the controls and assurances, the BAF also seeks to align outcomes against strategic objectives, and delivery against our planning objectives.

There are 17 principal risks that have been aligned to our six strategic objectives. The most significant risks to achieving our strategy are listed below:

- **Principal risk 1186 - attract, retain and develop staff with the right skills (risk score 20)**

  The health board's most significant challenge is to maintain the right number of people to be able to deliver safe, effective, and sustainable services. There is due to a number of factors, including geography, recognised national shortages in a number of professions and an aging workforce that mirrors our population. COVID-19 increased pressures on existing staff, not only during the response phase but also now as we try to deal with the resulting backlog, which has also led to an increasing number of retirements and reduction in hours within the older workforce. Becoming an employer of choice and attracting people to work for Hywel Dda is therefore fundamental to the achievement of our strategy.

  Our plans to address this risk includes implementing a flexible and responsive recruitment process that encourages local employment for local people, constructing a comprehensive workforce programme to encourage our local population into NHS and care related careers, implementing an informative and supportive induction process, having employee policies that support work-life balance and are person centred, having equitable access and agile approaches to training regardless of personal and professional circumstances, constructing a comprehensive talent, succession planning and leadership development programme, along with a robust workforce plan that will introduce new ways of working and new roles to mitigate against national skills shortage professions.

  Understanding our staff experience as we implement this work is essential. A baseline review was undertaken during the year which was reported in our second Discovery Report to understand more about staff experience so that approaches to rest, recovery and recuperation can be shaped over the next two years. Staff pulse engagement surveys

have also been introduced to sample 1,000 employees each month, selecting different staff each month.

- **Principal risk 1187 - strong enough reputation to attract people and partners (risk score 16)**

  This risk links with risk 1186 above and relates not only to having the right organisational culture to make Hywel Dda an attractive place to live and work, but also about staff having access to the latest equipment and state of the art facilities for training and work.

  In addition to the work that is taking place to improve the culture of the organisation, we have reviewed our capacity and capability for continuous engagement with the public in service planning and delivery, and to implement improvements over the next year. We need to develop a clinical education plan with the central aim to develop from within and attract from elsewhere, the very best clinicians. We are also working to implement a comprehensive approach to performance delivery and quality management that enables staff at all levels to strive for excellence whilst effectively delivering the basics.

- **Principal risk 1190 - capacity to engage and contribute to 'Improving Together' (risk score 16)**

  This risk also links to the above risks in that success breeds success, however responding to the pandemic impacted the ability of operational teams to engage in co-designing the implementation and developing sufficient organisational learning to move forward. Work has progressed in terms of developing outcome measures for the BAF and Integrated Performance Assurance Report (IPAR) measures have been mapped to each Planning Objective. Work is also progressing on Executive Performance Dashboards. The new team of OD relationship managers are developing the People Culture Plans Framework with staff side colleagues and will support connecting with the operational teams. Preliminary work on the Advanced Analytics Platform is underway which will establish real-time, integrated, easily accessible and comprehensible data to support our clinicians and managers with day-to-day operational delivery and planning, as well as supporting the shift of resources into primary and community settings.

- **Principal risk 1191 - wrong value set for best health and well-being (risk score 16)**

  This risk reflects the risk that our overall strategy may be limited by seeing health and well-being purely through the NHS lens, using incorrect measures, not effectively engaging with individuals and communities, and under and/or over-estimating potential for best health and well-being.

  Whilst the board does undertake engagement with its population it is still defining its approach to continuous engagement, its approach to tackling inequality/inequity, and its understanding of the social model of health and well-being and what this means to its local population and communities. Well-being assessments are being updated by the PSBs, however the board does not currently have an effective method of measuring the

well-being of individuals, communities, and the population. A number of plans and actions are currently in place to support mitigation of this risk, although not at population scale.

- **Principal risk 1198 - ability to support shifting of care in the community (risk score 16)**

  Achieving our strategic objectives will depend on the ability to overcome complex arrangements and systems. These will need be worked through to support a new approach to the delivery of care in line with our strategy, as well as a need to support the population in changing their behaviour and the way they have historically accessed services.

  Actions to address this risk is to develop a set of integrated locality plans with our local authority and third sector partners, develop and implement a comprehensive and sustainable 24/7 community and primary care unscheduled care service model, produce a final business case for the implementation of a new hospital in the south of the Hywel Dda area for the provision of urgent and planned care, and implement the remaining elements of the Transforming Mental Health Programme, the health board has also undertaken an assessment of all its Children and Young People Services and will implement a plan to address the findings. A five-year financial plan to breakeven has also been developed and shared across the organisation and key stakeholders for feedback and support.

- **Principal risk 1199 - achieving financial sustainability (risk score 16)**

  Achieving financial balance on a three-year rolling basis is a statutory requirement for the board, and a clear requirement from the board and WG. The health board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the health board's financial deficit has significantly deteriorated, significant workforce constraints remain, and the planning function remains small with significant opportunities to develop. These issues are exacerbated given the health board's financial deficit, with the need to not only shift resources to more appropriate settings, however, provide care at considerably lower cost.

  Actions being taken forward include development of a detailed three-year financial plan based on the finance team’s assessment of allocative and technical value improvements, income opportunities and third-party expenditure value-for-money that can be captured within that timeframe. Also, to review and refresh the assessment of technical and allocative value improvements and income opportunities open to the health board, construct a five-year financial plan that achieves financial balance and commands the support of the board and WG, implement a value based health care pathway costing programme for all clinical service within three years, undertake a full analysis of our supply chain and develop a plan to deliver £16m of recurrent savings.

Corporate Risk Register (CRR)

The health board's CRR contains significant operational risks to the delivery of health care in the here and now and is reported to every other board meeting. Each risk has been mapped to a board level committee to provide assurance to the board, through its update report, on the management of these risks.

During 2021/22, the CRR has been dynamic and responsive to new and emerging risks:

Total number of risks on CRR on 1 April 2021	22
New risks added during 2021/22	13
De-escalated/Closed during 2021/22	17
Total number of risks on CRR of 31 March 2022	**18**

The most significant risks during the year have included:

- **Corporate risk 1027 - delivery of integrated community and acute unscheduled care services (risk score 20)**

  Our ability to deliver our integrated community and acute unscheduled care services (risk 1027) fluctuated in-year as we responded to new waves of COVID-19 all against the backdrop of a significant and sustained staffing challenge. Increased hospital admissions were often compounded by an increase in infection outbreaks on wards which had a direct impact on acute care capacity which reduced our ability to admit and discharge patients within the system.

  For addressing our urgent and emergency care, our plan sets out a number of priorities to mitigate the level of pressures anticipated. These centred on an integrated 24/7 single point of contact model for urgent clinical assessment and streaming, so that patients access the right service at the right time in the right place. These included a 'Contact First'/Urgent Primary Care model in order to co-ordinate our urgent care response to the exacerbating health and care needs of our population and maintain people in their own homes and communities, a Clinical Streaming Hub, including Physician Streaming, Assessment and Triage (PTAS) of potential ambulance demand, Same Day Emergency Care (SDEC) models in acute and community settings, including comprehensive frailty assessment, and management of the frail elderly, including comprehensive geriatric assessment.

  In addition, our Winter Preparedness model tried to prevent the pressures crossing the threshold into our Emergency Departments, using the Enhanced Bridging Service (which we set up to provide social care), and the Delta Service, the conveyance avoidance and front door turnaround to minimise this occurrence.

- **Corporate risk 1297 - risk that the health board's underlying deficit will increase to level not addressed by additional medium term funding (risk score 20)**

  This risk replaced, in part, the previous corporate risk 1163 (Risk to the delivery of the health board's draft interim Financial Plan for 2021/22 of a £25.0m deficit). Issues have previously been raised over the ability of the health board to plan at a strategic and operational level. The health board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the health board's financial deficit has deteriorated and workforce constraints remain. The health board's Roadmap to Sustainability is largely predicated on a reduction to, or repurposing of, acute bed capacity; however, in the current climate of unprecedented pressures within unscheduled care and delivery of challenging recovery plans, the implementation of schemes to reduce the number of acute beds is exceptionally challenging.

  The medium-term 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. WG funding for the medium-term impact of the health board's response to COVID-19 and recovery has been confirmed, and there is currently a significant gap between the level of funding and expenditure trends and/or plans.

- **Corporate risk 1048 - risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22 (risk score 16)**

  The prevalence of COVID-19 increased during the winter months, and this had a further impact on in-patient pathways which led to a number of temporary ward closures across all sites associated with COVID-19 outbreaks and the impact of the wider urgent and emergency care pressures on the planned care patient pathway.

  Staffing resource, both in theatre, and post operatively, was a challenge before COVID-19, however the impact of increasing unscheduled care pressures during the autumn/winter period further reduced the available capacity to be dedicated to elective and surgical pathways. In January 2022, the health board approved the application of additional measures under the WG Local Choices Framework to reduce non-urgent elective outpatient and in-patient (IP) pathways to enable the further prioritisation of physical and staffing resources to support unscheduled care pathways. This was a temporary arrangement which was applied for two weeks, which resulted in the current risk score increasing to 20. Pathways that were affected have now been restored, reducing the current risk score back to 16.

  Non-urgent elective surgical pathways were also temporarily suspended across all sites with urgent/cancer IP surgery continuing at Prince Philip and Glangwili hospitals only. Elective operating has now recommenced at all four acute hospital sites with dedicated elective pathway beds provided at Prince Philip (orthopaedics and major cancer surgery),

Withybush (general surgical and gynaecology) and Bronglais (orthopaedics, general surgery and gynaecology) hospitals.

Outsourcing programmes were supported by recovery funding provided by WG although activity rates are limited by staffing challenges at a number of independent sector locations. The significant challenge across the urgent and emergency care system continues to impact upon planned care pathways.

- **Corporate risk 1032 -timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients (risk score 16)**

  This risk has reflected 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.

- **Corporate risk 1219 - insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19 (risk score 20)**

  Our risk relating to having insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19 (risk 1219) remained high all year reflecting our challenges to respond to new variants of COVID-19, as well as a lack of alignment of service, workforce and finance information on workforce requirements for unfunded service pathways could further jeopardise workforce availability in areas of need.

  Through the year, there have been monthly assessments of demand undertaken linked with service discussions in preparation for current demands and anticipated increased pressure in Winter. Several recruitment campaigns have been implemented, for areas such as the bridging service, vaccination service and TTP. Maximising use of temporary workforce availability including bank, overtime and agency by undertaking monthly assessment of resourcing pipeline and continuous review of bank Healthcare Support Workers (HCSW) recruitment. Work has also been undertaken to align funded establishment and unfunded posts to understand "workforce gap" across operational services. Continued engagement with HEIW and universities on medical, nursing, AHP/HCS and pharmacy programmes.

- **Corporate risk 684 - lack of agreed replacement programme for radiology equipment across the health board (risk score 16)**

This risk has been on the CRR since January 2019 and reflects the 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. 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-19 patients, which was an issue as requests for diagnostics for non-COVID-19 patients increased as essential services resumed.

Radiology is unable to increase its service provision to other clinical directorates due to limitations on current equipment, however the new demountable CT-scanner has provided much needed resilience at Glangwili Hospital. WG agreed funding for one new CT scanner and one new MRI scanner in 2021/22 (out of five scanners required). Commissioning of agreed equipment was delayed during COVID-19, however some equipment has been installed and is operational resulting in the risk being recently reduced to 16. In addition, controls and processes are in place to mitigate the risk e.g. service maintenance contracts, daily quality assurance checks, disaster recovery plan in place.

- **Corporate risk 813 - failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) (risk score 15)**

  There are a number of issues that the health board is working to address following a number of enforcement notices from Mid and West Wales Fire and Rescue Service (MWWFRS). One of these areas is the age, condition and scale of physical backlog, circa £20m (+), relating to fire safety (i.e. non-compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. Extensive fire safety improvement works are being undertaken at Withybush Hospital, Glangwili Hospital and at Bronglais Hospital from WG agreed funding, with phased timelines fully agreed with MWWFRS.

  A new system has been procured and will be implemented in 2022/23 to address the challenges of managing the actions within the current fire safety risk assessment system, and to enable complete transparency and ongoing management of actions assigned to responsible persons. Further training has also been developed for managers to improve the culture and ownership of fire safety across the health board.

  Delivery of face-to-face fire training stalled during COVID-19 however recent implementation of fire training over MS Teams has been used to improve level two fire training compliance, and this will be rolled out to other areas of fire training levels, such as Levels three, four and five.

A number of long-standing risks such as risk of delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery and the ability to meet the waiting times for the single cancer pathway were reviewed in light of the current context as we emerge from the pandemic. Our risk relating to cyber security was also reviewed following an external review and now reflects the current context and issues. These refreshed risks are outlined below:

- **Corporate risk 1340 - risk of avoidable harm for HDUHB patients requiring NSTEMI (non-ST segment elevation myocardial infarction) pathway care (risk score 16)**

  This risk replaced corporate risk 117 which related to the risk of delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery. The new risk is focused specifically on the NSTEMI pathway as NICE guidelines for Acute Coronary Syndromes (NG185) recommend 'coronary angiography (with follow-on PCI if indicated) within 72 hours of first admission (presentation) for people with unstable angina or NSTEMI who have an intermediate or higher risk of adverse cardiovascular events' (recommendation 1.1.6). In support of this target, the health board aims to identify and refer patients to Morriston Cardiac Centre for angiography within 24 hours of admission/presentation. For 2021 the median wait between admission/presentation and angiography for Hywel Dda patients was 213.5 hours (8.9 days) and the median time between admission/presentation and referral was 39.5 hours. For context, the 2021 position is a deterioration from that maintained in 2019 where the Prince Phillip Hospital Treat and Repatriate Service supported a median admission/ presentation to angiography wait of 120 hours (five days) - this service was suspended at the outset of COVID-19 due to Prince Phillip Hospital site pressures.

- **Corporate risk 1352 - risk of business disruption and delays in patient care due to a cyber-attack (risk score 16)**

  This risk replaced corporate risk 451 (cyber security breach) following an external assessment. There are daily threats to systems which are managed by Digital Health Care Wales and the health board. Cyber-attacks are becoming more prevalent, and previously hackers were not targeting health bodies, but the recent attack in Ireland, means that the possibility of an attack is ever present. A cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time.

  New actions include reviewing responsibilities for cyber security across the health board, training all Hywel Dda board members in cyber security including current threats to NHS Wales, carrying out a yearly table top exercise to practice the health board's response to a National Cyber Security Incident, implementing an Information Security Management System (i.e. ISO27001), conducting cyber security risk and vulnerability assessments of critical systems and supporting network infrastructure to capture and remediate risks to business continuity, as well as including cyber security (Secure by Design) in all maintenance, new digital and clinical initiatives and implementing a robust supply chain security process.

- **Corporate risk 1350 - risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre (risk score 12)**

  This risk replaced corporate risk 633 which related to the health board's ability to meet the 75% target for waiting times in 2020/21 for the new Single Cancer Pathway (SCP). The new risk reflects the current context and issues and the new ministerial measure in respect of the SCP, with new actions identified. The impact of COVID-19 increased the risk of the health board being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board in line with the infection control guidance that remain in place. The main area of concern is radiology. A decrease in capacity for appointments and results reporting within radiology, due to COVID-19 related sickness, current vacancies and planned annual leave within two of the four health board sites. Patients have been offered alternative appointments on other sites, however some patients have not agreed to attend and have requested an appointment close to home.

  There was a downward trajectory in cancer performance in quarter three during 2021/22. This was due to the increase in COVID-19 related sickness, management of COVID-19 related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short-term planned and unplanned step down of activity within outpatients and planned surgery. Performance since September 2021 has been steadily deteriorating and was reported at 53% in December 2021.

The heat map below presents the health board's corporate risks (by their internal reference number) in respect of their likelihood and impact as at the end of March 2022:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5		1016	813		
MAJOR 4			1307, 1350	684, 1032, 1048, 1219, 1296, 1337, 1340, 1352	1027, 1297
MODERATE 3				129, 1328 1335, 1342	
MINOR 2					
NEGLIGIBLE 1					

Further information on corporate risks in 2021/22 can be found in our board papers:

Corporate Risk Register Report at July 2021 Board Meeting in Public

Corporate Risk Register Report at November 2021 Board Meeting in Public

Corporate Risk Register Report at March 2022 Board Meeting in Public

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. The Major Incident Plan was activated in October 2021 in response to a major incident event in Pembrokeshire. Following the event, a debrief was held and lessons identified which have been built into major incident processes and the current review of the plan.

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. 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, a mixture of virtual and face to face training has been delivered over the last twelve months.

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 on page 18 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 several challenges to the organisation. A number of new and emerging risks where identified. Whilst the organisation did have a major incident and business continuity plan 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 Strategic Co-ordination Group.

The organisation continues 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.

The control framework

Quality governance arrangements

Providing high quality care is an inherently complex and fragile process, which needs to be underpinned by robust quality governance arrangements. A key purpose of these 'quality governance' arrangements is to monitor and where necessary improve standards of care.

Quality governance is led by the Executive Director of Nursing, Quality and Patient Experience. Our Quality, Safety and Experience Committee (QSEC) provides timely evidence-based advice to the board to assist it in discharging its functions and meeting its responsibilities with regards to quality and safety as well as providing assurance in relation to improving the experience of all those that come into contact with our services. Reports presented to QSEC in 2021/22 are listed in Appendix 2 with papers available on our website Quality, Safety and Experience Committee Meetings.

QSEC receive a regular assurance report which provides an overview of quality and safety across the health board. The health board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients. The report provides information on improvement work linked to themes within patient safety incident reporting, externally reported patient safety incidents, mortality review, and external inspections, for example Healthcare Inspectorate Wales (HIW).

QSEC is supported by two sub-committees. The Operational Quality, Safety and Experience Sub-Committee, which is responsible for monitoring the acute, mental health and learning disabilities services, primary and community services quality and safety governance arrangements at an operational level. The Listening and Learning Sub-Committee provides clinical teams across the health board with a forum to share and scrutinise learning from concerns arising from the following, 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.

The clinical executive directors hold weekly Quality and Safety Intelligence (Hot and Happening) meetings which consider significant issues which have arisen or that have the potential to impact on patient safety and identify any areas where immediate attention is required to protect safety of patients and staff. The clinical executive directors also continue to hold quality panels when required. Quality panels are the opportunity for the directors, directorate triumvirate teams and service management teams to explore quality governance issues. In 2021/22, the following Quality Panels have been held:

- Obstetrics and neonatal services
- Nosocomial COVID-19 – update on the progress of the health board reviews

- Theatres
- Primary care (General Practice)
- Health visiting
- Urology

During 2021/22, AW reviewed the Quality Governance arrangements at Hywel Dda, and found that whilst the health board is committed to providing safe, high-quality services and has aligned its strategy and plans with risk and quality improvement, there is an inconsistency between this strategic intent/ambition and operational delivery. The health board is committed to addressing these findings. An executive-led review of operational risk registers has been undertaken, and further reviews have been scheduled in 2022. A review of operational capacity has also commenced.

Quality Management System (QMS) Strategic Framework

The health board is developing a QMS Strategic Framework - the overarching formalised system that will achieve continuous improvement across the organisation. This will be delivered through 'Improving Together'. 'Improving Together' is the vehicle, which aligns the team vision to our strategic objectives and empowers teams to improve quality and performance across the organisation by setting key improvement measures aligned to their team vision. Visualisation of key data sets including improvement measures and regular team huddles help drive decision-making. The approach embraces coaching discussions and supports staff to develop solutions, embedding the principles of continuous improvement. The framework will offer a common approach to how we can adapt, adopt and spread good practice in a systematic way.

Health and Care Standards (HCS)

IA gave 'substantial' assurance in their review of the HCS in February 2021 confirming the maturity of the embedded HCS within the organisation's governance framework and 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.

During 2021/22, HIW undertook 10 pieces of assurance and inspection work in Hywel Dda. The work involved a variety of off-site checks and on-site work. There were five Quality Checks across acute, mental health and managed primary care services, and three on-site inspections in an acute and community hospital setting.

HIW also published two national reports which the health board was invited to respond to. These related to the national review of Welsh Ambulance Service NHS Trust during the summer of 2021 and the national review of mental health crisis prevention in the community, issued March 2022.

Clinical audit

The Clinical Audit programme in 2021/22 was intended 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. It has become clear that this has not been entirely possible due to the continuation of the pandemic and the impact of new variants. It is hoped that the next programme for 2022/23 will instead be able to focus on these areas.

The vast majority of National Clinical Audits and Outcome Review are still running in the health board although some clinical teams have struggled at various points to maintain full contribution. All projects continue to be assessed by the Clinical Audit Scrutiny Panel (CASP) who are liaising with services regarding improvement plans. The Clinical Audit Department will continue to work with the services to see these projects through to completion, many of which will likely carry over to 2022/23. The use of new technology in 2022/23 will help to make clinical audit resources and engagement more visible and accessible.

The Clinical Audit Department resumed its programme of Whole Hospital Audit meetings (WHAM) for 2021 in line with pre COVID-19 plans.

Mortality reviews

The Medical Examiner Service was fully established across the health board in 2021/22. A Clinical Lead for Mortality was appointed, with responsibility for supporting the development and delivery of effective processes and learning from mortality review, in line with all Wales Learning from Mortality Review Model Framework; and developing wider mortality accountability, scrutiny of all available mortality metrics and working with clinical directors and clinical leads to increase ownership and prioritisation of mortality across the health board.

Information governance (IG) arrangements

The health board has well established arrangements through 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 it is to support and drive the information governance (IG) agenda and provide the health board with the assurance that effective IG best practice procedures 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.

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 organisation has compliant IG practices are evidenced by:

- Quarterly reports to the IGSC, including key performance indicators;
- A detailed operational UK 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 the health board's 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 Personal Data breaches, including proactive reporting to the ICO;
- Regular monitoring of the health board's 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 health board; and
- All IG issues have been escalated through the People, Planning and Performance Assurance Committee (PPPAC) (until August 2021), and subsequently through Sustainable Resources Committee. The Committee papers can be viewed here: Sustainable Resources Committee and People, Planning and Performance Assurance Committee.

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.

The health board has undertaken a full review of its position against the Welsh Information Governance Toolkit and Caldicott Principles into Practice Assessment (CPIP). Both assessments demonstrate a good level of assurance of information governance risks.

Staff training numbers have steadily increased with the compliance at the end of March 2022 at 77.94%, a slight decrease from 78.79% over the past 12 months. This is attributed to the impact of the COVID-19 pandemic on the health board's workforce.

The health board continues to reinforce awareness of key principles of Data Protection legislation. This includes the overarching principle that users must only handle data in accordance with people's data protection rights.

Code of Corporate Governance

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 2022 against the main principles as they relate to an NHS public sector organisation in Wales. This assessment was informed by the AW Structured Assessment 2021: (Phase 2) Corporate Governance and Financial Management Arrangements, 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.

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 2021/22:

- 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 2022. This report is can be accessed in our ARAC papers here.

Health and safety

During 2021/22, the Health and Safety Executive confirmed that the health board had complied with all the extended Improvement Notices and recognised the very significant

improvement in the profile, understanding and leadership of health and safety management at senior level since their intervention in 2019.

Fire safety

The health board continues to address the five outstanding Enforcement Notices and 18 Letters of Fire Safety Matters issued by the Mid and West Wales Fire and Rescue Service (MWWFRS). Two additional Enforcement Notices have had all works completed, with the MWWFRS invited to inspect the completed work, by the end of March 2022. Extensive fire safety improvement works are being undertaken at Withybush Hospital, Glangwili Hospital and at Bronglais Hospital from WG agreed funding, with regular progress updates reported to the HSC, which provides assurance to the board on the work undertaken towards improving compliance.

Planning arrangements

In March 2020, the WG took the unprecedented decision to pause the IMTP and annual planning process to enable NHS Wales organisations to focus its attention on the immediate preparations for and response to the COVID-19 pandemic, advising that routine planning arrangements would be restarted at a more appropriate time.

Given the continuation of the pandemic, WG requested an Annual Plan for 2021/22, rather than an IMTP. In March 2021, the board approved its draft Annual Recovery Plan 2021/22, which set out to the organisation and WG the priorities for 2021/22. The full plan was submitted to June 2021 board for final approval and subsequently submitted to WG. The strategic objectives and planning objectives, approved by board in September 2020, formed 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.

Our plan recognised a planned deficit of £25m in the 2021/22 financial year and did not recover the cumulative deficit incurred to date (which was reset to 1 April 2020). As a result of this, we presented a budget which breached our statutory financial duty for the three-year period. 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.

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 been implemented sooner than envisaged, with digital enablement a prime example. This means that planning 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 2021/22, there have been unexpected opportunities presented to re-set, accelerate and expedite, where appropriate, the transformation of our services.

The health board wrote to WG in February 2022 to formally notify them through an accountability letter that, unfortunately, we would not be able to submit a financially balanced IMTP by 31 March 2022. Instead, it would be the board's intention to submit a draft Three-Year Plan 2022/25, with a robust and detailed focus on 2022/23 actions, which we intend will set the foundations for an IMTP to be submitted in the summer. This notification was based on the premise that the health board's underlying deficit has worsened over the last two financial years following the gaps in delivery of recurrent savings in 2020/21 and 2021/22 and, as such, there is currently insufficient assurance to allow the health board to propose an IMTP for the March 2022 submission.

We are committed to address these savings gaps and are in the process of constructing a clear core plan, focusing on recovery, which will allow us to get back on track with our financial roadmap. For 2022/23 this will be coupled with ensuring that the exceptional economic challenges we face next year are well described and assessed. A significant review of our COVID-19 response is already underway, aimed at restoring services or embedding beneficial changes that have been made over the last two years – establishing our new normal.

Value based health care approaches are being taken across the whole organisation, and it is our aspiration that a target operating model can be constructed to focus our delivery of services in the most optimum way for our patients, with this forming a critical part of our approach to the medium-term outlook and aligning with the design assumptions set out in our strategy and recent Programme Business Case.

Disclosure statements

Equality, diversity and inclusion

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.

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

- The board approved a revised Strategic Equality Plan and objectives for the period 2020/24. COVID-19 exacerbated inequalities for those with protected characteristics and

communities that are socio economically deprived so, in response we reviewed our plans outlining how we were going to meet those objectives;
- The requirements of the Socio-economic Duty which became law in 2021 were embedded into the health board's strategic decision making process;
- The Equality Impact Assessment (EqIA) process was reviewed, to incorporate the Socio-economic duty, and an EqIA training programme has been developed for staff.
- Equality and Human Rights training is mandatory for all staff;
- Progress in our work to advance equality and good relations is reported to WG, through the NHS Delivery Framework qualitative reporting process. Reports on work to address inequalities for specific groups are also periodically considered at Board Committees;
- A Strategic Equality Plan Annual Report is published annually, alongside a Workforce Equality Report and Gender Pay Gap Report.

This year, the health board received a Silver Award from Stonewall, the world's second-largest LGBTQ+ charity, in recognition of our commitment to the inclusion of lesbian, gay, bi, trans and queer people in the workplace.

Equality objectives

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 Well-being (Wales) Act 2014. For more information on the Strategic Equality Plan and objectives and progress outlined in the annual reports, visit https://hduhb.nhs.wales/about-us/governance-arrangements/equality-diversity-and-inclusion/equality-diversity-and-inclusion-documents/.

Examples of key highlights for 2021/22 include:

- The introduction of a Community Development Outreach Team, to engage with marginalised communities and those most affected by the COVID-19 pandemic, to be a trusted source of health promotion messages, increase the uptake of COVID-19 vaccines and remove barriers to accessing healthcare services;
- Provision of equality and diversity training for staff on a variety of topics, to give them the confidence and skills to challenge discrimination and create a fairer, more inclusive environment for all;
- Creation of a Black, Asian and Minority Ethnic Staff Network and re-launching the Enfys Network for LGBTQ+ staff and their allies;
- Undertaking 126 Equality Impact Assessments during 2021/22, including 8 associated with service change and 70 related to clinical 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 into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations. 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 about 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 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.

Environment, sustainability and carbon reduction

The health board has continued to improve performance in a number of key areas over the last year including carbon reduction, transport, waste, and energy despite the impact from the COVID-19 pandemic. Improved performance has been achieved through delivery of several energy efficiency/decarbonisation projects, maintenance of the Environmental Standard ISO14001, increased agile working, encouraging reuse and delivery of source segregated recycling schemes.

Additionally, in response to the publication of the 'All Wales NHS Decarbonisation Strategy' in March 2021, the health board has embedded this requirement within Planning Objective 6G and will work towards achieving this objective by developing and endorsing a strategic roadmap to respond to the WG ambition for NHS Wales to contribute towards a public sector wide net zero target by 2030.

The health board has commissioned the Carbon Trust to develop this strategic road map by the first quarter of 2022/23. The health board will set out a work programme and implement this plan to meet the targets established in the NHS Wales Decarbonisation Strategic Delivery Plan in the areas of carbon management, buildings, transport, procurement, estate planning and land use, and its approach to healthcare including promoting clinical sustainability. Where feasible, through the opportunities presented via the health board's transformation journey, it will look to exceed targets and establish best practice models and pilots, as exemplars for the NHS and wider public sector. In addition to the Decarbonisation Strategy, over the last year, the health board has also developed a Waste Strategy detailing the targets the health board will need to reach to meet legislative targets for waste management by 2030 and 2050. The overall aim of delivering on these strategies will be to reduce the health board's carbon footprint to support the wider public sector ambition to address the climate emergency and to embed the decarbonisation agenda and circular economy commitment across the organisation. In doing so, year on year performance in Environmental, Sustainability and Carbon reduction will improve.

From a climate change viewpoint, 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 four elements: flooding, severe winter weather, heatwave and drought. The arrangements cover elements such as risk, alerting mechanisms, multi-agency command and control structures, warning and informing and training/exercising.

In 2021, an extreme heat warning service was introduced to warn of the potential impacts of these higher temperatures helping people to make better decisions to stay safe. The warning is not threshold based and hence can consider forecast temperatures, the persistence of a hot spell, and information from partners regarding vulnerability of services to the heat etc when assessing whether a warning is required. This system is now being reflected in the Dyfed Powys LRF severe weather arrangements.

Data security

The health board has adopted and implemented a robust procedure for managing Personal Data Breaches across the organisation, that ensures incidents are reported in line with statutory requirements and lessons are learnt to improve future practice. The health board has had contact with the Information Commissioner's Office (ICO) in relation to 13 incidents during the year (self-reported by the health board). Nine incidents involved health board's medical records accessed by an unauthorised individual. Three incidents related to the health board's information being disclosed in error and one incident involved non-secure disposal (paper). Eleven incidents have been closed by the ICO with no further action required and two incidents are still being investigated by the ICO.

Throughout the pandemic, the scale of coordination and data management required for effectively implementing strategic plans to deal with the situation remained the same, and has relied on adopting digital technology and integrating it into the health board. Digital health technology can facilitate responses to the pandemic in ways that are difficult to achieve manually, however the health board has ensured that essential controls are maintained or quickly established to mitigate issues IG related risks.

Additionally, the Cyber Security Team continues to provide security architecture advice, ensuring designs follow security best practice and follow the requirements of the Network and Information Systems Regulations (NISR). The Cyber Security Team has also made progress with the tools and capabilities available to Hywel Dda. NISR is designed to protect critical national infrastructure against cyber-attacks. This regulation applies to all parts of the UK and EU and came into force in May 2018, alongside the GDPR/Data Protection Act. As part of NHS Wales, the health board is an Operator of Essential Services and has a legal obligation to comply with NISR.

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 ongoing 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. The Clinical Coding Development Plan has taken root and the health board is now regularly achieving 95% completion within one month of discharge.

Work continues to be undertaken to drive towards reducing the reliance on physical case notes and pushing the use of electronic documentation in line with the development of the Clinical Record Keeping Policy. This will further support the improvement of the clinical coding data and it's uses.

Ministerial Directions

The WG has issued a number of Non-Statutory Instruments during 2021/22. 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 directions issued have been fully considered by the Sustainable Resources Committee, on behalf of the board, and where appropriate, implemented (See Appendix 3).

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 we are aware of three individuals who have elected to join the 'Scheme Pays Scheme'. The scheme was extended to March 2022.

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 which can be found here.

Review of effectiveness

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:

- Feedback from WG and the specific statements issued by the Minister for Health and Social Services;
- Local Counter-Fraud and Post Payment Verification Activity;
- Inspections by Healthcare Inspectorate Wales;
- Delivery of audit plans and reports by external and internal auditors;
- Feedback from statutory Commissioners;
- Feedback from staff, patients, service users and members of the public;
- Assurance provided by ARAC and other committees of the board;
- AW Structured Assessment.

Internal Audit (IA)

IA provide me as Accountable Officer and the board through the Audit Committee 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 NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of

assurance available to the board in reviewing effectiveness and supporting our drive for continuous improvement.

The 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 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.

Throughout 2021/22, the Head of Internal Audit has met weekly with the board secretary and when required, the Director of Finance to discuss and consider any changes to the Internal Audit plan, either to accommodate fluctuations in operational demand or changing priorities.

Head of Internal Audit Opinion

As a result of responding to new variants of COVID-19, the IA programme has been subject to 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 Head of Internal Audit has concluded for 2021/22:

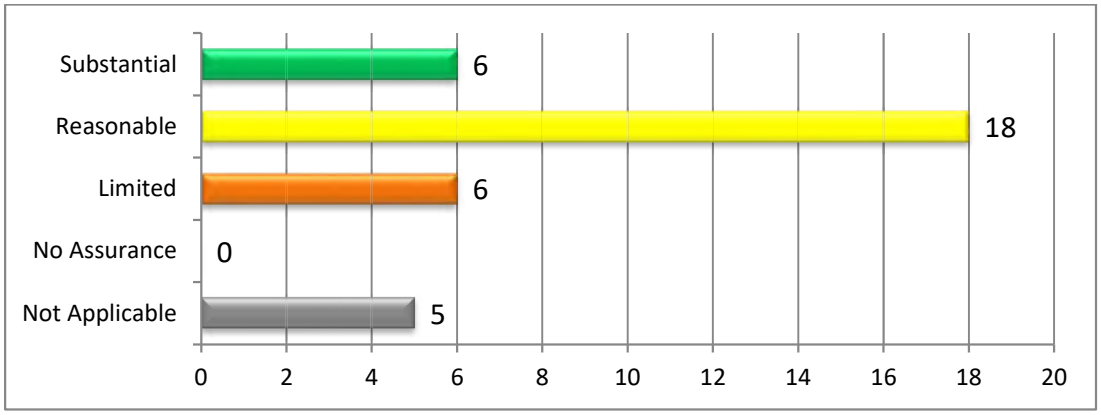
Reasonable assurance		The board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with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

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

During 2021/22, the health board has received positive audit opinions in a number of governance-related audits, including reviews on its Risk Management and Board Assurance Framework (Substantial), Financial Planning, Reporting and Monitoring (Reasonable), Performance Reporting and Monitoring (Substantial), Annual Recovery Plan/Planning Objectives (Reasonable), and Workforce Planning (Substantial). In addition to this, several Directorate Reviews were undertaken in Mental Health and Learning Disabilities, Women and

Children, Therapies and Health Sciences and Prince Philip Hospital which all provided Reasonable Assurance.

This opinion is based on the following opinions issued during the year:



Overall, IA have provided the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Summary of Audits 2021/22:

Substantial Assurance	Reasonable Assurance
• IT Back Ups • Workforce Planning • Performance Management & Reporting • NIS Directives • Organisational Values & Staff Well-being • Risk Management & Board Assurance Framework	• HTA Compliance • Single Tender Actions • Women & Child Health Directorate Governance • Medical Staff Recruitment • Waiting List Risk Management • Mental Health & Learning Disabilities Directorate Governance • Prince Phillip Hospital Directorate Governance • Planning Objectives and Recovery Plan • Therapies Directorate Governance • Financial Management & Reporting • IM&T Mental Health Patient Administration System (MH PAS) Follow up • Use of Consultancy Follow up • Waste Management • Primary Care Clusters

	• Women and Children Capital Scheme • Nurse Staffing Act • Partnership Governance Follow up • Infection Prevention & Control
Limited Assurance	**Advisory/Non-Opinion**
• Welsh Language Standards • Use of Consultancy • IM&T Mental Health Patient Administration System (MH PAS) • Tritech Governance • Non-Clinical Temporary Staffing • Prevention of Self Harm	• Field Hospital Decommissioning • Discharges • Records Management • Bank Staff Overpayment • Blackline Reconciliation Process
No Assurance	
N/A	

Whilst there were no audited areas that resulted in 'no assurance', the following audit reports were issued with a conclusion of limited assurance. Three of these requested by the health board. These areas have been included on the Internal Audit Plan for 2021/22:

- **Use of consultancy**

  This review highlighted one high priority matter relating to the absence of appropriate guidance setting out the definition of consultancy engagements and the impact this had on determining the appropriate level of approval required for the expenditure reviewed, along with three other medium priority recommendations. Other matters arising included incomplete evidence of progress monitoring/post completion reviews, absence of a central record and inaccurate financial coding of consultancy engagements, and that consultancy usage/spend is not collectively monitored or reported.

  The follow up review resulted in 'reasonable assurance' noting that action has been taken by management to address the findings, resulting in the high and one medium priority matters arising being addressed and now closed:

  - A 'Use of Consultancy' Financial Procedure has been developed setting out the circumstances, process and approval requirements for engaging external consultants. The procedure was approved by the Sustainable Resources Committee in October 2021;
  - The procedure requires an exit meeting with the consultant, to identify issues, lessons learnt, establish whether objectives were met and what did/not go well. Post Project Evaluation templates have been developed to facilitate this.

  Further action is required in relation to the two remaining medium priority matters arising.

- **Welsh Language Standards**

  This review identified several issues such as embedding the standards into the service plans of the organisation, the identification and recording of risks in relation to the standards and failure by some directorates to complete the self-assessment tool. Work has commenced regarding the strategic approach and ambition in terms of the Welsh language and this will be incorporated health board's three-year plan as a planning objective which can be measured. As some of the completion dates were not due until next year, this will be followed up as part of the 2022/23 Internal Audit plan.

- **Mental health patient administration system**

  This review looked at the arrangements in place for the implementation of the Welsh patient administration system in Mental Health and Learning Development and identified inadequate project management arrangements. Key matters arising concerned the lack of an internal business case, limited project planning, management and governance, inadequate resource made available to the project, both in number and skill-level, lessons learned not recorded throughout project lifecycle and post-implementation review not yet undertaken.

  The follow up, which resulted in 'reasonable assurance', recognised that considerable progress has been made in addressing the five matters arising from the previous internal audit, completed only two months ago. Management acted promptly to review and update project management documentation and strengthen governance arrangements. Agreed actions relating to four of the high priority recommendations have been addressed and closed, two are ongoing and not yet due for review and two have been partially implemented.

- **TriTech governance**

  This review was undertaken to evaluate and determine the adequacy of the systems and controls in place within the health board for governance arrangements for the TriTech Institute. Overall, the governance arrangements for the setup and establishment of the TriTech Institute have concluded 'limited assurance'. This was based on the lack of a board-approved business case and a lack of a clear financial structure.

  Whilst the lack of a board-approved business case impacts on many of the objectives within this review, IA provided assurance on the arrangements and actions that have been undertaken. IA also identified a number of matters arising that require refinement and further development. The report identified six matters arising, with two of these being high priority in respect of submission and approval of a business plan and the financial governance. This will be followed up as part of the 2022/23 Internal Audit plan.

- **Non-clinical agency**

  This review was undertaken to establish whether appropriate arrangements are in place for the appointment and monitoring of temporary staffing solutions. Two high priority matters have been identified relating to the procurement, identification and monitoring of non-clinical temporary staff. Accordingly, an overall rating of 'limited assurance' was concluded. This will be followed up as part of the 2022/23 Internal Audit plan.

- **Prevention of self-harm**

  This review was undertaken to establish whether there were robust arrangements in place for the prevention of self-harm following several improvement actions identified by Health Inspectorate Wales (HIW) to mitigate points of ligature risk within the health board.

  The arrangements in place for recording and monitoring HIW actions through to implementation were satisfactory, and no issues were identified with the arrangements for incident monitoring. However, a limited assurance rating was issued as IA identified three high priority matters requiring immediate attention relating to the arrangements for ligature audits, specifically:

  - the absence of sufficient, consistent processes in place for the completion of ligature audits, resulting in a lack of clarity regarding the audit requirements for community and learning disability residential sites, and use of a very basic inadequate template to undertake the audits;
  - whilst audits had been completed for most mental health inpatient sites during 2021, in some cases it was clear that they had not been completed annually; and
  - failure to clearly identify, monitor and implement improvement actions to address issues arising in the ligature audits.

This will be followed up as part of the 2022/23 Internal Audit plan.

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. The following audits were deferred.

Review Title	Objective
Quality & Safety Governance Framework	Deferred due to operational service pressures as a result of the pandemic.
Restart of Elective Work /Planned Recovery	Deferred due to operational service pressures as a result of the pandemic.
Clinical Audit	Deferred due to operational service pressures as a result of the pandemic.
Public Health	Deferred due to operational service pressures as a result of the pandemic.
Continuing Health Care	Deferred due to operational service pressures as a result of the pandemic
IT Infrastructure	Operational service pressures as a result of the pandemic impacted on timescales for infrastructure update.
Commissioning	Deferred due to operational service pressures as a result of the pandemic.
Consultants Job Planning	Deferred due to operational service pressures as a result of the pandemic.
Decarbonisation	Deferred based on changes to national deadlines and requirements.
Falls	Deferred due to operational service pressures as a result of the pandemic.

Audit Wales (AW) structured assessment

The AW Structured Assessment is a process that looks at whether the health board has made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. In 2021, AW undertook the structured assessment process in two phases.

Phase one considered the health board's operational planning arrangements and how these are helping to lay the foundations for effective recovery. AW overall assessment was that 'the health board's arrangements for developing operational plans are generally effective although it does not have the processes necessary to monitor and review progress in delivering its priorities'. This resulted in four recommendations that the health board is working to implement relating to alignment of plans, planning capacity, performance tracking and monitoring and reporting. The full report can be accessed on the AW website here.

Phase two considered how corporate governance and financial management arrangements adapted over the last 12 months. The key focus of the work has been on the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, and considered how business deferred in 2020 has been reinstated and how learning from the pandemic is shaping future arrangements for ensuring good governance and delivering value for money.

AW found through their Phase Two work that 'the health board has effective board and committee arrangements committed to high quality services and staff well-being and has well-developed plans that are now routinely monitored. A number of innovative approaches have been adopted to aid scrutiny and assurance, and although operational arrangements for risk and quality governance have posed some risks, improvement action is now underway'.

AW noted that the board continues to conduct business in an open and transparent way and has maintained good governance arrangements which have been adapted when needed. Other key messages in the report included:

- The health board has well developed plans for continuing its response to COVID-19 and to reset and recover services, whilst also laying the foundations to deliver its longer-term strategic intent;
- Partnerships are working well and there has been good engagement with the public.
- Availability of additional capacity is presenting risks to the health board, but there are now good mechanisms in place to monitor and scrutinise delivery of its plans;
- The health board is committed to delivering high quality services and supporting staff well-being;
- An innovative approach to enable effective scrutiny of strategic risks and outcomes is in place through the interactive Board Assurance Framework and performance dashboard;
- The health board has a well-managed approach to monitoring the implementation of audit and review recommendations;
- Operational risk and quality governance arrangements have posed a risk to receiving the required levels of assurance, but work is now underway to address these.

In respect of managing its financial resources, AW found that 'the health board continues to face significant financial challenges, it has maintained appropriate financial controls and monitoring and reporting is robust. The health board is working hard to achieve financial recovery but is managing a number of risks and delivery is being hindered by operational capacity to develop recurring saving schemes'. Key messages in the report included:

- The health board was unable to meet its financial duties for 2020-21, ending the year with a deficit of £24.9 million;
- The health board is on track to deliver its financial plan for 2021-22 but is managing a number of risks which could have consequences for future years, and it will continue to fail to meet its financial duties due to a planned year-end deficit;

- The health board has robust arrangements in place for monitoring and scrutinising its financial position, supported by comprehensive and transparent reporting.

It was the second consecutive year that the health board has not received any recommendations in respect to its corporate governance and financial management arrangements. The full report can be accessed in the ARAC papers here. This report alluded to the review of quality governance arrangements at Hywel Dda, which did identify that several recommendations be addressed in respect of the effectiveness of quality and safety sub-groups, operational leadership, operational risk registers and operational risk management.

AW also undertook a number of national reports on national programmes that were established in response to COVID-19, among these was their review 'Taking Care of the Carers? How NHS bodies supported staff well-being during the COVID-19 pandemic' which provided a number of recommendations for NHS bodies across Wales that included organisations retaining a strong focus on staff well-being, considering workforce issues in recovery plans, evaluating the effectiveness and impact of the staff well-being offer, enhancing collaborative approaches to supporting staff well-being, providing continued assurance to boards and committees on staff well-being, building on local and national staff engagement arrangements, evaluating the national staff well-being offer and the all-Wales COVID-19 Workforce Risk Assessment Tool. The organisation has taken forward a number of staff well-being initiatives during the year which are outlined in the Performance Report.

Conclusion

At the time of preparing this Governance Statement, the pandemic continues to have an impact on service delivery. 2021/22 has been our most challenging year to date, as we have continued to respond to the pandemic, deal with the backlog of patients that has prevailed, whilst keeping one eye firmly on the future. Whilst we anticipate that COVID-19 will be with us for the foreseeable future, we are looking to respond to the legacy of the pandemic and return as much as possible to 'business as normal'.

As Accountable Officer, based on the review process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. Taking into account the evidence detailed in this Statement, together with feedback from WG regarding our current escalation status of 'Enhanced Monitoring', from AW via their Structured Assessment and from Internal Audit's assurance assessment, I have concluded that overall, the health board's systems of internal control have not been materially affected and am assured that our internal control and governance systems have operated satisfactorily during 2021/22.

It has been encouraging that we have remained at 'enhanced monitoring' status particularly as the health board's underlying deficit has worsened over the last two financial years following the gaps in delivery of recurrent savings in 2020/21 and 2021/22. We are committed to reducing our status to 'routine monitoring' by addressing this challenge and are in the

process of constructing a clear core plan, focusing on recovery, and will allow us to get back on track with our financial roadmap. For 2022/23 this will be coupled with ensuring that the exceptional economic challenges we face next year are well described and assessed.

A significant review of our COVID-19 response is already underway, which will be transitioned into the new normal through our plans. Value based health care approaches are being taken across the whole organisation. It is our aspiration that a target operating model can be constructed to focus our delivery of services in the most optimum way for our patients and population, with this forming a critical part of our approach to the medium-term outlook. This will align with the design assumptions set out in our strategy and Programme Business Case. The health board aims to submit an IMTP to WG in July 2022 that will reconcile the need for a balanced IMTP against the health board's deficit and the ongoing focus on the recovery of our services.

For the second consecutive year, AW have provided positive feedback on our corporate arrangements for ensuring that resources are used efficiently, effectively, and economically during 2021, with no recommendations made regarding our corporate and financial governance arrangements. AW reported that that we have effective board and committee arrangements and have a number of innovative approaches to aid scrutiny and assurance, in fact commending us on our new interactive Board Assurance Framework and performance dashboard. The full report can be accessed on the AW website here. We are however fully cognisant of the need to build on this excellent work and strengthen our operational governance through the next year.

AW also reported that the health board continues to face significant financial challenges, it has maintained appropriate financial controls and monitoring, and reporting is robust. Gaining financial sustainability is a key ambition for the health board.

During 2021/22, we have proactively identified areas requiring improvement and requested IA undertake targeted reviews to improve our internal control. As expected, these have identified areas of improvement that will be addressed by management action. IA's focus on our governance arrangements included reviews into our financial planning, reporting and monitoring arrangements, our Annual Recovery Plan, performance reporting and monitoring and our risk management arrangements which have provided the board with both substantial and reasonable assurance in these areas.

Despite still being in a pandemic, we have now complied with all the Improvement Notices issued by the HSE and continue to address the Fire Enforcement Notices issued by MWWFRS.

As a board, we have continued to deliver against our strategic objectives and have made substantial developments over the last year. These have included the development of our Board Assurance Framework, the submission of our Programme Business case to WG, opening of the Special Care Baby Unit at Glangwili Hospital, the introduction of our Enhanced Bridging Service, the development of our decarbonisation agenda and the extension of our

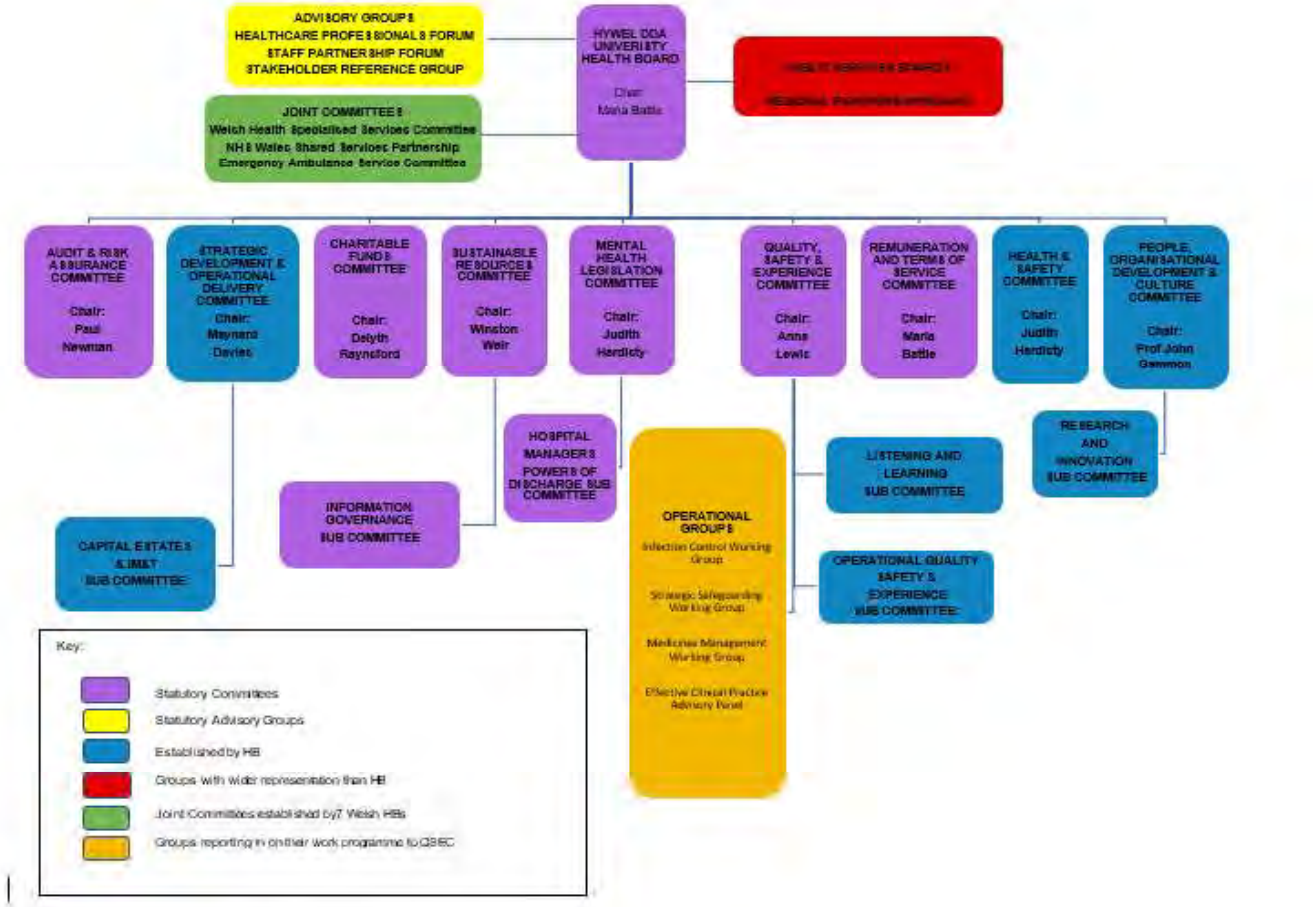
work around Value Based Healthcare and the Foundational Economy. During 2022/23, the health board will build upon the work started in 2021/22 around our planning objectives and has developed and re-designed these objectives to move us towards the future we set out in our long-term health and care strategy, 'A Healthier Mid and West Wales'.

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 to new and unprecedented risks. The need to respond and recover from the pandemic will be with the organisation and wider society for the foreseeable future. I will ensure our Governance Framework continues to consider and respond to this need.

Signed by: **Date:**

Steve Moore,
Chief Executive Officer

Appendix 1 – Board and Committee structure



Appendix 2 – A summary of key items considered by committees in 2021/22

Audit and Risk Assurance Committee (ARAC)

The role of the Audit Committee is to advise and assure the board, and the Accountable Officer, on whether effective arrangements are in place to support them in their decision taking and in discharging their accountabilities in accordance with the standards of good governance determined for the NHS in Wales. Items considered:

- IA Plans were submitted to each meeting providing details relating to outcomes, key findings and conclusions
- AW reports on current and planned audits
- Internal & External Audit Tracking Reports
- Post Payment Verification Reports
- Counter Fraud Reports
- Annual Accounts, Accountability and Remuneration Reports for 2020/21
- Financial Assurance Reports including single tender actions, special losses and payments
- Audit, Inspectorate and Regulator Tracker Reports
- Clinical Audit Reports
- Board Committee Assurance Reports
- Declarations of Interest Report
- Capital Governance Arrangements Internal Review

Charitable Funds Committee (CFC)

The CFC is charged with providing assurance to the Board in its role as corporate trustees of the charitable funds (CF) 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. Items considered:

- CF Sub Committee Update Reports
- CF Risk Reports
- CF Stories
- Approval of CF Expenditure and Decisions made through Chair's Action
- Charities performance Reports
- CF Annual Accounts Reports for 2020/21
- Planning Objective Update Reports

Health and Safety Committee (HSC)

The HSC provides assurance on 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. It also provides assurance on the health board's Emergency Management Plan. Items considered:

- HSE Enforcement
- Health and Safety legislation and audits
- Lifting Operations and Lifting Equipment (LOLER)
- Fire Enforcement
- Fire safety governance
- PREVENT and CONTEST
- Health and safety related risks and performance
- Policies for approval
- Planning Objective Update Reports

Mental Health Legislation Committee (MHLC)

The MHLC 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 MHLC 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. Items considered:

- Staff Story
- Specialist Child and Adolescent Mental Health Services (SCAMHS) admission and pathway
- Mental Health Act Quarterly Reports
- Health Board Response to Department of Health Consultation and Review of the Mental Health Act
- Section 117 Register
- Policies for approval
- Mental Health Review Tribunal (for Wales): use of video conference
- Risk Report
- Healthcare Inspectorate Wales visits to Mental Health and Learning Disabilities Facilities
- Updates from Power of Discharge Sub-Committee

People, Organisational Development and Culture Committee (PODCC)

PODCC was established to replace the 'People' element of the previous People, Planning and Performance Assurance Committee, to receive an assurance on all relevant planning objectives falling in the main under Strategic Objective 1 (Putting people at the heart of everything we do), 2 (Working together to be the best we can be), and 3 (Striving to deliver and develop excellent services). The committee has a focus on education and development of staff, recruitment, retention and talent management, becoming an employer of choice, performance and quality management systems, business intelligence capabilities and improvement training, patient experience, engagement and empowerment, workforce related policies, diversity and inclusion, carers support, regulatory and professional bodies compliance, arrangements to support ongoing transformation and board assurance framework development and research, development and innovation planning/deliver. Items considered:

- Staff Story
- NHS Wales Staff Survey, Nursing Climate Survey and Medical Engagement Scale Survey Outcomes Reports
- Speciality and Associate Specialist Contract Reform Implementation
- Welsh Language Standards Report
- Strategic Equality Plan Annual Report
- Performance Appraisal Development Review Performance Report
- Domiciliary Care Provision Report
- Staff Experience Discovery Report
- Bilingual Skills Policy Compliance
- Black, Asian and Minority Ethnic Advisory Group Update Reports
- Carers Report
- Making a Difference – Customer Service Programme
- Nursing and Midwifery Strategic Framework
- Workforce Dashboard and Performance Reports
- Contractual and legislative changes
- Policies for approval
- Risk Reports
- Planning Objective Update Reports

Quality and Safety Experience Committee (QSEC)

The QSEC is responsible for providing evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities about 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. Items considered:

- Maternity Services
- Nurse Staffing Levels (Wales) Act 2016 Reports
- Quality and Safety Assurance Reports
- Improving Together Report
- Children and Young People Plan for Delivery Report
- Health Board Response to the National Audit of Care at the End of Life (NACEL)
- Accessing Emergency Specialist Spinal Services Report
- Waiting List support Programme Report
- Winter Planning: Managing Urgent and Emergency Care and Quality and Safety Risks Reports
- Cardiac Surgery: Get it Right First Time Review
- Quality Management System Approach Report
- Nursing Assurance Annual Audit 2021 Report
- Clinical Audit Reports
- COVID-19 Update Reports
- Commissioned Services Assurance and Commissioning for Quality Reports
- Stroke Services Nurse Staffing Requirements Report
- Paediatric Services Report
- Long COVID-19 Patient Pathway Report
- AW Review of Quality Governance Arrangements
- National Screening Programmes Report
- Listening and Learning Sub-Committee Update Reports
- Research and Innovation Sub-Committee Update Reports
- Infection Prevention Strategic Steering Group Update Reports
- Strategic Safeguarding Working Group Update Reports
- Effective Clinical Practice Advisory Panel Update Reports
- Medicines Management Optimisation Group Update Reports
- Risk Reports and Deep Dive Reports into Cancer, Stroke, Nosocomial COVID-19 Review, Urgent Primary Care Out of Hours Service, MHLD Waiting Lists, Paediatrics, Radiology, Epilepsy and Neurology, Llwynhendy Tuberculosis, Cardiac Waiting Lists
- Policies for approval
- Planning Objectives Update Reports

Strategy Development and Organisational Delivery Committee (SDODC)

SDODC was established to replace the 'Planning' and 'Performance' elements of the previous People, Planning and Performance Assurance Committee, to receive an assurance on all relevant planning objectives falling in the main under Strategic Objective 4 (The best health and well-being for our individuals, families and our communities) and Strategic Objective 5 (Safe, sustainable, accessible and kind care). The Committee has a focus on

NHS Delivery Framework requirements, public health, health inequalities and screening services, Transformation Fund, Delivery of the "A Healthier Mid and West Wales" and Bronglais Hospital plan, Transforming MH and Transforming LD plan, integrated locality plans, children's and young people plan, out-of-hours care, national clinical audits compliance, fragile services plans, care home/domiciliary care market support and development. Items considered:

- Integrated Performance Assurance Reports
- Planned Care Recovery Reports
- Developing the IMTP 2022/23 -2024/25 Reports
- A Healthier Mid and West Wales Programme Business Case Reports
- Stroke Services Redesign Report
- Palliative Care Strategy
- Dementia Strategy
- Regional Partnership Board (RPB) Population Assessment (SSWBA)
- Public Service Boards Well-Being Assessment (WBFGA)
- RPB Market Stability Report
- ARCH Update Reports
- Influenza Season 2021/22 Report
- Winter Plan 2021/22
- Fire Enforcement Business Justification Case for GGH
- Pharmaceutical Needs Assessment Report
- Women and Children Phase 2 Project Update Report
- Contact First/Urgent Primary Care Update Report
- Domiciliary Care Provision Report
- Pentre Awel Update Reports
- Transformation Fund/Plan Report
- Carmarthen Hwb Plan Report
- Discretionary Capital Programme and Capital Governance Update Reports
- Capital, Estates and IM&T Sub-Committee Update Reports
- Risk Reports
- Policies for approval
- Quarterly Annual Plan Monitoring Reports
- Planning Objectives Update Reports

Sustainable Resources Committee (SRC)

SRC was established to replace the previous Finance Committee, to receive an assurance on all relevant planning objectives falling in the main under Strategic Objective 6 (Sustainable use of resources), with a focus on financial plans and delivery of the Route Map to financial recovery, improving value, PROMS/FROMS roll out and impact, carbon reduction and green

health initiatives, foundational economy work, national IT programmes delivery, and budget setting. Items considered:

- Financial Performance and Forecast Reports
- Capital Financial Management Reports
- Financial Outlook 2021/22
- Risks to delivery of the Financial Plan for 2021/22
- Savings Plan 2021/22
- Monthly Monitoring Returns and Commentary Reports
- Draft Annual Accounts 2020/21
- Year End Debrief
- Balance Sheet Analysis Reports
- Opportunities and Savings Plan 2021/22
- Financial Mid and Long Term Planning Reports
- Accountable Officer Letter Report
- Programme Business Case Costings
- Healthcare Contracting Reports
- SMART Medical Equipment investment Report
- Investment in Clinical Equipment Report
- Strategy for Social Value Impact
- Schedule of Costs and Decisions – Field Hospitals
- Value Based Health and Care Update Reports
- Digitalisation of Health Records Interim Business Case
- New Oracle System
- Long Term Agreements – Contract Values, Approach and Development 2021/22
- Strategic and Operational Business Intelligence Report
- Business Case Approval Flowchart
- Social Value and Decarbonisation Reports
- Digital Inclusion
- Cyber Security Report
- Extension of Lightfoot Solutions
- Use of Consultancies Report
- County Resource Allocation and Consumption
- COVID-19 Fixed Term Contract Staff Report
- NWSSP Performance Quarterly Reports
- Commissioning Group Update Report
- Agile Digital Business Group Update Report
- Information Governance Sub-Committee Update Report
- Financial Procedures for approval
- Integrated Performance Assurance Reports
- Ministerial Directions Reports

- Risk Reports
- Planning Objective Update Reports

Appendix 3 – Ministerial Directions

Ministerial Directions (MDs)	Date/Year of Adoption	Action to demonstrate implementation/response
2021. No.15 - The National Health Service (Cross-Border Healthcare) (Wales) (Amendment) Directions 2021	April 2021	This Ministerial Direction has been enacted.
2021. No.41 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2021	April 2021	This Ministerial Direction has been enacted.
2021. No.59 – The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	July 2021	This Direction is currently being implemented. There is an Integrated Autism Service (IAS) established which is an integrated health and social care service, and a dedicated Neurodevelopmental Disorder(ASD) service for children and young people. The Regional Partnership Board has also established a Strategic Autism Group.
2021. No.65 – The Primary Care (PfizerBioNTech Vaccine COVID-19 Immunisation Scheme) Directions 2021	July 2021	This Ministerial Direction has been enacted.
2021. No.70 – The Primary Care (Contracted Services: Immunisations) Directions 2021	August 2021	This Ministerial Direction has been enacted.
2021. No.75 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2021	September 2021	This Ministerial Direction has been enacted.
2021. No.77 – The National Health Service (General Medical Services – Recurring Premises Costs during the COVID-19 Pandemic) (Wales) (Revocation) Directions 2021	September 2021	This Ministerial Direction has been enacted.
2021. No.83 – The Pharmaceutical Services (Fees for Applications) (Wales) Directions 2021	October 2021	This Ministerial Direction has been enacted.

2021. No.84 – The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2021	October 2021	This Ministerial Direction has been enacted.
2021. No.85 – The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2021	October 2021	This Ministerial Direction has been enacted.
2021. No.88 – The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2021	October 2021	This Ministerial Direction has been enacted.
2021. No.89 – The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2021	October 2021	This Ministerial Direction has been enacted.
2021. No.90 – The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) (Wales) (No. 2) (Amendment) Directions 2021	November 2021	Framework exists should Primary Care contractors intend to deliver the vaccine.
2021. No.93 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2021	December 2021	This Ministerial Direction has been enacted.
2021. No.97 – The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2021	December 2021	Framework exists should Primary Care contractors intend to deliver the vaccine.
2022. No.06 – The Pharmaceutical Services (Clinical Services) (Wales) Directions 2022	March 2022	This Ministerial Direction has been enacted.
2022. No.13 – The Wales Infected Blood Support Scheme (Amendment) Directions 2022	March 2022	N/A- for action by Velindre University NHS Trust.

Part 2 - Remuneration and Staff Report

Remuneration Report

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.

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 health board's honours submission recommendations.

The membership of the RTSC Committee during 2021/22 was as follows:

Name	Position	Role on 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, Organisational Development and Culture Committee (PODCC)	Member
Anna Lewis	Independent Member and Chair of Quality, Safety and Experience Assurance Committee (QSEC)	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 can 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 2021/22 year, no termination payments were made.

Service contract details for senior managers

Name	Position	Date of Contract	Date of Expiration	Compensation for early termination
Steve Moore	Chief Executive Officer	05/01/2015	N/A	N/A
Lisa Gostling	Executive Director of Workforce and Organisational Development	09/01/2015	N/A	N/A
Phil Kloer	Executive Medical Director/Deputy Chief Executive	25/06/2015	N/A	N/A
Mandy Rayani	Executive Director of Nursing, Quality and Patient Experience	19/06/2017	N/A	N/A
Ros Jervis	Executive Director of Public Health	17/07/2017	01/04/2022	N/A
Alison Shakeshaft	Executive Director of Therapies and Health Science	01/01/2018	N/A	N/A
Huw Thomas	Executive Director of Finance	10/12/2018	N/A	N/A
Andrew Carruthers	Executive Director of Operations	01/12/2019	N/A	N/A
Lee Davies	Executive Director of Strategic Development and Operational Planning	26/04/2021	N/A	N/A
Joanne Wilson	Board Secretary	01/01/2018	N/A	N/A

Jill Paterson	Director of Primary Care, Community & Long Term Care	19/01/2018	N/A	N/A

Changes to Board membership in 2021/22

During 2021/22, there were the following changes to Board membership:

- Winston Weir, Independent Member (Finance) commenced duties on 1 April 2021
- Cllr Gareth John, Independent Member (Local Authority) commenced duties on 1 April 2021
- Iwan Thomas, Independent Member (Third Sector) commenced duties on 1 May 2021
- Lee Davies, Executive Director of Strategic Development and Operational Planning, 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.

2021/22

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration (£000)	Total (Bands of £5k)
Executive Members and Directors						
Steve Moore, Chief Executive Officer	200 - 205	0	0	80-85	0	280 - 285
Mandy Rayani, Executive Director	135 - 140	0	0	55-60	0	195 - 200

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration (£000)	Total (Bands of £5k)
of Nursing, Quality and Patient Experience						
Lee Davies, Executive Director of Strategic Development and Operational Planning (from 26/04/21) *	115 - 120	0	0	101-105	0	215 -220
Lisa Gostling, Executive Director of Workforce and Organisational Development	135 - 140	0	0	55-60	0	190 - 195
Phil Kloer, Executive Medical Director/ Deputy Chief Executive	180 - 185	0	0	60-65	0	240 - 245
Andrew Carruthers, Executive Director of Operations **	145 - 150	0	0	45-50	0	195 - 200
Alison Shakeshaft, Executive Director of Therapies and Health Science	120 - 125	0	0	50-55	0	175 - 180
Ros Jervis, Executive Director of Public Health	120 - 125	0	0	40-45	0	160 - 165
Huw Thomas, Executive Director of Finance	145 - 150	0	0	85-90	0	230 -235
Jill Paterson, Director of	125 - 130	0	8200	40-45	0	175 - 180

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration (£000)	Total (Bands of £5k)
Primary, Community and Long Term Care						
Joanne Wilson, Board Secretary	105 - 110	0	0	60-65	0	170 - 175
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
Professor John Gammon	10 - 15	0	0	0	0	10 - 15
Paul Newman	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 (to 30/04/21)	0 - 5	0	0	0	0	0 - 5
Maynard Davies	10 - 15	0	0	0	0	10 - 15
Ann Murphy	5 - 10	0	0	0	0	5 - 10
Cllr Gareth John (from 01/04/21)	10 - 15	0	0	0	0	10 - 15
Iwan Thomas (from 01/05/21)	10 - 15	0	0	0	0	10 - 15
Winston Weir (from 01/04/21)	10 - 15	0	0	0	0	10- 15

* Lee Davies full year salary £123k

** Andrew Carruthers salary includes £8k paid for relocation expenses

2020/21

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration ** (£000)	Total (Bands of £5k)
Executive Members and Directors						
Steve Moore, Chief Executive Officer	195 - 200	0	0	10-15	0	205 - 210
Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience	130 - 135	0	0	20-25	0	155 - 160
Karen Miles, Executive Director of Planning, Performance and Commissioning (to 11/10/20)	80 - 85	0	0	0	167	250 -255
Lisa Gostling, Executive Director of Workforce and Organisational Development	130 - 135	0	0	50-55	0	180 - 185
Phil Kloer, Executive Medical Director/ Deputy Chief Executive	175 - 180	0	0	50-55	0	225 - 230
Andrew Carruthers, Executive Director of Operations	130 - 135	0	0	60-65	0	195 - 200
Alison Shakeshaft, Executive Director of Therapies and Health Science	115 - 120	0	0	55-60	0	170 - 175

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration ** (£000)	Total (Bands of £5k)
Ros Jervis, Executive Director of Public Health	115 - 120	0	0	30-35	0	145 - 150
Huw Thomas, Executive Director of Finance	135 - 140	0	0	5-10	0	140 -145
Jill Paterson, Director of Primary, Community and Long Term Care	120 - 125	0	8200	25-30	0	155 - 160
Sarah Jennings, Director of Partnerships and Corporate Services (to 04/09/20)	45 - 50	0	0	0-5	0	50 - 55
Joanne Wilson, Board Secretary	105 - 110	0	0	25-30	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

Name and title	Salary (Bands of £5k)	Bonus payments (Bands of £2.5k)	Benefits in kind (to the nearest £100)	Pension benefits (Bands of £5k)	Other remun-eration ** (£000)	Total (Bands of £5k)
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

Associate Members are not included in the above tables as they attend Board meetings on an ex-officio basis, and do not have any voting rights.

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 2021-22 financial year is the first year that disclosures in respect of:

- the 25th percentile pay ratio and 75th percentile pay ratio are required including the requirements for prior year comparatives
- the percentage change in the remuneration of the highest paid director or minister and the percentage change in the remuneration of the employees of the entity taken as a whole are required.

The banded remuneration of the highest-paid director in the health board in the financial year 2021/22 was £200,000 - £205,000 (2020/21, £195,000 - £200,000). This was 6 times (2020/21: 6 times) the median remuneration of the workforce, which was £31,533 (2020/21, £34,027).

In 2021/22, 29 (2020/21, 24) employees received remuneration in excess of the highest-paid Director. Remuneration for staff ranged from £22,439 to £334,158 (2020/21, £21,879 to £318,973). 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.

	2021/22	2020/21
Band of Highest paid Director's Total Remuneration £000	200 - 205	195 - 200
Median Total Remuneration £000	32	34
Median Ratio	6.34	5.82
25th percentile pay £000	20	23
25th percentile pay ratio	10.15	8.61
75th percentile pay £000	39	34
75th percentile pay ratio	5.21	5.82

** 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 2022 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Steve Moore, Chief Executive Officer	5-7.5	2.5-5	60-65	135-140	1,153	1,049	99	0
Mandy Rayani, Executive Director of Nursing, Quality & Patient Experience	2.5-5	10-12.5	65-70	205-210	1,601	1,481	113	0
Lee Davies, Executive Director of Strategic Development and Operational Planning (from 12/04/21)	5-7.5	7.5-10	30-35	55-60	439	352	80	0
Lisa Gostling, Director of Workforce and Organisational Development	2.5-5	2.5-5	55-60	110-115	1,036	953	78	0
Dr Phil Kloer, Deputy Chief Executive/Executive Medical Director	2.5-5	0-2.5	60-65	120-125	1,137	1,050	83	0
Andrew Carruthers, Executive Director of Operations	2.5-5	0-2.5	40-45	70-75	570	517	50	0
Alison Shakeshaft, Executive Director of Therapies and Health Science	2.5-5	2.5-5	55-60	120-125	1,135	1,049	81	0
Ros Jervis, Executive Director of Public Health	2.5-5	0-2.5	30-35	45-50	530	478	50	0
Huw Thomas, Executive Director of Finance	2.5-5	0-2.5	25-30	5-10	310	255	53	0
Jill Paterson, Director of Primary, Community and Long Term Care	2.5-5	7.5-10	45-50	145-150	0	0	0	0
Joanne Wilson, Board Secretary	2.5-5	2.5-5	30-35	55-60	469	409	58	0

Staff Report

Staff numbers

As of 31 March 2022, the health board employed 12,750 staff including bank and locum staff; this equated to 9,545.85 Full Time Equivalent (FTE). The numbers (headcount) of female and male Board Members and employees are as follows:

	Female	Male	Total
Board Members	11	11	22
Employees	9,926	2,802	12,728
Total	**9,937**	**2,813**	**12,750**

*Included in the Board Members figures is one additional Director and the Board Secretary (both non-voting) who are members of the Executive Team and attend Board meetings.

	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Executive Team	6.00	6	5.00	5	11.00	11
Independent Members	5.00	5	6.00	6	11.00	11
Total	**11.00**	**11**	**11.00**	**11**	**22.00**	**22**

Staff composition as at 31 March 2022

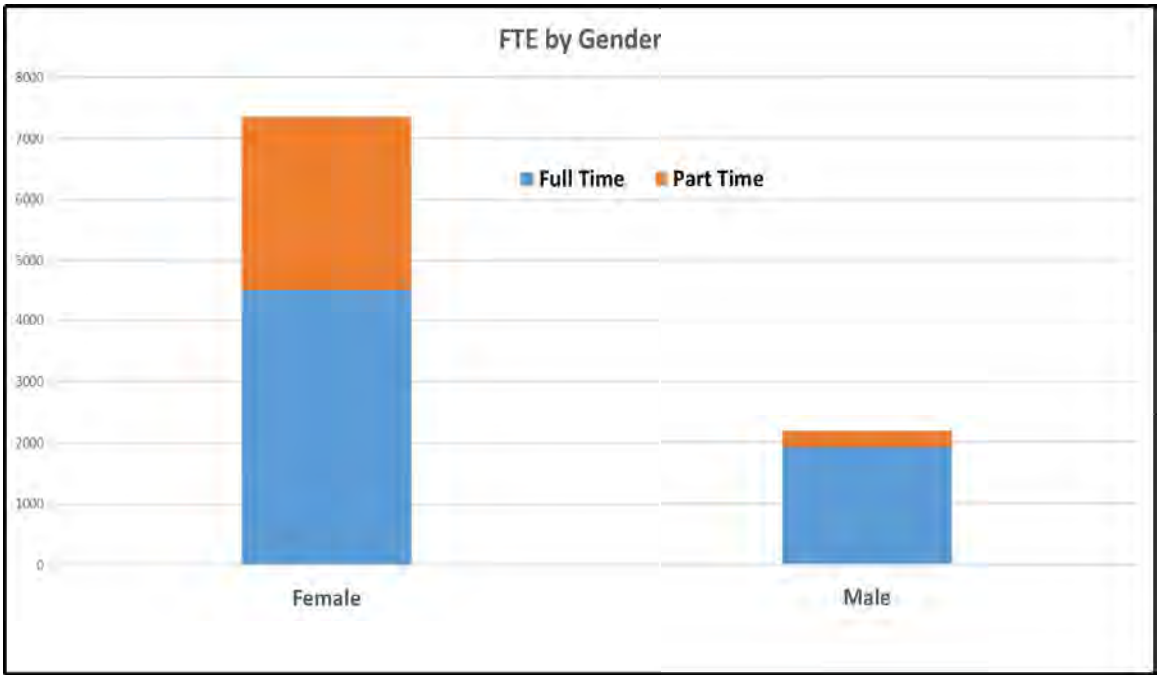
	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Add Prof Scientific and Technic	247.32	300	79.99	96	327.32	396
Additional Clinical Services	1,718.32	2,652	380.05	479	2,098.37	3,131
Administrative and Clerical	1,620.40	1,924	367.63	397	1,988.04	2,321
Allied Health Professionals	497.04	612	153.19	173	650.24	785
Estates and Ancillary	416.12	726	460.82	639	876.95	1,365
Healthcare Scientists	111.86	123	83.80	86	195.66	209
Medical and Dental	187.28	341	419.29	670	606.57	1,011
Nursing and Midwifery Registered	2,561.65	3,259	241.06	273	2,802.71	3,532
Students	0	0	0	0	0	0
Total	**7,360.01**	**9,937**	**2,185.84**	**2,813**	**9,545.85**	**12,750**

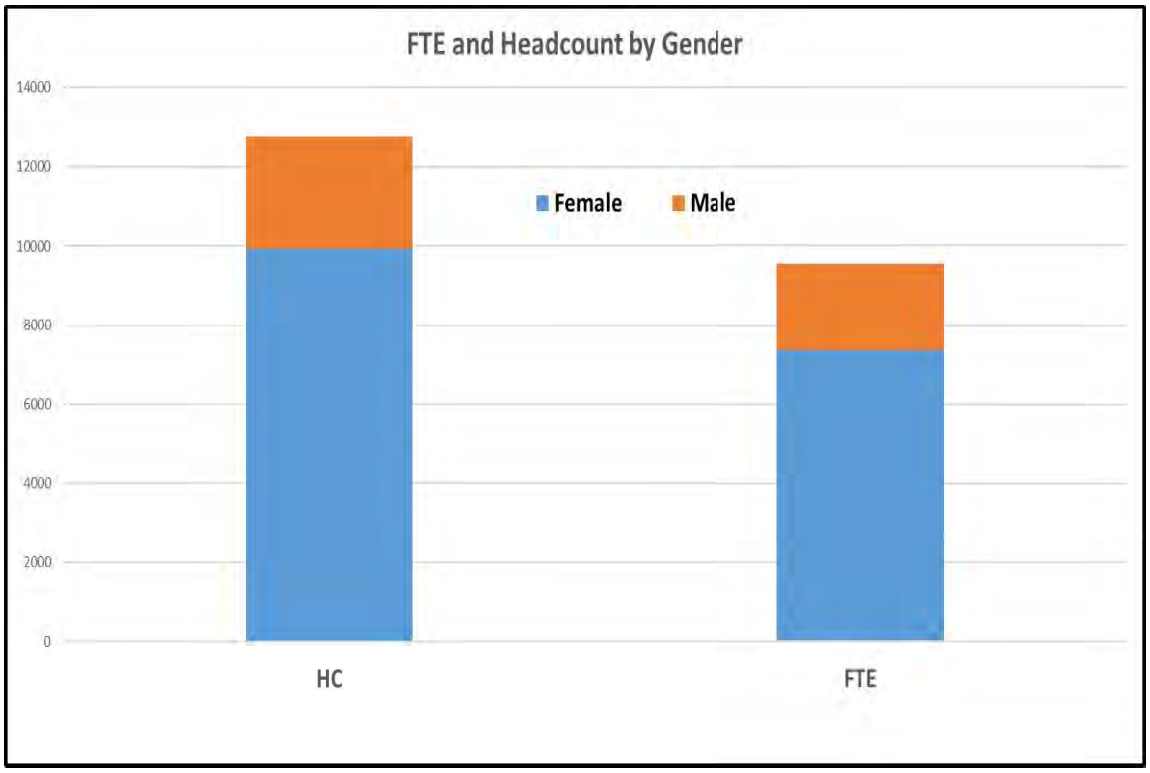
At the end of March 2022, the health board employed 12,750 staff including bank and locum staff; this equated to 9,545.85 FTE. 78% of the workforce was female by FTE and 22% male. The staff covered a wide range of professional, technical and support staff groups. Over 50% (by headcount) were within the Nursing and Midwifery and Additional Clinical Services staff groups. Senior Manager (Band 8a and above) were 1.7% of the workforce - 63% of these by FTE were female and 37% male.

Senior Managers are administrative and clerical staff (Bands 8a to 9)

	Female		Male		Total	
	FTE	Head count	FTE	Head count	FTE	Head count
Band 8a	56.31	58	31.40	32	87.71	90
Band 8b	46.80	47	19.00	19	65.80	66
Band 8c	15.53	16	14.00	14	29.53	30
Band 8d	9.00	9	5.00	5	14.00	14
Band 9	3.00	3	7.85	8	10.85	11
Total	**130.65**	**133**	**77.25**	**78**	**207.90**	**211**

The Board does not have any issue with its staff composition.





Staff sickness data

The following table provides information on the number of days lost due to sickness:

	2021/22	2020/21
Days lost (long term)	172,366	153,993
Days lost (short term)	80,935	59,136
Total days lost	253,301	213,129
Total Staff Years as of 31 March	9,493.62	9,402.23
Average Working Days Lost	13.82	11.83
Total Staff employed as of 31 March (headcount)	12,750	12,476
Total Staff employed in period with no absence (headcount)	3,353	4,542
Percentage of staff with no sick leave	33.13%	45.37%

The health board undoubtedly experienced higher levels of sickness absence throughout 2021/22 than in the years prior to the pandemic. General sickness levels were higher throughout the year – this was particularly noticeable in the summer months when rates are usually lower. However, as the impact of the pandemic began to subside in June/July 2021, general sickness rates actually increased and many staff were demonstrating fatigue.

The cumulative average sickness rate throughout the year was around 6.06% which has included approximately 1.5% impact of COVID-19. In recognition of the impact on well-being

of the workforce, the health board implemented a range of measures to support staff – this is referenced in the Performance Report. In addition, special provisions were introduced as part of an all-Wales initiative in order to provide extended full and half pay for staff impacted with long Covid.

Whilst sickness rates were higher than usual, the rates in Hywel Dda were the lowest of all of the larger health boards in Wales, as was the case prior to the pandemic. The Workforce team supported individuals and managers in managing sickness absence and helping people to stay in or return to work.

Sickness absence rates proved challenging to manage over the year due to the prevalence of COVID-19. The top three reasons for sickness absence in 2021/22 were anxiety/stress/ depression/other psychiatric illnesses, musculoskeletal problems and chest and respiratory problems.

Whilst the health board saw generally lower absence rates than other health boards over the year, it did experience some of the highest rates ever recorded in the health board. Work has commenced to identify a 12-month trend reduction target for sickness absence to replace the former national delivery framework target of 4.79%.

Staff policies

One of the health board's planning objectives in 2021/22, was to review our local staff policies and to develop more people-centred and relevant policies that reflect the strategic direction of the health board. The new approach centred on much closer collaboration with staff, Trade Union partners and other stakeholders. During 2021, the Policy Stakeholder Group reviewed all 42 policies and determined a priority order and timeframe for more in-depth review of the initial priority areas. Work commenced on the Retirement Policy, Over and Underpayments Policy and the extension of sick pay flowchart.

On an all-Wales basis, the new *Respect & Resolution Policy* implemented in May 2021 combined and replaced the former Dignity and Respect at Work and Grievance policies. In November 2021, the revised all-Wales *NHS Staff to Raise Concerns Procedure (Whistleblowing)* was ratified by the Health Board.

Equality, diversity and inclusion

The health board believes that all forms of discrimination are wrong and recognises that some groups and individuals are more at risk of experiencing unfair treatment in employment and when accessing public services. We are committed to undertaking any necessary steps to identify and address exclusion, discrimination, harassment, victimisation, marginalisation and exploitation of groups and individuals.

During 2021, the health board undertook a review of its Equality, Diversity and Inclusion Policy led by the Equality, Diversity and Inclusion Task and Finish Group and in consultation with staff networks. The policy aims to support the health board to implement its values and principles, comply with equality and human rights legislation and eliminate discrimination and

harassment. It outlines the steps it will take to address non-compliance and procedures for those who feel that they have been victims of discrimination. An information poster was developed for staff to promote the policy and provide a summary of the contents to support implementation.

We continued to work in close conjunction with representatives of our Black, Asian and Minority Ethnic (BAME) workforce to conduct listening exercises and we also established a specific task and finish group in order to address concerns of bullying and harassment of BAME staff. The task and finish group reported to the BAME Advisory group which was established by the Chair of the health board.

Recruitment activity

Recruiting and retaining an inclusive and diverse workforce and developing talent is crucial to the health board being able to deliver its ambition to be an employer of choice. Recruiting and attracting new people, retaining our existing people and managing and developing talent is essential to delivering our workforce challenges and critical to our success.

During 2021/22, a Buddy Scheme was introduced by the BAME Network Group, offering support to individuals within the medical and dental staff group as they arrive from overseas. Feedback was positive and further promotion of the scheme is planned.

As a learning organisation and in a bid to understand the reasons why some members of our community do not, or feel they cannot, apply to our health board and to understand what is important to them, we reached out to over 25 partner organisations across our three counties to gain intelligence to help inform positive action.

Work was commissioned to raise awareness of gender stereotyping and the gender pay gap, which included working with the local education authority/local Welsh medium schools.

Other work commenced included a targeted recruitment campaign to reach out to over 55,000 households across our 3 counties and the scoping with regional partners on targeted employment/engagement campaigns.

In a bid to ensure that our recruitment is inclusive, training was made available for staff and a guide developed for managers about reasonable adjustments.

The health board achieved Disability Confident Level 2 status and is undertook a gap analysis for Disability Confident Leader status.

Supporting research, innovation and improvement

Following the first wave of the pandemic, the health board undertook research to understand staff views and feedback of their experience working during the pandemic. This provided us with rich intelligence, not only about our staff's reflections but also about the type of culture they wanted to see across the workplace. As a result, an action plan was developed to take forward a number of priorities:

- Growing inspirational leaders
- Creating spaces and ways of working that enable our people and services to thrive
- Creating the working experience that enable our people and services to thrive
- Putting Well-being at the heart of Hywel Dda
- Building on our Covid team spirit
- Enabling learning and innovation

Work commenced to put the plan into action and ensure that we listen and respond to staff feedback. Some highlights included:

- Securing funding for creating rest areas for staff
- Developing a programme of 'You Said, We Did' feedback for our staff
- Reviewing and evolving our leadership strategy
- Evolving our working environment to support the retention and recruitment of staff, including looking at flexible working options for nursing staff
- Reviewing and evolving the 'well-being offer' and ensuring it is fit for purpose
- Develop people culture plans to co-produce vision with teams
- Embed shared learning opportunities across the health board to ensure that there is dissemination of good ideas and practice

Further staff engagement exercises are planned in 2022/23 to gather further intelligence on their experiences.

Bilingual skills policy

The launch of the health board's Bilingual Skills Policy in March 2020 positively impacted on the Welsh Government's ambition to ensure that the number of people able to enjoy speaking and using Welsh to 1 million by 2050.

The health board's target is to ensure that 50% of its workforce have a skill level which is at foundation level or above within the next 10 years. This target is aligned to the 47% of the Hywel Dda population who confirmed that they were able to speak Welsh in the "Welsh Language Use Survey 2018".

We introduced definitions of the level of Welsh language skill required in our job descriptions. The number of Welsh essential vacancies advertised in 2021/22 has increased from 30 in 2020/21 to 83. As at March 2022, 36.26% of our workforce had a skill level at foundation level or above. This is a positive step forward for the health board in attracting and retaining Welsh speakers, enabling more patients to receive care through the medium of Welsh.

Learning and development

Customer service programme 'Making a Difference'

We designed the "Making a Difference" fully bilingual programme, which will be launched in April 2022. This programme focusses not just on the customer service needs of our

population and colleagues, but the needs of individuals. Designed through evidence-based research, it focuses on our external customers (population, patients, visitors, stakeholders), internal customers (our colleagues, considering how actions impact colleague well-being and patient experience) and ourselves (recognising that how we feel impacts each interaction we have with individuals). It gives staff some time to themselves to reflect on their learning and to rest and take time out. Being able to focus on individual needs, the Making a Difference Programme provides information and signposting to well-being services, staff benefits, community groups (BAME, Enfys, Carers, etc) and provides an opportunity for staff voices to be heard. It will provide information on how they can reach their full potential, identifying development opportunities and how to access additional support.

New induction programme

Moving from the traditional style of Induction, the 'Hywel Dda Welcome' saw a phased approach in its design, with implementation planned from April 2022. The programme begins before individuals join the organisation, with a focus on the full induction period lasting a total of six months. Designed through evidence-based research, Induction will begin from Day 0 (from unconditional offer letter). Learning will continue throughout their onboarding journey, through an automated system, from Day 1 to Month 6.

The 'Hywel Dda Welcome' workshop will focus on some of the key principles of Hywel Dda, such as the Values and Behaviour Framework, A Healthier Mid and West Wales strategy, as well as key information all new employees need to know. A platform was developed to host key information from across Hywel Dda, creating a more accessible online information source. This provides signposting to other departments including Payroll, Pensions, Training, Chaplaincy and Spiritual Care. Learning and Development will then contact new employees at regular intervals to check their onboarding progress, as well as suggesting workshops and training available to attend to broaden their professional development and support them in reaching their potential. Induction will be available in English and Welsh, offering fully bilingual resources.

Lifelong Learning Fund

The launch of the Lifelong Learning Fund enabled staff to access up to a maximum of £100 per person to learn a new skill/craft/hobby. The funds can be used to access any form of learning or self-development, which will support new skills that will help them to recover from the experience of the pandemic and support the restoration of their well-being. The benefits of lifelong learning on health and well-being include boosting self-esteem and confidence and satisfaction from personal achievement, which in turn increases motivation and progression. This initiative is now live, supporting the rest and recovery of our workforce.

Mandatory training

The support offered to increase mandatory training compliance was linked to other learning and development interventions. Departments were supported through use of monthly reports from our electronic staff record system based on department compliance. Staff who apply for study leave or higher awards and have a compliance of less than 100% are advised and supported to increase compliance. A focused role was introduced to drive compliance and offer support.

Leadership development

During 2021/22, delivery of the leadership programme progressed at pace.

Coaching network

Coaching is an invaluable tool for developing people and the health board is certainly embracing the benefits of coaching for leaders and staff across the organisation. The Internal Coaching Network is strongly aligned with the health board's organisational values and reinforces the need to pause, reflect and learn.

The internal coaching network grew, supporting and underpinning Hywel Dda's leadership development, succession planning and talent management provision. The network's vision is to have 100 internal qualified coaches and numbers steadily increased in 2021/22, with further cohorts planned in 2022. Coaching provided by our external and internal coaches exceeded 230 sessions, which shows the organisational demand for this support.

STAR programme

The STAR Programme was created for senior sisters, as leaders who play a pivotal role in upholding standards of care and compassion, quality and performance of service delivery and stewardship of resources. The programme was designed around four modules of leadership development with full support through action learning and coaching. Two cohorts completed the programme in 2021/22. The programme had a fantastic following with participants really feeling part of a leadership community.

New consultant development programme

We launched our new consultant development programme in November 2021, with 16 new consultants from varying sites and specialities across the health board. The programme was created in collaboration with the senior medical body in response to the medical recruitment and retention challenges. This seven-day programme is delivered over a 12-month period, exploring a range of topics including strategy, culture, performance, well-being, research and innovation, education, CPD and more. Participation in this programme will enable new consultants to learn more about the health board as an organisation, while simultaneously establishing themselves as a consultant. Feedback was extremely positive.

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 £1,741,293 on consultancy services as follows:

Transforming clinical services	£431,329
Demand capacity modelling/consultancy for agile working	£201,897
VAT/tax advice	£79,986
IT consultancy	£563,005
Estates advice	£147,255
Other service reviews/advice	£317,821

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.

During the year, the health board implemented 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 was finalised in conjunction with changes to the Off-payroll Working legislation which took effect from 1 April 2021.

The health board is currently working on enhancing monitoring and record keeping in connection with off-payroll appointees so that it may in future publish usage data.

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). £2,500 exit costs was paid in 2021/22 in relation to settlement claims, the year of departure (2020/21 £357,287). 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:

Exit packages cost band (including any special payment element)	**2021/22** Number of compulsory redundancies Number	**2021/22** Number of other departures Number	**2021/22** Total number of exit packages Number	**2021/22** Number of departures where special payments have been made Number	**2020/21** Total number of exit packages Number
less than £10,000	0	1	1	1	1
£10,000 to £25,000	0	0	0	0	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	0	0	0	1
£150,000 to £200,000	0	0	0	0	1
more than £200,000	0	0	0	0	0
Total	**0**	**1**	**1**	**1**	**5**

Exit packages cost band (including any special payment element)	**2021/22** Cost of compulsory redundancies £'s	**2021/22** Cost of other departures £'s	**2021/22** Total cost of exit packages £'s	**2021/22** Cost of special element included in exit packages £'s	**2020/21** Total cost of exit packages £'s
less than £10,000	0	2,500	2,500	2,500	1,000
£10,000 to £25,000	0	0	0	0	45,287
£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	0	0	0	143,529
£150,000 to £200,000	0	0	0	0	167,471
more than £200,000	0	0	0	0	0
Total	**0**	**2,500**	**2,500**	**2,500**	**357,287**

Part 3 - Parliamentary Accountability and Audit Report

Regularity of Expenditure

Common with the public sector in general the health board continued to face exceptional challenges in 2021/22 to deal with the on-going impact of the COVID-19 pandemic. Significant funding was again provided from WG to support with delivering the response to COVID-19 and recovery from it. However, the health board has not been able to deliver a balance over three years to meet its financial duty. The expenditure of £84.9m which it has incurred more than 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 of 31 March 2022:

	2021/22	2020/21
	£000's	£000's
Guarantees	0	0
Indemnities*	1,427	27
Letters of Comfort	0	0
Total	1,427	27

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

Chapter 3

Financial Accounts 2021/22

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

HYWEL DDA UNIVERSITY 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 2021-22. 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 2022

	Note	2021-22 £000	2020-21 £000
Expenditure on Primary Healthcare Services	3.1	**204,170**	199,452
Expenditure on healthcare from other providers	3.2	**250,710**	252,310
Expenditure on Hospital and Community Health Services	3.3	**708,966**	665,902
		1,163,846	1,117,664
Less: Miscellaneous Income	4	**(70,370)**	(63,335)
LHB net operating costs before interest and other gains and losses		**1,093,476**	1,054,329
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**(28)**	(20)
Finance costs	7	**(39)**	(30)
Net operating costs for the financial year		**1,093,409**	**1,054,279**

See note 2 on page 26 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 73 form part of these accounts.

Other Comprehensive Net Expenditure

	2021-22 £000	2020-21 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(7,383)**	(3,020)
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**	0
Other comprehensive net expenditure for the year	**(7,383)**	(3,020)
Total comprehensive net expenditure for the year	**1,086,026**	1,051,259

The notes on pages 8 to 73 form part of these accounts.

Statement of Financial Position as at 31 March 2022

	Notes	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Property, plant and equipment	11	**331,552**	290,648
Intangible assets	12	**2,784**	1,349
Trade and other receivables	15	**68,904**	59,024
Other financial assets	16	**0**	0
Total non-current assets		**403,240**	351,021
Current assets			
Inventories	14	**10,399**	9,029
Trade and other receivables	15	**53,285**	42,207
Other financial assets	16	**0**	0
Cash and cash equivalents	17	**1,565**	2,313
		65,249	53,549
Non-current assets classified as "Held for Sale"	11	**0**	392
Total current assets		**65,249**	53,941
Total assets		**468,489**	404,962
Current liabilities			
Trade and other payables	18	**(175,380)**	(152,942)
Other financial liabilities	19	**0**	0
Provisions	20	**(22,400)**	(21,116)
Total current liabilities		**(197,780)**	(174,058)
Net current assets/ (liabilities)		**(132,531)**	(120,117)
Non-current liabilities			
Trade and other payables	18	**0**	(1,123)
Other financial liabilities	19	**0**	0
Provisions	20	**(70,059)**	(59,381)
Total non-current liabilities		**(70,059)**	(60,504)
Total assets employed		**200,650**	170,400
Financed by :			
Taxpayers' equity			
General Fund		**168,450**	140,985
Revaluation reserve		**32,200**	29,415
Total taxpayers' equity		**200,650**	170,400

The financial statements on pages 2 to 7 were approved by the Board on 9th June 2022 and signed on its behalf by:

Chief Executive and Accountable Officer Steve Moore Date: 9th June 2022

The notes on pages 8 to 73 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2022

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2021-22			
Balance as at 31 March 2021	140,985	29,415	**170,400**
Adjustment	0	0	**0**
Balance at 1 April 2021	140,985	29,415	**170,400**
Net operating cost for the year	(1,093,409)		**(1,093,409)**
Net gain/(loss) on revaluation of property, plant and equipment	0	7,383	**7,383**
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	4,598	(4,598)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2021-22	(1,088,811)	2,785	**(1,086,026)**
Net Welsh Government funding	1,095,811		**1,095,811**
Notional Welsh Government Funding	20,465		**20,465**
Balance at 31 March 2022	168,450	32,200	**200,650**

The notes on pages 8 to 73 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2021

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
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**

The notes on pages 8 to 73 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2022

	Notes	2021-22 £000	2020-21 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,093,409)**	(1,054,279)
Movements in Working Capital	27	**(11,868)**	62,450
Other cash flow adjustments	28	**71,739**	41,945
Provisions utilised	20	**(12,854)**	(17,690)
Net cash outflow from operating activities		**(1,046,392)**	(967,574)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(50,669)**	(33,949)
Proceeds from disposal of property, plant and equipment		**581**	475
Purchase of intangible assets		**(1,152)**	(228)
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
Net cash inflow/(outflow) from investing activities		**(51,240)**	(33,702)
Net cash inflow/(outflow) before financing		**(1,097,632)**	(1,001,276)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,095,811**	1,001,297
Capital receipts surrendered		**0**	0
Capital grants received		**1,073**	638
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		**1,096,884**	1,001,935
Net increase/(decrease) in cash and cash equivalents		**(748)**	659
Cash and cash equivalents (and bank overdrafts) at 1 April 2021		**2,313**	1,654
Cash and cash equivalents (and bank overdrafts) at 31 March 2022		**1,565**	2,313

The notes on pages 8 to 73 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 2021-22 Manual for Accounts. The accounting policies contained in that manual follow the 2021-22 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 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.

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 development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the 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 2021-22 and 2020-21. 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 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.

The Annual leave accrual is also estimated based on available data at the time of preparing the Accounts.

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.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

1.26 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'

The Health Board has no PFI schemes.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. 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.

1.26.2. 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.

1.26.3. 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.

1.26.4. 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.

1.26.5. 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.

1.27. 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.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
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.

1.30. Accounting standards issued that have been adopted early

During 2021-22 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the 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

	2019-20	2020-21	2021-22	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	928,650	1,054,279	1,093,409	**3,076,338**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,400	1,889	1,547	**4,836**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Total operating expenses	930,050	1,056,168	1,094,956	**3,081,174**
Revenue Resource Allocation	895,107	1,031,258	1,069,956	**2,996,321**
Under /(over) spend against Allocation	(34,943)	(24,910)	(25,000)	**(84,853)**

Hywel Dda University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2019-20 to 2021-22.

The Health Board received £16m strategic cash only support in 2021-22.
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

	2019-20	2020-21	2021-22	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	41,686	35,483	62,677	**139,846**
Add: Losses on disposal of donated assets	0	0	0	**0**
Less NBV of property, plant and equipment and intangible assets disposed	(323)	(455)	(553)	**(1,331)**
Less capital grants received	0	0	0	**0**
Less donations received	(1,099)	(637)	(1,073)	**(2,809)**
Charge against Capital Resource Allocation	40,264	34,391	61,051	**135,706**
Capital Resource Allocation	40,295	34,451	61,113	**135,859**
(Over) / Underspend against Capital Resource Allocation	31	60	62	**153**

Hywel Dda University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2019-20 to 2021-22.

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 temporary planning arrangements were implemented.

As a result the extant planning duty for 2021-22 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:

	2021-22	2020-21
Total number of non-NHS bills paid	**240,786**	201,912
Total number of non-NHS bills paid within target	**229,189**	192,345
Percentage of non-NHS bills paid within target	95.2%	95.3%

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	2021-22 Total £000	2020-21 Total £000
General Medical Services	76,935		**76,935**	74,179
Pharmaceutical Services	20,401	(6,109)	**14,292**	14,610
General Dental Services	21,738		**21,738**	19,578
General Ophthalmic Services	1,216	4,562	**5,778**	5,462
Other Primary Health Care expenditure	6,449		**6,449**	5,644
Prescribed drugs and appliances	78,978		**78,978**	79,979
Total	**205,717**	**(1,547)**	**204,170**	199,452

Staff Costs of £14.1m paid by the Health Board are included in General Medical Services

3.2 Expenditure on healthcare from other providers

	2021-22 £000	2020-21 £000
Goods and services from other NHS Wales Health Boards	**44,776**	41,765
Goods and services from other NHS Wales Trusts	**9,497**	13,560
Goods and services from Welsh Special Health Authorities	**2,363**	0
Goods and services from other non Welsh NHS bodies	**1,712**	2,193
Goods and services from WHSSC / EASC	**109,290**	102,617
Local Authorities	**19,655**	31,529
Voluntary organisations	**2,735**	3,393
NHS Funded Nursing Care	**2,888**	2,799
Continuing Care	**48,638**	49,440
Private providers	**9,131**	4,870
Specific projects funded by the Welsh Government	**0**	0
Other	**25**	144
Total	**250,710**	252,310

3.3 Expenditure on Hospital and Community Health Services

	2021-22 £000	2020-21 £000
Directors' costs	2,392	2,294
Operational Staff costs	520,279	496,799
Single lead employer Staff Trainee Cost	9,672	4,209
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	91,417	76,804
Supplies and services - general	10,363	7,708
Consultancy Services	1,741	1,838
Establishment	15,783	8,819
Transport	1,357	1,642
Premises	23,657	35,259
External Contractors	1,885	676
Depreciation	21,640	19,184
Amortisation	472	457
Fixed asset impairments and reversals (Property, plant & equipment)	5,436	6,970
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	11	0
Audit fees	360	371
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,617	1,649
Research and Development	0	0
Other operating expenses	884	1,223
Total	**708,966**	665,902

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2021-22 £000	2020-21 £000
Clinical negligence;		
Secondary care	21,967	(5,209)
Primary care	0	0
Redress Secondary Care	244	103
Redress Primary Care	0	0
Personal injury	195	2,399
All other losses and special payments	342	342
Defence legal fees and other administrative costs	839	522
Gross increase/(decrease) in provision for future payments	23,587	(1,843)
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	109	(62)
Less: income received/due from Welsh Risk Pool	(22,079)	3,554
Total	1,617	1,649

	2021-22 £	2020-21 £
Permanent injury included within personal injury £:	75,652	213,187

4. Miscellaneous Income

	2021-22 £000	2020-21 £000
Local Health Boards	20,680	19,673
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	2,697	2,459
NHS Wales trusts	8,732	6,790
Welsh Special Health Authorities	3,670	2,588
Foundation Trusts	0	0
Other NHS England bodies	3,737	2,210
Other NHS Bodies	0	0
Local authorities	7,815	6,515
Welsh Government	3,680	5,539
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	3	4
Dental fee income	1,734	1,077
Private patient income	20	5
Overseas patients (non-reciprocal)	169	29
Injury Costs Recovery (ICR) Scheme	623	784
Other income from activities	614	463
Patient transport services	0	0
Education, training and research	7,633	7,035
Charitable and other contributions to expenditure	998	819
Receipt of NWSSP Covid centrally purchased assets	0	3,189
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	213	348
Receipt of Government granted assets	860	364
Non-patient care income generation schemes	448	348
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	193	48
Contingent rental income from finance leases	0	0
Rental income from operating leases	514	39
Other income:		
Provision of laundry, pathology, payroll services	147	108
Accommodation and catering charges	1,343	1,112
Mortuary fees	180	178
Staff payments for use of cars	217	235
Business Unit	0	0
Scheme Pays Reimbursement Notional	923	0
Other	2,527	1,376
Total	**70,370**	63,335

Other other income of £2.527m Includes ;

Creche Fees	178	143
Design Fees Recharge	411	341
Drugs Rebate	612	0
Contribution from Ty Bryngwyn Hospice	207	0
Werndale Recharge of CSSD packs	137	195
Total	**1,545**	679

Injury Cost Recovery (ICR) Scheme income

	2021-22 %	2020-21 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	22.43

Welsh Government Covid-19 allocation is not included above and is detailed in Note 34.2.

5. Investment Revenue

	2021-22 £000	2020-21 £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

	2021-22 £000	2020-21 £000
Gain/(loss) on disposal of property, plant and equipment	28	20
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	**28**	20

7. Finance costs

	2021-22 £000	2020-21 £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	**(39)**	(30)
Other finance costs	0	0
Total	**(39)**	(30)

8. Operating leases

LHB as lessee

As at 31st March 2022 the LHB had 36 operating lease agreements in place for the leases of premises, 220 arrangements in respect of equipment and 240 in respect of vehicles, with 5 premises, 63 equipment and 68 vehicle leases having expired in year.

Payments recognised as an expense	**2021-22**	2020-21
	£000	£000
Minimum lease payments	**3,101**	9,656
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**3,101**	9,656

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**2,132**	1,326
Between one and five years	**4,459**	2,584
After 5 years	**1,577**	2,288
Total	**8,168**	6,198

LHB as lessor

Rental revenue	**£000**	£000
Rent	**436**	162
Contingent rents	**0**	0
Total revenue rental	**436**	162

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**386**	426
Between one and five years	**2,251**	1,501
After 5 years	**0**	1,280
Total	**2,637**	3,207

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	2020-21
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	386,629	3,812	30,907	7,789	0	7,860	436,997	414,805
Social security costs	39,044	0	0	867	0	759	40,670	35,434
Employer contributions to NHS Pension Scheme	65,913	0	0	1,016	0	17	66,946	62,927
Other pension costs	265	0	0	0	0	0	265	199
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	491,851	3,812	30,907	9,672	0	8,636	544,878	513,365

Charged to capital	662	97
Charged to revenue	544,216	513,268
	544,878	513,365
Net movement in accrued employee benefits (untaken staff leave total accrual included in note above)	511	11,877
The net movement in accrued employee benefits footnote above includes Covid 19 Net movement in accrued employee benefits	511	11,877

Please give detail of staff under "Other"

Stafflow and Medacs costs
Scheme Pays Payment Provision

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2020-21
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	1,978	49	1	0	0	0	2,028	1,883
Medical and dental	607	11	3	152	0	35	808	764
Nursing, midwifery registered	2,803	4	334	0	0	0	3,141	2,994
Professional, Scientific, and technical staff	327	0	0	0	0	0	327	339
Additional Clinical Services	2,098	0	1	0	0	0	2,099	2,067
Allied Health Professions	650	0	0	0	0	29	679	614
Healthcare Scientists	196	0	0	0	0	0	196	180
Estates and Ancilliary	877	0	14	0	0	0	891	953
Students	0	0	0	0	0	0	0	1
Total	9,536	64	353	152	0	64	10,169	9,795

9.3. Retirements due to ill-health

	2021-22	2020-21
Number	12	12
Estimated additional pension costs £	438,633	246,309

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)	2021-22 Number of compulsory redundancies	2021-22 Number of other departures	2021-22 Total number of exit packages	2021-22 Number of departures where special payments have been made	2020-21 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	0	0	0	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	0	0	0	1
£150,000 to £200,000	0	0	0	0	1
more than £200,000	0	0	0	0	0
Total	0	1	1	1	5

Exit packages cost band (including any special payment element)	2021-22 Cost of compulsory redundancies	2021-22 Cost of other departures	2021-22 Total cost of exit packages	2021-22 Cost of special element included in exit packages	2020-21 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	2,500	2,500	2,500	1,000
£10,000 to £25,000	0	0	0	0	45,287
£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	0	0	0	143,529
£150,000 to £200,000	0	0	0	0	167,471
more than £200,000	0	0	0	0	0
Total	0	2,500	2,500	2,500	357,287

Exit costs paid in year of departure	Total paid in year 2021-22	Total paid in year 2020-21
	£	£
Exit costs paid in year	0	312,000
Total	0	312,000

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 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The 2021-22 financial year is the first year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

	2021-22	**2021-22**	**2021-22**	2020-21	2020-21	2020-21
	£000	**£000**	**£000**	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**203**	**20**	**10.15**	198	23	**8.61**
Median pay	**203**	**32**	**6.34**	198	34	**5.82**
75th percentile pay ratio	**203**	**39**	**5.21**	198	34	**5.82**
Salary component of total pay and benefits						
25th percentile pay ratio	**203**	**20**	**10.15**	198	23	**8.61**
Median pay	**203**	**32**	**6.34**	198	34	**5.82**
75th percentile pay ratio	**203**	**39**	**5.21**	198	34	**5.82**

In 2021-22, 29 (2020-21, 24) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £22,439 to £334,158 (2020-21, £21,879 to £318,973).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

The Chief Executive is the highest paid Director.

Financial year summary

The median pay of the workforce has remained consistent year on year

9.6.2 Percentage Changes	**2020-21 to 2021-22**	2019-20 to 2020-21
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**2**	2
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**1**	7
Performance pay and bonuses	**0**	0

The NHS and social care financial recognition scheme bonus of £735 payment to reward eligible NHS staff has not been included in the NHS Remuneration Report calculations. This bonus payment is not a contractual payment, but a one off payment to reward eligible s taff for their commitment and tireless efforts in the most challenging circumstances.

9.7 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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 £50,270 for the 2021-2022 tax year (2020-2021 £6,240 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.

	2021-22	**2021-22**	2020-21	2020-21
NHS	**Number**	**£000**	Number	£000
Total bills paid	**3,303**	**286,827**	3,795	273,347
Total bills paid within target	**3,162**	**283,597**	3,402	265,111
Percentage of bills paid within target	**95.7%**	**98.9%**	89.6%	97.0%
Non-NHS				
Total bills paid	**240,786**	**454,040**	201,912	504,230
Total bills paid within target	**229,189**	**438,209**	192,345	486,363
Percentage of bills paid within target	**95.2%**	**96.5%**	95.3%	96.5%
Total				
Total bills paid	**244,089**	**740,867**	205,707	777,577
Total bills paid within target	**232,351**	**721,806**	195,747	751,474
Percentage of bills paid within target	**95.2%**	**97.4%**	95.2%	96.6%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2021-22	2020-21
	£	£
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 2021	24,952	236,937	7,944	12,430	82,428	93	29,495	12,001	406,280
Indexation	299	7,821	375	0	0	0	0	0	8,495
Additions									
- purchased	0	1,005	0	38,714	15,784	36	3,601	569	59,709
- donated	0	0	0	0	212	0	0	0	212
- government granted	0	0	0	27	821	0	0	0	848
Transfer from/into other NHS bodies	0	0	0	0	(456)	0	0	0	(456)
Reclassifications	0	13,656	105	(13,802)	0	0	41	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	205	2,608	0	0	0	0	0	0	2,813
Impairments	0	(8,757)	0	0	(541)	0	0	0	(9,298)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,673)	0	0	(3)	(2,676)
At 31 March 2022	25,456	253,270	8,424	37,369	95,575	129	33,137	12,567	465,927
Depreciation at 1 April 2021	0	29,489	1,443	0	60,437	93	17,491	6,679	115,632
Indexation	0	1,124	68	0	0	0	0	0	1,192
Transfer from/into other NHS bodies	0	0	0	0	(364)	0	0	0	(364)
Reclassifications	0	(2)	2	0	0	0	0	0	0
Revaluations	0	0	0	0	(72)	0	0	0	(72)
Reversal of impairments	0	(573)	0	0	0	0	0	0	(573)
Impairments	0	(386)	0	0	(90)	0	0	0	(476)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,601)	0	0	(3)	(2,604)
Provided during the year	0	9,618	369	0	6,351	2	3,920	1,380	21,640
At 31 March 2022	0	39,270	1,882	0	63,661	95	21,411	8,056	134,375
Net book value at 1 April 2021	24,952	207,448	6,501	12,430	21,991	0	12,004	5,322	290,648
Net book value at 31 March 2022	25,456	214,000	6,542	37,369	31,914	34	11,726	4,511	331,552
Net book value at 31 March 2022 comprises :									
Purchased	25,203	209,795	6,542	37,369	30,145	34	11,612	4,388	325,088
Donated	253	4,181	0	0	758	0	103	123	5,418
Government Granted	0	24	0	0	1,011	0	11	0	1,046
At 31 March 2022	25,456	214,000	6,542	37,369	31,914	34	11,726	4,511	331,552
Asset financing :									
Owned	25,456	214,000	6,542	37,369	31,914	34	11,726	4,511	331,552
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 2022	25,456	214,000	6,542	37,369	31,914	34	11,726	4,511	331,552

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000
Freehold	329,869
Long Leasehold	1,683
Short Leasehold	0
	331,552

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 latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation modelset 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 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

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 latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. 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
The LHB has received the following donated assets during the year :

Hywel Dda General Fund Charity (1147683) Plant and Machinery	£205,005
UK Government Department of Health & Social Care Granted Assets	£821,387
Other Contributions	£34,323
Total Donated Assets	£1,060,715

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 latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

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 been no 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.
Cardigan Health Centre and Neyland Health Centre were previously held for sale and have been sold in the period.

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 2021	196	196	0	0	0	**392**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	8	0	0	0	0	**8**
Less assets sold in the year	(193)	(196)	0	0	0	**(389)**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	(11)	0	0	0	0	**(11)**
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 2022	0	0	0	0	0	**0**
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**

12. Intangible non-current assets

2021-22

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure-internally generated	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	4,040	0	77	0	0	4,117
Revaluation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Additions- purchased	1,895	0	0	0	0	1,895
Additions- internally generated	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0
Additions- government granted	12	0	0	0	0	12
Reclassified as held for sale	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Gross cost at 31 March 2022	5,947	0	77	0	0	6,024
Amortisation at 1 April 2021	2,691	0	77	0	0	2,768
Revaluation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Impairment	0	0	0	0	0	0
Provided during the year	472	0	0	0	0	472
Reclassified as held for sale	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Amortisation at 31 March 2022	3,163	0	77	0	0	3,240
Net book value at 1 April 2021	1,349	0	0	0	0	1,349
Net book value at 31 March 2022	2,784	0	0	0	0	2,784
At 31 March 2022						
Purchased	2,774	0	0	0	0	2,774
Donated	0	0	0	0	0	0
Government Granted	10	0	0	0	0	10
Internally generated	0	0	0	0	0	0
Total at 31 March 2022	2,784	0	0	0	0	2,784

12. Intangible non-current assets
2020-21

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure-internally generated	**Total**
	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2020	3,695	0	77	0	0	**3,772**
Revaluation	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Additions- purchased	345	0	0	0	0	**345**
Additions- internally generated	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	**0**
Gross cost at 31 March 2021	**4,040**	**0**	**77**	**0**	**0**	**4,117**
Amortisation at 1 April 2020	2,234	0	77	0	0	**2,311**
Revaluation	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	**0**
Provided during the year	457	0	0	0	0	**457**
Reclassified as held for sale	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	**0**
Amortisation at 31 March 2021	**2,691**	**0**	**77**	**0**	**0**	**2,768**
Net book value at 1 April 2020	**1,461**	**0**	**0**	**0**	**0**	**1,461**
Net book value at 31 March 2021	**1,349**	**0**	**0**	**0**	**0**	**1,349**
At 31 March 2021						
Purchased	1,349	0	0	0	0	**1,349**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	**0**
Total at 31 March 2021	**1,349**	**0**	**0**	**0**	**0**	**1,349**

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 2022 was £2,261,382.

13 . Impairments

	2021-22 Property, plant & equipment £000	2021-22 Intangible assets £000	2020-21 Property, plant & equipment £000	2020-21 Intangible assets £000
Impairments arising from :				
Loss or damage from normal operations	0	0	0	0
Abandonment in the course of construction	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Changes in market price	0	0	0	0
Others (specify)	8,834	0	9,440	0
Reversal of Impairments	(3,386)	0	(2,470)	0
Total of all impairments	**5,448**	**0**	6,970	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	5,448	0	6,970	0
Charged to Revaluation Reserve	0	0	0	0
	5,448	**0**	6,970	0

14.1 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	**5,052**	4,008
Consumables	**5,014**	4,853
Energy	**333**	168
Work in progress	**0**	0
Other	**0**	0
Total	**10,399**	9,029
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2022	31 March 2021
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	31 March 2022 £000	31 March 2021 £000
Welsh Government	2,857	4,653
WHSSC / EASC	2,079	585
Welsh Health Boards	535	577
Welsh NHS Trusts	3,319	2,076
Welsh Special Health Authorities	266	277
Non - Welsh Trusts	40	10
Other NHS	327	308
2019-20 Scheme Pays - Welsh Government Reimbursement	923	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	28,672	25,233
NHS Wales Primary Sector FLS Reimbursement	4	0
NHS Wales Redress	1,390	1,347
Other	0	0
Local Authorities	2,135	1,050
Capital debtors - Tangible	0	0
Capital debtors - Intangible	0	0
Other debtors	6,886	4,163
Provision for irrecoverable debts	(1,077)	(967)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	4,929	2,895
Other accrued income	0	0
Sub total	**53,285**	42,207
Non-current		
Welsh Government	0	0
WHSSC / EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	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	68,904	59,024
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	**68,904**	59,024
Total	**122,189**	101,231

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2022 £000	31 March 2021 £000
By up to three months	195	197
By three to six months	26	13
By more than six months	48	35
	269	245

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(967)	(1,171)
Transfer to other NHS Wales body	0	0
Amount written off during the year	0	0
Amount recovered during the year	0	0
(Increase) / decrease in receivables impaired	(110)	204
Bad debts recovered during year	0	0
Balance at 31 March	(1,077)	(967)

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	889	(90)
Other	0	0
Total	889	(90)

16. Other Financial Assets

	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£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

	2021-22	2020-21
	£000	£000
Balance at 1 April	**2,313**	1,654
Net change in cash and cash equivalent balances	**(748)**	659
Balance at 31 March	**1,565**	2,313
Made up of:		
Cash held at GBS	**1,385**	1,902
Commercial banks	**160**	384
Cash in hand	**20**	27
Cash and cash equivalents as in Statement of Financial Position	**1,565**	2,313
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,565**	2,313

The movement relates to cash, no comparative information is required by IAS 7 in 2021-22.

18. Trade and other payables

Current	**31 March 2022 £000**	31 March 2021 £000
Welsh Government	**0**	0
WHSSC / EASC	**910**	1,007
Welsh Health Boards	**693**	1,766
Welsh NHS Trusts	**1,770**	918
Welsh Special Health Authorities	**94**	0
Other NHS	**8,950**	9,009
Taxation and social security payable / refunds	**4,692**	4,669
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	**5,817**	5,794
Non-NHS payables - Revenue	**27,040**	18,164
Local Authorities	**10,642**	11,993
Capital payables- Tangible	**19,467**	9,367
Capital payables- Intangible	**1,037**	294
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	**83,649**	69,118
Deferred Income:		
Deferred Income brought forward	**237**	67
Deferred Income Additions	**576**	218
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**(193)**	(48)
Other creditors	**9,999**	20,606
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**175,380**	152,942
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**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	**0**	321
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	**0**	699
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	103
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**0**	1,123
Total	**175,380**	154,065

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.
Movement in Other creditors includes £11.3m in relation to the NHS Staff Bonus payment accrued in 2020-21
Non NHS Accruals includes £12.8m 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 2022 £000**	31 March 2021 £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 2022 £000**	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £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 2021	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 2022
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	11,051	0	375	4,916	18,819	(8,027)	(11,811)	0	15,323
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	893	0	41	0	597	(239)	(353)	0	939
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	4,894	0	77	0	263	(518)	(86)	(38)	4,592
All other losses and special payments	0	0	0	0	346	(342)	(4)	0	0
Defence legal fees and other administration	824	0	0	156	1,031	(692)	(508)		811
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	20			0	9	(18)	0	0	11
2019-20 Scheme Pays - Reimbursement	0			0	18	0	0	0	18
Restructuring	0			0	0	0	0	0	0
Other	3,434		(474)	0	580	(2,570)	(264)		706
Total	21,116	0	19	5,072	21,663	(12,406)	(13,026)	(38)	22,400
Non Current									
Clinical negligence:-									
Secondary care	58,702	0	0	(4,916)	15,429	(249)	(470)	0	68,496
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	0	18	0	0	0	18
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	679	0	0	(156)	368	(199)	(52)		640
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	905	0	0	0	905
Restructuring	0			0	0	0	0	0	0
Other	0		0	0	0	0	0		0
Total	59,381	0	0	(5,072)	16,720	(448)	(522)	0	70,059
TOTAL									
Clinical negligence:-									
Secondary care	69,753	0	375	0	34,248	(8,276)	(12,281)	0	83,819
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	893	0	41	0	597	(239)	(353)	0	939
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	4,894	0	77	0	281	(518)	(86)	(38)	4,610
All other losses and special payments	0	0	0	0	346	(342)	(4)	0	0
Defence legal fees and other administration	1,503	0	0	0	1,399	(891)	(560)		1,451
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	20			0	9	(18)	0	0	11
2019-20 Scheme Pays - Reimbursement	0			0	923	0	0	0	923
Restructuring	0			0	0	0	0	0	0
Other	3,434		(474)	0	580	(2,570)	(264)		706
Total	80,497	0	19	0	38,383	(12,854)	(13,548)	(38)	92,459

Expected timing of cash flows:

	In year to 31 March 2023	Between 1 April 2023 31 March 2027	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	15,323	68,496	0	83,819
Primary care	0	0	0	0
Redress Secondary care	939	0	0	939
Redress Primary care	0	0	0	0
Personal injury	4,592	18	0	4,610
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	811	640	0	1,451
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	11	0	0	11
2019-20 Scheme Pays - Reimbursement	18	25	880	923
Restructuring	0	0	0	0
Other	706	0	0	706
Total	22,400	69,179	880	92,459

20. Provisions (continued)

	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**

21. Contingencies

21.1 Contingent liabilities

	2021-22 £'000	2020-21 £'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	108,513	71,875
Primary care	155	0
Redress Secondary care	0	0
Redress Primary care	0	0
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	2,112	1,894
Continuing Health Care costs	481	1,196
Other	0	0
Total value of disputed claims	111,261	74,965
Amounts (recovered) in the event of claims being successful	(107,945)	(71,081)
Net contingent liability	3,316	3,884

21.2 Remote Contingent liabilities

	2021-22 £000	2020-21 £000
Guarantees	**0**	0
Indemnities	**1,427**	27
Letters of Comfort	**0**	0
Total	**1,427**	**27**

21.3 Contingent assets

	2021-22 £000	2020-21 £000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2021-22 £000	2020-21 £000
Property, plant and equipment	**14,182**	4,411
Intangible assets	**0**	0
Total	**14,182**	4,411

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 during the financial year

	Amounts paid out during period to 31 March 2022	
	Number	£
Clinical negligence	65	8,276,003
Personal injury	34	518,608
All other losses and special payments	143	581,278
Total	242	9,375,889

Analysis of cases in excess of £300,000

	Case Type	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
12RYNMN0077	Clinical Negligence	0	0	1	9,354,500
13RYNMN0032	Clinical Negligence	1	60,000	1	8,540,000
17RYNMN0094	Clinical Negligence	1	118,750	1	3,969,628
12RYNMN0056	Clinical Negligence	1	14,461	1	3,003,661
16RYNMN0070	Clinical Negligence	1	1,930,000	1	1,930,000
16RYNMN0026	Clinical Negligence	1	725,000	1	1,235,000
13RYNMN0041	Clinical Negligence	0	0	1	1,150,000
16RYNMN0063	Clinical Negligence	1	75,000	1	1,101,046
15RYNMN0034	Clinical Negligence	0	0	1	1,072,345
18RYNMN0096	Clinical Negligence	1	965,000	1	1,025,000
21RYNMN0008	Clinical Negligence	1	741,000	1	795,000
06RR6MN0026	Clinical Negligence	0	0	1	665,465
14RYNMN0070	Clinical Negligence	0	0	1	542,000
18RYNMN0022	Clinical Negligence	1	52,585	1	475,585
18RYNPI0016	Personal Injury	1	115,385	1	468,356
16RYNMN0015	Clinical Negligence	1	400,000	1	400,000
16RYNMN0060	Clinical Negligence	0	0	1	385,000
14RYNMN0075	Clinical Negligence	1	220,000	1	350,000
Sub-total		**12**	**5,417,181**	**18**	**36,462,586**
All other cases		230	3,958,708	282	10,485,369
Total cases		**242**	**9,375,889**	**300**	**46,947,955**

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 2022 £000**	31 March 2021 £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 2022**	31 March 2021
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 2022**	31 March 2021
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 2022	31 March 2021
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 2022	31 March 2021
	£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 2022	**31 March 2022**	**31 March 2022**
	£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 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

	31/03/2022
	£000
Total present value of obligations for on-SoFP PFI contracts	**0**

25.3 Charges to expenditure	2021-22	2020-21
	£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:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract

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

	2021-22 £000	2020-21 £000
(Increase)/decrease in inventories	**(1,370)**	187
(Increase)/decrease in trade and other receivables - non-current	**(9,880)**	(923)
(Increase)/decrease in trade and other receivables - current	**(11,078)**	26,300
Increase/(decrease) in trade and other payables - non-current	**(1,123)**	1,123
Increase/(decrease) in trade and other payables - current	**22,438**	33,806
Total	**(1,013)**	60,493
Adjustment for accrual movements in fixed assets - creditors	**(10,843)**	(1,306)
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**(12)**	3,263
	(11,868)	62,450

28. Other cash flow adjustments

	2021-22 £000	2020-21 £000
Depreciation	**21,640**	19,184
Amortisation	**472**	457
(Gains)/Loss on Disposal	**(28)**	(20)
Impairments and reversals	**5,447**	6,970
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	**0**	(3,189)
Donated assets received credited to revenue but non-cash	**(213)**	(348)
Government Grant assets received credited to revenue but non-cash	**(860)**	(364)
Non-cash movements in provisions	**24,816**	(15)
Other movements	**20,465**	19,270
Total	**71,739**	41,945

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 9th June 2022; post the date the financial statements were certified by the Auditor General for Wales.

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
Gareth John	Independent Member	County Councillor, Carmarthenshire Member of Delta Wellbeing Governance Group, Carmarthen Town Council
Hazel Lloyd-Lubran	Associate Member, Chair, Stakeholder Reference Group	Company Secretary of Cymdeithas Mudiadau Gwirfoddol Ceredigion / Ceredigion Association of Voluntary Organisations (CAVO)
Iwan Thomas	Independent Member	Independent Board Member on Pembrokeshire College Board (Chair) Chief Executive of PLANED
Huw Thomas	Director of Finance	Partner working in Ceredigion County Council
John Gammon	Independent Member	Independent Board Member on Pembrokeshire College Board
Judith Hardisty	Independent Member	Assessor for the Corporate Health Standard under auspices of A2 Consultancy who are instructed by Welsh Government
Lisa Gostling	Director of Workforce & OD	Independent Board Member on Pembrokeshire College Board
Maynard Davies	Independent Member	Member of the Information Governance Review Panel for the SAIL Databank run by Swansea University
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 Trustee of the Faculty of Medical Leadership & Management (FMLM) and FMLM Wales Lead
Ros Jervis	Director of Public Health	Close family member working at Sandwell & West Birmingham Hospital NHS Trust
Steve Moore	Chief Executive	Honorary Professor in University of Wales Trinity St David
Winston Weir	Independent Member	Non-Executive Director - Birmingham & Solihull Mental Health Foundation NHS Trust

Total value of transactions are with entities at which Board members and key senior staff have influential interests in 2021-22:

	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Birmingham & Solihull MH NHS Trust	2	0	0	0
Carmarthenshire County Council	17,554	3,578	5,848	1,352
CAVO	436	0	0	0
Ceredigion County Council	10,506	1,518	1,467	450
Community Pharmacy Wales	133	0	0	0
FMLM Applied Ltd	2	0	0	0
Jamo Group Ltd	39	0	0	0
Magawell Ltd	5,864	0	0	0
Pembrokeshire College	23	0	0	0
Pembrokeshire County Council	17,616	4,254	3,327	328
Pembrokeshire Local Action Network for Enterprise and Development LTD TA (PLANED)	2	0	0	0
Royal College of Nursing	7	0	0	0
Sandwell & West Birmingham Hospitals NHS Trust	1	0	0	0
Swansea University	977	430	6	31
University of Wales Trinity St David	344	27	11	26
	53,506	**9,807**	**10,659**	**2,187**

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	2	1,100,941	0	2,857
Aneurin Bevan University Health Board	316	993	2	59
Betsi Cadwaladr University Health Board	242	5,170	0	58
Cardiff & Vale University Health Board	6,574	617	118	31
Cwm Taf Morgannwg University Health Board	750	565	32	13
Digital Health & Care Wales (DHCW)	4,213	715	94	208
Powys Teaching Health Board	266	8,957	35	285
Public Health Wales NHS Trust	2,361	3,180	86	232
Swansea Bay University Health Board	39,561	4,398	471	89
Velindre NHS Trust	22,490	5,044	1,514	15,120
Welsh Ambulance Services Trust	5,343	417	170	19
Welsh Health Specialised Services Committee	109,290	2,697	910	2,079
Health Education & Improvement Wales (HEIW)	0	8,240	0	58
	191,408	**1,141,934**	**3,432**	**21,108**

31. Third Party assets

The LHB held £1,391,087 cash at bank and in hand at 31 March 2022 (31st March 2021, £1,425,138) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £1,017,369 at 31st March 2022 (31st March 2021, £954,366). 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 Carmarthenshire County Council on the 1st October 2009. Under the arra ngement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment st ore. 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 Coun cil and the Health Board. Payments for services provided by Carmarthenshire County Council in the sum of £408,941 are accounted for as ex penditure 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 o f the NHS (Wales) Act 2006 for the provision of Carmarthenshire Community Health and Social Care services. The section 33 agreement it self will initially only provide the framework for taking forward future schedules and therefore references all community based health, social ca re (adults & children) and related housing and public protection services so that if any future developments are considered a separate agr eement will not have to be prepared. There are currently no pooled budgets related to this agreement.

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 p ool is hosted by Ceredigion County Council and a memorandum note to the final accounts will provide details of the joint income and expenditur e. The financial operation of the pool is governed by a pooled budget agreement between Ceredigion County Council and the Health Board. Paymen ts for services provided by Ceredigion County Council in the sum of £376,000 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 an agreement with Pembrokeshire County Council on the 31st March 2011 under section 33 of t he NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store and from 1st October 2012 the agreement h as operated as a pooled fund. The pool is hosted by Pembrokeshire County Council and a memorandum note to the final accounts will provide detail s of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Pembrokesh ire County Council and the Health Board. The Health Board accounts for its share of the assets, liabilities, income and expenditure aris ing from the activities of the pooled budget, identified in accordance with the pooled budget agreement and the sum of £274,792 has been accounted for as expenditure in the accounts of the Health Board.

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

The Health Board has no 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 2021 to 31 March 2022. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2021 and February 2022 alongside Health Board/Trust/SHA data for March 2022.

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:

	2021-22
Statement of Comprehensive Net Expenditure for the year ended 31 March 2022	**£000**
Expenditure on Primary Healthcare Services	**267**
Expenditure on Hospital and Community Health Services	**20,198**
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2022	
Net operating cost for the year	**20,465**
Notional Welsh Government Funding	**20,465**
Statement of Cash Flows for year ended 31 March 2022	
Net operating cost for the financial year	**20,465**
Other cash flow adjustments	**20,465**
2.1 Revenue Resource Performance	
Revenue Resource Allocation	**20,465**
3. Analysis of gross operating costs	
3.1 Expenditure on Primary Healthcare Services	
General Medical Services	**267**
3.3 Expenditure on Hospital and Community Health Services	
Directors' costs	**206**
Staff costs	**19,683**
Single Lead Employer staff trainee costs	**309**
9.1 Employee costs	
Permanent Staff	
Employer contributions to NHS Pension Scheme	**20,465**
Charged to capital	**39**
Charged to revenue	**20,426**
18. Trade and other payables	
Current	
Pensions: staff	**0**
28. Other cash flow adjustments	
Other movements	**20,465**

34. Other Information

34.2 Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales bodies:

	2021-22 £000	2020-21 £000	
Capital			
Capital Funding Field Hospitals		3,590	
Capital Funding Equipment & Works	23,065	8,990	
Capital Funding other (Specify)	0	0	
Welsh Government Covid 19 Capital Funding	**23,065**	**12,580**	
			As previously reported in 2020-21
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
Bonus Payment			11,250
Independent Health Sector			0
Stability Funding	63,991	84,274	
Covid Recovery	19,232	0	
Cleaning Standards	1,435	0	
PPE (including All Wales Equipment via NWSSP)	2,646	3,275	
Testing / TTP- Testing & Sampling - Pay & Non Pay	2,132	1,193	
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	6,740	3,369	
Extended Flu Vaccination / Vaccination - Extended Flu Programme	837	636	
Mass Covid-19 Vaccination / Vaccination - COVID-19	8,630	2,248	
Annual Leave Accrual - Increase due to Covid	510	11,733	
Urgent & Emergency Care	2,536	2,460	
Private Providers Adult Care / Support for Adult Social Care Providers	2,001	3,548	
Hospices	0	0	
Other Mental Health / Mental Health	0	625	
Other Primary Care	0	1,304	
Social Care	1,583	0	
Other	153	1,528	
Welsh Government Covid 19 Revenue Funding	**112,426**	**116,193**	

Other includes COVID Therapeutic Medicines (Treatment)

34. Other Information

34.3 Changes to accounting standards not yet effective - IFRS 16 Impact

IFRS 16 Leases supersedes IAS 17 Leases and is effective in the public sector from 1 April 2022. IFRS 16 provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value. The FReM makes two public sector adaptions

- The definition of a contract is expanded to include intra UK government agreements that are not legally enforceable;
- The definition of a contract is expanded to included agreements that have nil consideration.

IFRS 16 gives a narrower definition of a lease that IAS 17 and IFRIC 4 by requiring that assets and liabilities will be recognised initially at the discounted value of minimum lease payments After initial recognition, right of use assets will be depreciated on a straight line basis and interest recognised on the liabilities. Except where modified for revaluation where material, the cost model will be applied to assets other than peppercorn leases which will be measured on a depreciated replacement cost basis. The right of use asset in a peppercorn lease is accounted for similarly to a donated asset.

As required by the FReM IFRS 16 will be implemented using the accumulated catch up method.

The right of use assets and leasing obligation have been calculated and indicated that the total discounted value of right of use assets and liabilities under IFRS 16 is lower than the value of minimum lease commitments under IAS 17 due to the discount factor applied. The impact of implementation is a

- decrease in expenditure of £12k for 2022/23;
- increase in assets and liabilities of £13,216k.

These figures are calculated before intercompany eliminations are made, these will not have a material impact on the figures.

Right of Use (RoU) Assets Impact

		Property £000	Non Property £000	Total £000
Statement of financial Position				
RoU Asset Recognition				
+	Transitioning Adjustment	9,498	3,718	**13,216**
+	As at 1 April 2022	9,498	3,718	**13,216**
+	Renewal / New RoU Assets 2022-23	83	767	**850**
-	Less (Depreciation)	(1,301)	(770)	**(2,071)**
+	As at 31 March	8,280	3,715	**11,995**

RoU Asset Liability		Property £000	Non Property £000	Total £000
-	Transitioning Adjustment	(9,498)	(3,718)	**(13,216)**
-	As at 1 April 2022	(9,498)	(3,718)	**(13,216)**
-	Renewal / New RoU Liability 2022-23	(83)	(767)	**(850)**
+	Working Capital	1,289	793	**2,082**
-	Interest	(54)	(37)	**(91)**
-	As at 31 March	(8,346)	(3,729)	**(12,075)**

Charges	Property £000	Non Property £000	Total £000
Expenditure			
RoU Asset DEL depreciation [1]	1,301	770	**2,071**
RoU Asset AME depreciation [1]	0	0	**0**
Interest on obligations under RoU Asset leases [2]	54	37	**91**
	1,355	807	**2,162**

LHB

1 Expenditure on Hospital and Community Health Services

2 Finance Costs

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

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 2022 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 UK adopted 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 Health Board as at 31st March 2022 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted 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.

Opinion on regularity

In my opinion, except for the matter described in the *Basis for Qualified Opinion on Regularity* section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of Hywel Dda University Health Board's financial statements because:

- those statements include a provision of £922,586 relating to the Trust's estimated liability arising from the Ministerial Direction dated 18 December 2019 on senior clinicians' pensions. In my view, this expenditure is irregular and material by its nature.
- The Hywel Dda University Health Board has breached its resource limit by spending £84.853 million over the amount that it was authorised to spend in the three-year period 2019-2020 to 2021-2022. This spend constitutes irregular expenditure.

Further detail is set out in my 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.

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 and Staff Report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Performance 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 on pages 9 and 10, 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's 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 Hywel Dda University Local Health Board 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 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.

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 the 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 attached

Adrian Crompton
Auditor General for Wales
15th June 2022

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 Health Board (the LHB's) financial statements. I am reporting on these financial statements for the year ended 31 March 2022 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 qualification of my 'regularity' opinion relating to expenditure recognised as a result 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 2021-22 Hywel Dda University 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 2019-20 to 2021-22.

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 £2,996.321 million by £84.853 million.

Where an LHB does not balance its books over a rolling three-year period, any expenditure over the resource allocation (i.e. 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 2021-22 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 2019-20 because due to the pandemic, the duty to prepare a new three-year plan for the period 2021-22 to 2023-24 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 £200k in 2011-12 to £40k 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 has received sufficient information during the year 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, expenditure has been recognised as a provision as shown in note 20 of the financial statements.

All NHS bodies will be held harmless for the impact of the Ministerial Direction, however in my opinion, the transactions included in the LHB's financial statements to recognise this liability are 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. As a result, I have qualified my 'regularity' opinion for 2021-22.

Adrian Crompton

Auditor General for Wales

15th June 2022