Bundle Audit Committee Part 1 13 May 2019

0	AGENDA
	Agenda Audit Committee 13 May 2019.doc
1	PART 1 PRELIMINARY MATTERS
1.1	Welcome & Introductions
1.2	Apologies for absence
1.3	Declarations of Interest
1.4	Unconfirmed Mintes of the meeting held on 1 April 2019
	1.4 Unconfirmed Minutes of the PART 1 meeting held on 1 April 2019.docx
1.5	Matters Arising not contained within the Action Log
	1.5 Audit Committee Action Log AC 13 May 2019.docx
1.6	Action Log
2	PART 2 INTERNAL CONTROL AND RISK MANAGEMENT
2.1.1	Draft 2018/19 Annual Accounts
	2.1 Accounts Report for Audit Committee 2018-19 AC 13 May 2019.doc
2.1.2	Appendix 1 Cwm Taf LHB Annual Accounts 2018-19 - Draft - consolidated - for Annual report
	2.1 Appendix 1 Cwm Taf LHB Annual Accounts 2018-19 - Draft - consolidated - for Annual report.pdf
2.1.3	WHSS/EASC Draft 2018/19 Annual Accounts
	2.1.1 Report on the Draft Accounts AC 13 May 2019.doc
2.1.4	Appendix 1 WHSSC & EASC Draft Annual Accounts AC 13 May 2019
	2.1.2 Appendix 1 WHSSC & EASC Draft Annual Accounts AC 13 May 2019.pdf
2.1.5	WHSSC Draft Annual Governance Statement for year ending 31 March 2019
	2.1.3 2018-19 AGS Draft v0.3.docx
2.1.6	EASC Draft Annual Governance Statement
	2.1.4 EASC Annual Governance Statement 2018-2019 AC 13 May 2019.docx
2.2	Chief Executive Draft Accountability Report
	2.2 'Draft' Accountability Report 3 May 2019 Final draft AC 13 May 2019.docx
2.3	Audit Recommendations Tracker Updates
	2.3 Audit Recommendations Tracker CT AC 13 May 2019.docx
3	PART 3 INTERNAL AUDIT
3.1	Internal Audit Progress Report
	3.1 IA Progress Report AC 13 May 2019.pdf
3.2	Internal Audit Report - Mobile Phone Arrangements
	3.2 Mobile Phones - Revised Final Internal Audit Report AC 13 May 2019.pdf
3.3	Internal Audit Report - Commissioning
	3.3 IA Commissioning - Final AC 13 May 2019.pdf
3.4	Internal Audit Report - Cyber Security
	3.4 IA Cyber Security - Final report AC 13 May 2019.pdf
3.5	Internal Audit Report - EASC Governance & Performance Report
	3.5 EASC Governance Arrangements Final Internal Audit Report AC 13 May 2019.pdf
3.6	Internal Audit Report - Sustainability
	3.6 IA Sustainability Reporting - Internal Audit Report Final AC 13 May 2019.pdf
3.7	Internal Audit Report - Annual Quality Statement
	3.7 Final AQS Internal Audit Report AC 13 May 2019.pdf
3.8	Draft Internal Audit Annual Report 2018/19
	3.8 CT- Opinion Annual Report 18-19 - DRAFT AC 13 May 2019.pdf
4	PART 4 EXTERNAL AUDIT
4.1	Wales Audit Office Update on Progress with 2018/19 Accounts Audit

5 PART 5 ANY OTHER URGENT BUSINESS

5.1 Closure of the meeting - Date and time of next meeting

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING

13 MAY 2019

Audit Committee to meet with the Auditors at 9.00am

A meeting of the Audit Committee will be held on Monday 13 May 2019 at Ynysmeurig House, Navigation Park, Abercynon commencing at 9.30am.

PAUL GRIFFITHS
CHAIR

AGENDA

		LEAD / ATTACHED
PART 1. PREMLIMINARY MATTERS		
1.1	Welcome and Introductions	Chair/Oral
1.2	Apologies for Absence	Chair/Oral
1.3	Declarations of Interest	Chair/Oral
1.4	Unconfirmed Minutes of the meeting held on 1 April 2019	Chair **Attachment**
1.5	Matters arising not contained within the Action Log	Chair **Attachment**
1.6	Action Log	Chair **Oral**
PART 2. INTERNAL CONTROL AND RISK MANAGEMENT		
2.1	'Draft' 2018/2019 Annual Accounts • 2.1.1 WHSSC/EASC Draft 2018/19 Annual Accounts • 2.1.2 WHSSC draft Annual Governance Statement for year ending 31 March 2019 • 2.1.3 EASC draft Annual Governance Statement	Director of Finance **Attachments**

2.2	Chief Executive 'Draft' Accountability Report	Chief Executive & Director of Governance / Board Secretary **Attachment**
2.3	Audit Recommendations Tracker – to include specific updates on: • JAG Accreditation – Closure Report required • Fire Management • Performance Management • Facilities Management	Director of Governance / Board Secretary **Attachment**

PART 3. INTERNAL AUDIT

3.1	Internal Audit Progress Report	Head of Internal Audit & Assurance **Attachment**
3.2	Mobile Phone Arrangements	**Attachment**
3.3	Commissioning	**Attachment**
3.4	Cyber Security	**Attachment**
3.5	EASC – Governance & Performance Report	**Attachment**
3.6	2019/2020 Sustainability Report	**Attachment**
3.7	2019/2020 Annual Quality Statement Report	**Attachment**
3.8	Draft Annual Report for 2018/19	**Attachment**

PART 4. EXTERNAL AUDIT

4.1	WAO Update on progress with 2018/19 Accounts Audit	Wales Audit Office **Oral**

PART 5. ANY OTHER URGENT BUSINESS

5.1	Close of the meeting – Date and time of next meetings: • Time TBC, 30 May 2019 (to approve the Annual Accounts 2018-19)	Oral/Chair

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 1 APRIL 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Jayne Sadgrove	-	Independent Member
Maria K Thomas	-	Independent Member
Dilys Jouvenat	-	Independent Member

IN ATTENDANCE

Len Cozens	-	Head of Local Counter Fraud Services
David Jones	-	Local Counter Fraud Specialist
David Thomas	-	Wales Audit Office
Gareth Lucey	-	Wales Audit Office
Paul Dalton	-	NHS Wales Shared Services Partnership (NWSSP) – Head of Internal Audit & Assurance
Simon Cookson	-	NWSSP – Internal Audit & Assurance
Emma Samways	-	NWSSP – Internal Audit & Assurance
Steve Webster	-	Director of Finance
Gwenan Roberts	-	Interim Board Secretary
Huw Evans	-	Head of Finance
Emma Walters	-	Committee Secretariat
Elisabeth Williams	-	Finance Manager (Observing)
John Palmer	-	Chief Operating Officer (in part)
Scott Lavender	-	All Wales Post Payment Verification Manager (in part)
Sara Jeremiah	-	Post Payment Verification Location Manager (in part)

AC/19/047 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting, particularly Elisabeth Williams, Finance Manager, who was attending the meeting as an observer, Len Cozens, Head of Local Counter Fraud Services and Scott Lavender and Sara Jeremiah who were attending the meeting to present an update on Post Payment Verification.

AC/19/048 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Sara Utley and Robert Williams.

AC/19/049 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interests, to those previously notified.

AC/19/050 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 11 FEBRUARY 2019.**

The minutes of the meeting held on 11 February 2019, were **CONFIRMED** as a true and accurate record. The Chair extended his thanks to Members who provided their comments in relation to the draft minutes following their circulation.

AC/19/051 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 11 February 2019 was reviewed by Members and the following was **NOTED**:

18/099 – Members advised that they still required sight of the JAG Accreditation Review Closure report and **REQUESTED** that this was presented to the next meeting **(action log updated).**

19/023 – Gwenan Roberts advised that a discussion had not yet taken place in relation to introducing a nominated person who would be responsible for receiving any protected disclosures. Members **NOTED** that this was subject of urgent discussions and work was being undertaken in relation to the de-escalation plan.

19/044 – Members **NOTED** that a review of the forward work plan would need to be undertaken over the next couple of months.

AC/19/052 **MATTERS ARISING**

There were no matters arising.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/053 **POST PAYMENT VERIFICATION REPORT – END OF YEAR UPDATE**

Scott Lavender and Sara Jeremiah were in attendance for this item.

Scott Lavender presented the report which summarised the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS). Members **NOTED** that the report would also be presented to the Primary & Community Care Committee for information.

Members **NOTED** that the Bridgend realignment in relation to Primary Care services had been undertaken successfully and that some work had been undertaken with the Risk Analyst to include improved data within the report. Members **NOTED** that the team were looking to create a traffic light system which could be allocated to practices.

Members **NOTED** that PPV planned training sessions with Ophthalmic Contractors had been rescheduled and would now be held in April. Members **NOTED** that training sessions would focus on the importance of patient records and accurate record keeping. Scott Lavender advised that one pilot session had been held which was successful.

Members **NOTED** that only 1 practice had breached the claim error element which was positive.

Steve Webster advised that it would be helpful if future reports highlighted performance of Cwm Taf Morgannwg as a whole and whether performance was improving as well as information on individual practice performance and how this compared to the rest of Wales.

Dilys Jouvenat questioned what support was being provided to practices with high error rates in order to help them improve. Members **NOTED** that practices were constantly being reminded of the patient safety element associated with high error rates and practices had also been provided with a list of Frequently Asked Questions (FAQs).

The Chair extended his thanks to Scott Lavender for presenting the report and advised that the Committee had been encouraged by the update provided and that Steve Webster had offered his support to contribute to suggestions in relation to the future format of reports.

Members **RESOLVED** to:

- **NOTE** the report;
- **RECEIVE** a further update in six months.

Scott Lavender and Sara Jeremiah left the meeting at 10.21am.

AC/19/054 **AUDIT RECOMMENDATIONS TRACKER**

Gwenan Roberts presented the report and advised that the changes discussed at the last meeting in relation to classifying what each recommendation meant had not yet been executed.

Members **NOTED** that in relation to Internal Audit, 48 recommendations remained outstanding, 23 of which were overdue their original date for implementation.

Members **NOTED** that in relation to Wales Audit Office reports 27 recommendations were outstanding with 13 overdue their originally agreed implementation date, most of which related to Follow Up Outpatients Not Booked (FUNB).

Gwenan Roberts provided Members with an update on progress made against the outstanding recommendations and suggested that the Committee received detailed updates from the Executive Leads against the following areas at the next meeting:

- Fire Management;
- JAG Accreditation – Closure report also required;
- Performance Management;
- Facilities Management.

Members **NOTED** that the majority of other Internal Audit recommendations should be completed by the next meeting.

In relation to FUNB, Members **NOTED** that work was progressing in this area and that scrutiny of the position continued to be undertaken at Finance, Performance & Workforce Committee and Quality, Safety & Risk Committee. The Chair referred to a suggestion that had been made at Finance, Performance & Workforce Committee that additional resource would be required to address the FUNB position moving forward. Members **NOTED** that Demand & Capacity plans would need to be strengthened to enable a decision to be made as to whether additional resource would be required.

A discussion was held in relation to the overall approach and process in place regarding audit recommendations and it was **AGREED** that a discussion would be held outside of the meeting with Internal and External Audit on the processes in place. Gwenan Roberts advised that it would be helpful if a discussion could be held on what completing a recommendation meant and what evidence the Committee would require to provide them with assurance that an action had been closed correctly.

Members **RESOLVED** to:

- **NOTE** the update received;
- **ENDORSE** the progress made to date and agree any related further actions, particularly relating to the High Risk recommendations, where action has been significantly delayed beyond originally intended completion dates;

- **REQUEST** detailed updates against four key areas at the next meeting.

AC/19/055 **PROCUREMENTS AND SCHEME OF DELEGATION REPORT**

Huw Evans presented the report which provided an update on the transactions approved as exceptions within the Scheme of Delegation for the period 1.12.18 to 28.2.19. The report also provided an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP).

Members **NOTED** that there had been no off contract engagements during the period and that there had been 3 Single Tender Actions undertaken.

Members **NOTED** the additional information provided within the report in relation to the Single Quotation Tender for Urology and **NOTED** that there had been one contract which required Ministerial approval which related to the Digitisation of Medical Records.

Members **NOTED** that the UHB had managed to maintain 95% performance against Purchase to Pay.

Members **RESOLVED** to:

- **NOTE** the position on procurement matters for the period 1.12.18 to 28.2.19;
- **NOTE** the update regarding Purchase to Pay.

AC/19/056 **LOSSES AND SPECIAL PAYMENTS REPORT**

Huw Evans presented the report which provided an update on the losses and special payments made by the UHB for the period 1 December 2018 to 28 February 2019, as required in the Standing Financial Instructions.

Members **NOTED** that there had been a slight reduction in provision for Medical Negligence cases as a result of the reduction in cost estimates. Members **NOTED** that the impact of the Permanent Injury Benefit claim was now known and had resulted in a provision of £1.6m which had been fully funded by Welsh Government.

Members **NOTED** that there had been a £311k overspend on claims in Month 11 partly offset by a substantial reduction in Personal Injury Claims expenditure. Members **NOTED** that a Deep Dive report into Claims Expenditure had been received by the Finance, Performance & Workforce Committee where opportunities for improvement had been identified.

Members **RESOLVED** to:

- **NOTE** the losses and special payments made for the period 1 December 2018 to 28 February 2019.

AC/19/057 **DRAFT FINANCIAL CONTROL PROCEDURE (FCP) – MEDICAL VARIABLE PAY**

Steve Webster provided Members with an oral update and advised that the draft FCP for Medical Variable Pay was currently out for consultation. Members **NOTED** that the FCP highlighted the new areas of control that were being put in place regarding 'Retinue' and a final version of the procedure would be presented once feedback had been received from senior teams.

Members **NOTED** that the procedure was not contentious although there was a risk that the policy would not be complied with. Members **NOTED** that Internal Audit would be undertaking a review of the operation of the new procedure during 2019/20.

Members **RESOLVED** to:

- **NOTE** the update provided.

AC/19/058 **STANDING ORDERS AND SCHEME OF DELEGATION INCLUDING THE REVIEW OF DECLARATIONS OF INTERESTS RECEIVED**

Gwenan Roberts presented the report which provided the Committee with an update on the review of the UHB's Standing Orders and to request that the Committee **ENDORSE** the updated Standing Orders and supporting schedules and the changes to the Schedule of Additional Delegations linked to the Standing Financial Instructions (SFIs), for **APPROVAL** by the Board.

Members **NOTED** the following key changes:

- Changing Cwm Taf University Health Board (CTUHB) to Cwm Taf Morgannwg University Health Board (CTMUHB)
- New corporate logo to reflect the new corporate identity as Cwm Taf Morgannwg UHB

- The foreword had been updated to include reference to the legislative changes that were made to legally sanction the transfer of responsibility of the Bridgend area to Cwm Taf UHB
- Minor housekeeping amendments had been made to the Scheme of Reservation and Delegation of Powers and the following sentence had been included 'Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels'

Members **NOTED** that in relation to Schedule 3, each Committee's Terms of Reference were in the process of being updated formally through individual committees and would be received by the Board with through the Annual Reports produced by each Committee during the summer months.

A discussion was held in relation to Schedule 8, Committee Chairs and Champions. Members **NOTED** the Chair's intention to introduce different committees; Maria Thomas advised that she required further clarification on the role of Committee Chairs and Champions which she would discuss further with Gwenan Roberts outside of the meeting.

Gwenan Roberts provided Members with an update in relation to the declarations of interest process and advised that declarations had been sought from staff for 2019. Members **NOTED** that for the first time staff members' names would be published and consideration would also need to be given to capturing declarations of interests for Bridgend staff.

Members **RESOLVED** to:

- **NOTE** the amendments to the Board's Standing Orders; and
- **ENDORSE** the updated Standing Orders and supporting Schedules and the changes to the Schedule of additional delegations linked to the Standing Financial Instructions (SFIs), for **APPROVAL** by the Board.

PART 3. CHARITABLE FUNDS

AC/19/059 **CHARITABLE FUNDS**

Huw Evans presented the report which provided the Committee with an update of the activity and balances on charitable funds for the period 1 December 2018 to 28 February 2019. The report also provided an update on the transfer of balances associated with the Bridgend Boundary Change.

Members **NOTED** that the balance at the end of February was £1.852m which was an increase of £10k since the last report. In relation to investment, the market value at 28 February was £1.790m, which was a fall of £20k from the end of November, compared to an investment of £1.5m, which was a surplus of £290k (19.3%).

Members **NOTED** the work that had been undertaken to incorporate the Bridgend Charitable Funds and **NOTED** the report that had been developed and presented to Abertawe Bro Morgannwg UHB. Members **NOTED** that 4 funds that had been previously identified to transfer to Cwm Taf Morgannwg would now remain with Swansea Bay UHB.

Members **NOTED** that the UHB's name change would need to be reflected in a new name for the Charity. The objects of the Charitable Fund would also need to be changed to allow for transferred monies relating to an 'African Health Links' Fund to continue to be used for the purpose intended. Members **NOTED** that it was therefore proposed to amend the objects to add the wording currently used within ABMU.

Members **NOTED** the proposal to increase staffing resources as a result of the 50% increase in activity that would be undertaken and that agreement had been given in principle to invest in additional resource.

A discussion was held as to whether the Committee had the authority to approve the actions proposed for registering the name change and revised objects with the Charity Commissioner. Following discussion, Gwenan Roberts **AGREED** to seek advice from the UHB Chair as to whether the Committee had this authority.

Members **RESOLVED** to:

- **NOTE** the current balances and investment performance of Cwm Taf Funds;
- **NOTE** the process for determining funds to be transferred, and their balances at 31.12.18;
- Subject to advice sought from the UHB Chair, **APPROVE** (by Chairs action) the actions proposed for registering the name change and revised objects with the Charity Commissioner;
- **ENDORSE** the increase in staffing resources required to administer the additional funds being transferred.

PART 4. INTERNAL AUDIT

AC/19/060 **INTERNAL AUDIT PROGRESS REPORT**

Paul Dalton, Head of Internal Audit & Assurance, presented the Internal Audit & Assurance progress report. Since the February 2019 meeting, Members **NOTED** that the following 9 reports had been finalised.

Management of Major Capital	**Limited Assurance**
Patient Experience	**Reasonable**
Welsh Risk Pool	**Substantial**
Directorate Review - Primary Care Compliance	**Reasonable**
Risk Management	**Reasonable**
Service Change Plan	**Reasonable**
Core Financial Systems – Cash Management	**Substantial**
WHSSC – Risk Management	**Reasonable**
WHSSC – Governance Arrangements	**Reasonable**

Maria Thomas questioned when the Committee would be receiving the limited assurance reports on Cyber Security and Water Safety. Paul Dalton assured Members that these would be presented to the next meeting.

Paul Dalton also provided assurance that all reviews would have been completed in time to provide a Head of Internal Audit opinion and advised that if there were any emerging concerns these would be escalated to the Executive Team.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/061 **INTERNAL AUDIT & ASSURANCE AUDIT REPORTS**

Common Issues identified within Directorate Reviews

Paul Dalton presented the report which had been updated and strengthened following discussion held at the last meeting.

Members **RESOLVED** to:

- **NOTE** the report.

Core Financial Systems – Cash Management – Substantial Assurance

Emma Samways presented the report which had been given a substantial assurance rating with no recommendations made.

Members **RESOLVED** to:

- **NOTE** the report.

Welsh Risk Pool – Substantial Assurance

Emma Samways presented the report which had been allocated a substantial assurance rating, with 1 low priority recommendation made which related to administrative processes.

The Chair requested that thanks were passed onto the staff working under the two areas which received substantial assurance ratings.

Members **RESOLVED** to:

- **NOTE** the report.

Service Change Plans Early Cancer Diagnosis – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating, with 4 recommendations made, 2 high, 1 medium and 1 low.

Members **NOTED** that the 2 high priority findings related to Internal Audit not being able to find any specific targets in order to measure outcomes. Furthermore, there was no evidence that risks were being properly captured, even though they were being discussed. The one medium priority finding related to clearer and evidence based monitoring of financial spend.

Members **NOTED** that all recommendations had been accepted by management and it was felt that the timescales set were realistic. Members **AGREED** to refer the report to the Early Cancer Diagnosis Project Board.

Members **RESOLVED** to:

- **NOTE** the report;
- **REFER** the report to the Early Cancer Diagnosis Project Board for information.

Patient Experience – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating. Members **NOTED** that the review focussed on how the UHB gathered patient experience data and identified that a significant amount of data was being captured.

Members **NOTED** that 4 recommendations had been made, 3 of which were medium priority and 1 low priority finding. Members **NOTED** that the review identified that there were inconsistencies in processes in different directorates and the patient experience plan had not been as detailed as previous year's plans.

Maria Thomas assured Members that the inconsistencies were being addressed through the Quality Governance Framework which had been discussed at the Quality, Safety & Risk Committee. Members **NOTED** that the Patient Experience Team were also addressing the issues identified in relation to the patient experience plan. Members **AGREED** to refer the report to the Quality, Safety & Risk Committee for information.

Members **RESOLVED** to:

- **NOTE** the report;
- **REFER** the report to the Quality, Safety & Risk Committee for information.

Directorate Review – Primary Care Compliance – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating. Members **NOTED** that 3 recommendations had been made, 1 of which was high and 3 of which were low.

Members **NOTED** that the high priority finding related to the lack of an inventory of non-capital assets; this had been a common theme within other Directorate reviews. Members **NOTED** that the Directorate had started to action the recommendations made and there was confidence that timescales for completion would be achieved.

Gwenan Roberts confirmed that the Internal Audit report had been referred to within the Directors update report to the Primary & Community Care Committee taking place on 3 April 2019.

Members **RESOLVED** to:

- **NOTE** the report.

Risk Management – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating, with 1 high and 2 medium priority recommendations made.

The one high priority recommendation related to the Board Assurance Framework which was in the process of being reviewed. Members **NOTED** that the review identified the need for clarity on which Committee would be reviewing the document with various references being made to both the Audit Committee and Quality, Safety & Risk Committee.

Members **NOTED** that the review also identified that there was no evidence available as to why changes had been made to risk scores contained within the risk register and the review looked at what challenges were being made in Committee meetings on the changes made.

Members **NOTED** that a follow up review had also been undertaken of the 2017/18 recommendations, some of which had been partially completed.

Gwenan Roberts advised that the work being undertaken to develop the Board Assurance Framework had been paused as the Chair of the UHB had requested that a Board Development Session was held in relation to Risk Management and Risk Appetite. Members **NOTED** that this discussion would be held at the April Board Development session.

Members **RESOLVED** to:

- **NOTE** the report.

Internal Audit Plan 2019/2020

Paul Dalton presented the report which outlined the Internal Audit Plan for 2019/2020. Members **NOTED** that the plan was risk based and had been developed from the accumulation of knowledge of the UHB and from the attendance at Committee meetings throughout the year. Members **NOTED** that discussions had also taken place with Executive Directors and Wales Audit Office colleagues.

John Palmer arrived at 11.29am.

Members **NOTED** that there had been an increase in the number of Internal Audit days as a result of the larger organisation which would be under a greater degree of risk as a result of the Bridgend transition.

Paul Dalton advised that the plan would be kept under review during the course of the year and provided assurance that the number of days allocated would be achievable.

Paul Dalton **AGREED** to amend the report to reflect that the Executive Lead for Health & Safety and Freedom of Information was the Director of Corporate Services & Governance.

Steve Webster explained the allocation of days outlined within the report and advised that 100 core days would be for core Cwm Taf and the new core days for Bridgend was 240. Members **NOTED** that Shared Services had reallocated the days from ABMU to CT and there was potential for some additional work to be undertaken on transition assimilation.

Members **RESOLVED** to:

- **APPROVE** the Internal Audit Plan for 2019/20;
- **APPROVE** the Internal Audit Charter;
- **NOTE** the associated Internal Audit resource requirements and Key Performance Indicators.

Medical Devices and Equipment – Internal Audit Action Plan

John Palmer was in attendance for this item.

John Palmer presented Members with an update on the Medical Devices and Equipment Internal Audit Action plan which needed to be strengthened following discussion at the last meeting.

Members **NOTED** that a timeline had now been put into place in relation to the development of a policy, and that an overarching governance process was being put into place with further work to be undertaken on training needs analysis.

In relation to the issues identified on equipment being purchased and not used, John Palmer advised that a piece of equipment had been purchased using year end funding, which the Team had not been ready to utilise. However, the equipment would be used in the future. Members **NOTED** that a Statement of Need had been in place for the item.

The Chair welcomed the report which provided the Committee with greater assurance and it was recognised that further work was required to address all issues. Members **NOTED** that various references had been made within the update report in relation to funding requirements and it was **NOTED** that the Directorate had

submitted a funding request of £105k to enable administrative/governance processes to be put into place.

Steve Webster advised that this would need to be considered alongside other high priority investment areas.

The Chair extended his thanks to John Palmer for presenting the update and advised that he would be invited to the next meeting to present an update on the three outstanding areas highlighted within the audit tracker update report.

Members **RESOLVED** to:

- **NOTE** the update.

PART 5. EXTERNAL AUDIT

AC/19/062 **WALES AUDIT OFFICE UPDATE REPORT**

Dave Thomas presented the report which provided the Committee with an update on current and planned Wales Audit Office work.

Members **NOTED** that work would be undertaken within the next few weeks to plan for the Annual Accounts.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/063 **WALES AUDIT OFFICE REPORT – 2019 AUDIT PLAN**

Dave Thomas presented the report which provided Members with the 2019 Audit Plan.

Members **NOTED** that the Wales Audit Office planned to present the Annual Audit of Accounts to the Board meeting being held on 30 May 2019. Members **NOTED** the financial audit risks outlined within the report which had been split between significant risks and other areas of risks.

Members **NOTED** the areas which required Audit attention, which included the requirement of the UHB to breakeven and the Bridgend Boundary change. Members **NOTED** the outline of the work being undertaken in relation to Charitable Funds, for which there were no issues identified during 2018/19. Members **NOTED** that an independent examination would be undertaken during 2019/20 and close monitoring of the funds which related to Bridgend would be undertaken.

Members **NOTED** that in relation to performance, an annual structured assessment would be undertaken alongside an in depth review of Quality Governance arrangements on an All Wales basis.

Dave Thomas advised that the WAO would need to work closely with Healthcare Inspectorate Wales (HIW) during this review. Gwenan Roberts advised that HIW had advised the UHB of their intention to undertake a review of Quality Governance and that the Delivery Unit (DU) had also developed a draft report following their attendance at Quality, Safety & Risk Committee. Members **NOTED** that the WAO would be meeting with both HIW and DU to discuss the work being undertaken.

Dave Thomas advised that the local programme of work had been kept open in order to determine what risks would emerge from Bridgend and consideration was being given as to how to utilise the themes that had emerged from the Joint Transition Board.

Members **NOTED** that there had been a slight reduction in the fee charged by WAO as a result of changes to skill mix within the Team.

Steve Webster advised that a discussion had been held by the Executive Team who agreed that the WAO audit plan needed to focus on Quality Governance.

The Chair welcomed the reduction in fees and **NOTED** that the make-up of the fee had changed, with 10% more resource allocated to the structured assessment work. Dave Thomas advised that more resource had been allocated to this area as a large volume of work needed to be undertaken in this area.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/064 **WALES AUDIT OFFICE REPORT – STRUCTURED ASSESSMENT 2018**

Dave Thomas presented the report which set out the findings from the Auditor General's 2018 structured assessment work at Cwm Taf University Health Board.

Dave Thomas advised that he was pleased to advise that all recommendations had been accepted by management and that he felt the response had been reasonable and pragmatic and recognised where pace of change was required.

In relation to recommendation 6, it had been **NOTED** that a new audit tracker would be developed and that a tracker would also be developed for Quality, Safety & Risk Committee.

Gwenan Roberts advised that at present there were two separate trackers for WAO and Internal Audit recommendations and it was **NOTED** that through internal processes, agreement had been given for additional resource to be allocated to the Chief Operating Officer and Director of Primary, Community & Mental Health to support in tracking progress made against completing the recommendations.

In relation to recommendation 8, it was **NOTED** that the UHB were planning to develop a Cyber Security action plan and there were also plans to introduce an Information Communication and Technology (ICT) Committee once a new Independent Member for ICT was in post.

Members **NOTED** that the structured assessment would need to inform the wider work being undertaken on enhanced monitoring and WAO had ensured that the recommendations made were in line with the recommendations made by WG.

Members **RESOLVED** to:

- **NOTE** the report.

PART 6. ITEMS FOR INFORMATION

AC/19/065 **COMMITTEE FORWARD WORK PLAN 2019-20**

Members **RECEIVED** and **NOTED** the Forward Work Plan. The Chair advised that the plan would be discussed further outside of the meeting with Gwenan Roberts and Robert Williams.

PART 6. ANY OTHER URGENT BUSINESS

The Chair extended his thanks to Huw Evans for the support and contribution he had made to the Committee and wished him all the very best for the future.

AC/19/067 **ITEMS FOR REFERRAL TO OTHER COMMITTEES**

Members referred the following items:

- Internal Audit Report - Service Change Plans Early Cancer Diagnosis to Early Cancer Diagnosis Project Board
- Internal Audit Report – Patient Experience to Quality, Safety & Risk Committee

AC/19/068 **CLOSE OF PART 1 OF THE MEETING – DATE AND TIME OF NEXT MEETING:**

In closing part 1 of the meeting, Members **RESOLVED** that in accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

The next meeting of the Committee would be held at 09:00hrs on Monday 13 May 2019.

…….

Paul Griffiths, Chair

Date ……

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 1 APRIL 2019

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
18/028	16/4/ 2018	Audit Recommendations Tracker	Amend Audit tracker template to include specific dates for Director updates and to stipulate that if no progress made within a 3 month period the Director should attend an Audit Committee meeting to explain why limited progress made	May 2018	Interim Board Secretary	**On agenda** Executive Directors are invited to attend the Committee within 3 months.
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a review of the Declarations of Interests received to ensure all submissions had been captured.	October 2018	Interim Board Secretary	**Ongoing – Update report to be presented at the July meeting**
18/099	8/10/ 2018	JAG Accreditation	Closure report to be presented to a future meeting.	January 2019	Deputy Chief Operating Officer / Interim Board Secretary	**On agenda**
19/007	14/1/ 2019	Post Payment Verification Progress Report	Consideration to be given to including benchmarking information in future iterations of the report. Reporting process to be amended so that reports are received on progress made year to date and the forward plan for the following year.	April 2019	Post Payment Verification Manager	**Completed**
19/023	14/1/ 2019	Internal Audit Report – Raising Concerns	Discussion to be held with the Executive Team in relation to introducing a nominated person who would be responsible for	February 2019	Director of Workforce and OD / Interim Board Secretary	**In progress** Subject to urgent discussions and the work being undertaken in relation to the de-escalation plan.

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
			receiving any protected disclosures.			
19/025	14/1/ 2019	WAO Report – Structured Assessment 2018	Discussion to be held with the Executive Team in relation to the content of the management response	February 2019	Interim Board Secretary	**Completed Discussion held at the April meeting**
19/037	11/2/ 2019	Audit Recommendation Tracker	Consideration to be given as to whether the statement made within the report that recommendations had reportedly been completed would need to be reworded. Discussions to be held outside of the meeting as to whether the audit tracker process could be strengthened and refined.	April 2019	Interim Board Secretary	**In progress Work remains ongoing in relation to refining the audit tracker**
19/039	11/2/ 2019	Internal Audit Report – Common Issues Identified within Directorate Reviews	Discussion to be held with the Executive Team in relation to putting a process in place to enable lessons learnt from Directorate reviews to be shared amongst Directorates	April 2019	Interim Board Secretary	**In progress**
19/039	11/2/ 2019	Internal Audit Report – Medical Devices & Equipment	Amended management response to be developed alongside an explanation as to how a piece of equipment was purchased and never used.	April 2019	Chief Operating Officer	**Completed Detailed update report presented to the April meeting**
19/044	11/2/ 2019	Committee Forward Work Plan	Consideration to be given to the content of the work plan moving forward in light of the Bridgend transition.	April 2019	Interim Board Secretary	**In progress**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
			Consideration to be given to increasing the frequency of future meetings.			
19/059	1/4/19	Charitable Funds	A discussion was held as to whether the Committee had the authority to approve the actions proposed for registering the name change and revised objects with the Charity Commissioner. Following discussion, Gwenan Roberts **AGREED** to seek advice from the UHB Chair as to whether the Committee had this authority.	May 2019	Interim Board Secretary	**In progress**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.1** **13 May 2019**

Audit Committee Report
DRAFT ANNUAL ACCOUNTS 2018-19

Executive Lead: Director of Finance
Author: Finance Manager, Financial Accounts, Capital & Systems
Contact Details for further information: Liz Williams on 01443 443803 or Elisabeth.williams@wales.nhs.uk

Purpose of the Audit Committee Report
To present the Draft Annual Accounts, subject to audit, for the financial year ended 31 March 2019.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019-22 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	Draft Annual Accounts 2018-19

Engagement – Who has been involved in this work?
N/A

Audit Committee Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is asked to: • **NOTE** the Draft Annual Accounts for 2018-19, subject to any issues that may arise from the ongoing external audit process.						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	No specific impact
Legal implications	Legal requirement to produce a set of accounts for each financial year, to be approved by the Board
Population Health	No specific impact
Quality, Safety & Patient Experience	No specific impact
Resources	The accounts highlights the resources received and the use of those resources for 2018-19 in accordance with Welsh Government requirements
Risks and Assurance	This report is a key element of the governance and assurance process on financial matters
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. Link to Health & Care Standards Welsh Government web site The work reported in this summary takes into account many of the related quality themes.
Workforce	No specific workforce implications
Freedom of information status	Open

DRAFT ANNUAL ACCOUNTS 2018-19

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to present the draft Annual Accounts for the financial year ended 31 March 2019, and provide an opportunity for the Audit Committee to raise any questions or concerns in relation to them.

The draft accounts remain subject to audit and may therefore be amended prior to formal approval by the Audit Committee and at the Health Board meeting on 30 May 2019.

2. BACKGROUND

The UHB has prepared a set of accounts in line with Welsh Government guidance and relevant International Financial Reporting Standards (IFRS). The format of the accounts is set by the Welsh Government, with the timetable for 2018-19 requiring their completion and audit by the 31 May. These Draft Accounts were completed and submitted for audit on 26 April.

The audit process is currently being undertaken. Any changes recommended by the Auditors, and accepted by the UHB, will require these draft accounts to be amended accordingly. Any such changes will be reported to the 30 May Audit Committee. The Audit Committee will not be asked to approve the Accounts until they have received the outputs from the audit.

Production of Accounts

The timetable continues to be a considerable challenge in the preparation of the accounts. In order to achieve this timetable, a pragmatic approach has had to be taken on areas requiring estimates and judgements. Such approaches have been discussed and agreed with audit both at a local and all-Wales level.

As Cwm Taf UHB is host organisation to the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), the accounts of Cwm Taf UHB need to incorporate WHSSC and EASC. As in previous years, figures are shown relating to Cwm Taf only, where appropriate, as well as the consolidated Cwm Taf/WHSSC/EASC positions. The key statements therefore have a separate column for Cwm Taf UHB activities only with the total column representing the consolidated position. In line with normal consolidation practices, any transactions between Cwm Taf UHB, WHSSC and EASC will have been removed within the consolidated column.

Prior year figures are shown where appropriate, complying with normal accounting standards.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Financial Targets

The UHB is required by Welsh Government to remain within the:

- Revenue Resource Limit (over a 3 year rolling period)
- Capital Resource Limit

The UHB remained within its Revenue Resource Limit achieving an under-spend of £16k in the year, shown on page 22 of the Accounts. This target has been met in each of the 3 years with a cumulative surplus of £57k over the 3-year period.

Similarly, an under-spend of £10k against the Capital Resource Limit was achieved in 2018-19, shown on page 22 of the Accounts. A cumulative surplus of £23k was achieved over the 3 year period.

There is also a financial duty to have an approved Integrated Medium Term Plan. Again, this has been achieved in each of the last 3 years, and is noted on page 23.

The UHB has met its creditor payment target having paid 96.1% of non-NHS invoices within 30 days compared to a 95% requirement, shown on page 34 of the Accounts. In value terms, the UHB paid 95.9% of its non-NHS invoices over the financial year as a whole within 30 days. Although the UHB only paid 80.4% of its NHS invoices in 30 days, the value was 97.1% reflecting that all LTA payments are paid directly by bank transfer on the first working day each month. All these prompt payment figures are consolidated with WHSSC/EASC.

A commentary on the main statements within the Accounts (Cwm Taf UHB column only) is provided below.

Statement of Comprehensive Net Expenditure (page 2)

This statement reports the net costs of the Health Board's operating activities.

Primary healthcare services expenditure totalled £147.605m, an increase of £2.752m (1.9%) on the previous year. The main increases were in General Medical Services (7.3%), and General Dental Services (6.6%). The detail of primary healthcare services expenditure is given in note 3.1 on page 24.

Expenditure on healthcare from other providers totalled £176.628m, an increase of £20.83m (13.4%) on the previous year. The main increases are in Continuing Care (£9.7m) and Local Authorities (£3.3m) which relates to the new Care Home Accommodation Pooled Budget, and WHSSC/EASC (£5.2m). The detail of expenditure on healthcare from other providers is given in note 3.2 page 24.

Expenditure on hospital and community health services totalled £465.602m, up £38.101m (8.9%) on the previous year. Excluding the impact of fixed assets impairments, which can fluctuate considerably from year to year and is funded based on actual costs by Welsh Government, the increase goes down to £23.721m (5.5%)

There was a £16.1m increase in staff costs (4.9%) of which £10.2m relates to the implementation of the 3 year pay agreement. Other operating expenses increased by £3.9m which include Bridgend transition costs, National Imaging Academy costs and winter hospital to home pilots. There was a net increase in impairments of fixed assets in 2018-19 of £11.57m, a breakdown is shown on Page 42 of the Accounts.

The detail of expenditure on hospital and community services is given in note 3.3 on page 25.

Miscellaneous income totalled £102.517m, up by £19.665m (23.7%). Local Authority income increased by £10.9m which relates to the new Care Home Accommodation Pooled budget detailed in note 32 on page 63a, Integrated Care Funding received from Welsh Government (£2.9m) and the receipt of donated assets (£3.1m) detailed on page 37. The detail on miscellaneous income is given in note 4 on page 26.

Statement of Financial Position- Balance Sheet (page 4)

This statement provides a summary of the organisation's assets and liabilities.

Assets

The total value of property, plant and equipment (PPE) has increased by £0.8m, and a reduction of £0.1m in the value of intangible assets (mainly software licences). Capital investment of £27.3m took place during the year. Indexation of land and buildings increased the book value by £1.2m, and this is offset by depreciation of £16.2m and net impairments of £11.57m. Impairment reviews were mainly as a result of bringing new assets into use, in particular the Neonatal unit at PCH and Phase 1a of the Ground & First Floor Project. A narrative on impairments is included on page 37.

Capital investment was higher than depreciation by £11.1m. The main areas of investment were in buildings/assets under construction (£18.0m investment, £8.7m depreciation), plant & machinery which includes medical equipment (£4.7m investment, £4.3m depreciation) and information technology including intangibles (£4.6m investment, £2.7m depreciation). The detail on property, plant and equipment is given in note 11 pages 35 to 38 and note 12 pages 39 to 41 for intangibles.

Trade and other receivables current and non current have increased by £19.9m. The biggest change relates to amounts due/recoverable from the Welsh Risk Pool which has increased by £11.7m to reflect changes in clinical negligence provisions/payments. Local Authority receivables have also increased by £4.7m largely due to the new Care Home Accommodation Pooled budget arrangement.

With the implementation of IFRS 9 in 2018-19 the methodology for the calculation of the provision for irrecoverable debts changed. Note 34 on page 65a gives further details. The change in the methodology resulted in an increase in the Expected Credit Loss/Provision for impairment of receivables of £763k for UHB up to 31 March 2018 which was processed as an adjustment on the opening balance. The detail of trade and other receivables is given in note 15 on page 44.

Liabilities

Trade and other liabilities current and non-current have increased by £23m. The main areas of increase relate to accruals (£13m) which include Funding Nursing care and Continuing Health care accruals (£7m) and Holiday pay accrual (£1m) and Other creditors (£6.6m) which relates mainly to the movement from provisions to creditors for Clinical negligence and personal injury payments. The detail of trade and other liabilities is given in note 18 on page 46.

There are also significant balances relating to provisions for potential future liabilities for events which happened on or before the 31 March 2019 but the liability is still to be determined. These liabilities are based on estimates of the probable outcome and include clinical negligence £79.5m (compared to £76.4m in the previous year), continuing healthcare £2.6m reported within other provisions, (£3.2m in previous year) and personal injury £4.8m (£4.7m in previous year). An analysis of the provisions and their movement during the year is shown within note 20 on page 48.

Statement of Changes in Tax Payers Equity (page 5)

This statement reports movements in the general fund and revaluation reserve. The general fund is the cumulative year on year position of cash funding received from the Welsh Government less net operating costs. Cash funding received in year totalled £682.3m which funded both revenue and capital activities (£661.9m in 17-18). The revaluation reserve records retained increases in assets values as a result of indexation and any transfer between reserves. There has been a net decrease of £4.7m in the reserve for 2018-19.

Statement of Cashflow (page 7)

This statement provides a summary of the cash transactions for the period. Cash spent on revenue activities amounted to £655.8m in the year. Capital activities (including intangibles) resulted in a net £25.7m cash outflow. This cash spend was funded through cash receipts of £682.3m from the Welsh Government.

The cash balance held at the end of the financial year was £316k.

Accounting Notes

Included in the accounts are notes which provide further detail on the amounts reported in the four main statements.

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the Draft Annual Accounts for 2018-19, subject to any issues that may arise from the ongoing external audit process.

Freedom of information status	Open

CWM TAF 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 1 October 2009 following the merger of Cwm Taf NHS Trust, Rhondda Cynon Taf Local Health Board and Merthyr Tydfil Local Health Board.

The Welsh Health Specialised Services Committee (WHSSC) was established on 1 April 2010, responsible for the joint planning of specialised and tertiary services on behalf of Local Health Boards in Wales. The Committee is hosted by Cwm Taf University Local Health Board.

The Emergency Ambulance Services Committee was established on 1 April 2014, responsible for planning and securing the provision of emergency ambulance services on behalf of Local Health Boards in Wales. The Committee is hosted by Cwm Taf University Local Health Board.

Performance Management and Financial Results

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014 the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

These accounts are a consolidation of the Health Board and WHSSC activities, with the balances relating to Cwm Taf Health Board only separately disclosed where appropriate.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000 Cwm Taf HB Activities	2018-19 £'000	2017-18 £'000 Cwm Taf HB Activities	2017-18 £'000
Expenditure on Primary Healthcare Services	3.1	**147,605**	**147,605**	144,853	144,853
Expenditure on healthcare from other providers	3.2	**176,628**	**830,091**	155,798	783,863
Expenditure on Hospital and Community Health Services	3.3	**465,602**	**472,295**	427,501	431,707
		789,835	**1,449,991**	728,152	1,360,423
Less: Miscellaneous Income	4	**(102,517)**	**(762,673)**	(82,852)	(715,123)
LHB net operating costs before interest and other gains and losses		**687,318**	**687,318**	645,300	645,300
Investment Revenue	5	**(1)**	**(1)**	(4)	(4)
Other (Gains) / Losses	6	**(44)**	**(44)**	(40)	(40)
Finance costs	7	**74**	**74**	82	82
Net operating costs for the financial year		**687,347**	**687,347**	**645,338**	**645,338**

See note 2 on page 22 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 66 form part of these accounts

Other Comprehensive Net Expenditure

	2018-19	2017-18
	£'000	£'000
Net gain / (loss) on revaluation of property, plant and equipment	1,184	12,032
Net gain / (loss) on revaluation of intangibles	0	0
Net gain / (loss) on revaluation of available for sale financial assets	0	0
Gain /(loss) on other reserves	0	0
Impairment and reversals	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0
Other comprehensive net expenditure for the year	1,184	12,032
Total comprehensive net expenditure for the year	686,163	633,306

Statement of Financial Position as at 31 March 2019

	Notes	31 March 2019 £'000 Cwm Taf HB Activities	31 March 2019 £'000	31 March 2018 £'000 Cwm Taf HB Activities	31 March 2018 £'000
Non-current assets					
Property, plant and equipment	11	**363,772**	**363,772**	362,968	362,968
Intangible assets	12	**913**	**913**	1,061	1,061
Trade and other receivables	15	**38,734**	**38,734**	48,087	48,087
Other financial assets	16	**0**	**0**	0	0
Total non-current assets		**403,419**	**403,419**	412,116	412,116
Current assets					
Inventories	14	**4,291**	**4,291**	4,372	4,372
Trade and other receivables	15	**86,580**	**96,195**	57,333	67,972
Other financial assets	16	**0**	**0**	22	22
Cash and cash equivalents	17	**316**	**8,957**	(289)	11,285
		91,187	**109,443**	61,438	83,651
Non-current assets classified as "Held for Sale"	11	**0**	**0**	0	0
Total current assets		**91,187**	**109,443**	61,438	83,651
Total assets		**494,606**	**512,862**	473,554	495,767
Current liabilities					
Trade and other payables	18	**(98,897)**	**(128,833)**	(75,689)	(109,582)
Other financial liabilities	19	**0**	**0**	0	0
Provisions	20	**(47,797)**	**(47,959)**	(34,733)	(34,895)
Total current liabilities		**(146,694)**	**(176,792)**	(110,422)	(144,477)
Net current assets/ (liabilities)		**(55,507)**	**(67,349)**	(48,984)	(60,826)
Non-current liabilities					
Trade and other payables	18	**(1,466)**	**(1,466)**	(1,621)	(1,621)
Other financial liabilities	19	**0**	**0**	0	0
Provisions	20	**(43,372)**	**(43,372)**	(53,833)	(53,833)
Total non-current liabilities		**(44,838)**	**(44,838)**	(55,454)	(55,454)
Total assets employed		**303,074**	**291,232**	307,678	295,836
Financed by :					
Taxpayers' equity					
General Fund		**277,070**	**265,228**	276,961	265,119
Revaluation reserve		**26,004**	**26,004**	30,717	30,717
Total taxpayers' equity		**303,074**	**291,232**	307,678	295,836

The financial statements on pages 2 to 7 were approved by the Board on 30 May 2019 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 30th May 2019

The notes on pages 8 to 66 form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2019

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2018-19			
Balance as at 31 March 2018	265,119	30,717	**295,836**
Adjustment for Implementation of IFRS 9	-763	0	**-763**
Balance at 1 April 2018	264,356	30,717	**295,073**
Net operating cost for the year	(687,347)		**(687,347)**
Net gain/(loss) on revaluation of property, plant and equipment	0	1,184	**1,184**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	5,897	(5,897)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2018-19	(681,450)	(4,713)	**(686,163)**
Net Welsh Government funding	682,322		**682,322**
Balance at 31 March 2019	265,228	26,004	**291,232**

The notes on pages 8 to 66 form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2018

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2017-18			
Balance at 1 April 2017	248,152	19,078	**267,230**
Net operating cost for the year	(645,338)		**(645,338)**
Net gain/(loss) on revaluation of property, plant and equipment	0	12,032	**12,032**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	393	(393)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2017-18	(644,945)	11,639	**(633,306)**
Net Welsh Government funding	661,912		**661,912**
Balance at 31 March 2018	265,119	30,717	**295,836**

The notes on pages 8 to 66 form part of these accounts

Statement of Cash Flows for year ended 31 March 2019

	Notes	2018-19 £'000 Cwm Taf HB Activities	2018-19 £'000	2017-18 £'000 Cwm Taf HB Activities	2017-18 £'000
Cash Flows from operating activities					
Net operating cost for the financial year		**(687,347)**	**(687,347)**	(645,338)	(645,338)
Movements in Working Capital	27	**1,255**	**(1,678)**	(9,856)	(2,495)
Other cash flow adjustments	28	**41,789**	**41,789**	37,170	37,264
Provisions utilised	20	**(11,521)**	**(11,521)**	(11,731)	(11,759)
Net cash outflow from operating activities		**(655,824)**	**(658,757)**	(629,755)	(622,328)
Cash Flows from investing activities					
Purchase of property, plant and equipment		**(25,471)**	**(25,471)**	(32,672)	(32,672)
Proceeds from disposal of property, plant and equipment		**44**	**44**	44	44
Purchase of intangible assets		**(298)**	**(298)**	(162)	(162)
Proceeds from disposal of intangible assets		**0**	**0**	0	0
Payment for other financial assets		**0**	**0**	0	0
Proceeds from disposal of other financial assets		**22**	**22**	79	79
Payment for other assets		**0**	**0**	0	0
Proceeds from disposal of other assets		**0**	**0**	0	0
Net cash inflow/(outflow) from investing activities		**(25,703)**	**(25,703)**	(32,711)	(32,711)
Net cash inflow/(outflow) before financing		**(681,527)**	**(684,460)**	(662,466)	(655,039)
Cash Flows from financing activities					
Welsh Government funding (including capital)		**682,322**	**682,322**	661,912	661,912
Capital receipts surrendered		**0**	**0**	0	0
Capital grants received		**0**	**0**	0	0
Capital element of payments in respect of finance leases and on-SoFP		**(190)**	**(190)**	(156)	(156)
Cash transferred (to)/ from other NHS bodies		**0**	**0**	0	0
Net financing		**682,132**	**682,132**	661,756	661,756
Net increase/(decrease) in cash and cash equivalents		**605**	**(2,328)**	(710)	6,717
Cash and cash equivalents (and bank overdrafts) at 1 April 2018		**(289)**	**11,285**	421	4,568
Cash and cash equivalents (and bank overdrafts) at 31 March 2019		**316**	**8,957**	(289)	11,285

The notes on pages 8 to 66 form part of these accounts

Notes to the Accounts
1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2018-19 Manual for Accounts. The accounting policies contained in that manual follow the European Union version of the International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations
Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income and funding
The main source of funding for the Local Health Boards (LHBs) are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the Local Health Board. Welsh Government funding is recognised in the financial period in which the cash is received.

Non discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers is applied, as interpreted and adapted for the public sector, in the Financial Reporting Manual (FReM). It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. Upon transition the accounting policy to retrospectively restate in accordance with IAS 8 has been withdrawn. All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.
A review consistent with the portfolio approach was undertaken by the NHS Technical Accounting Group members, which

- identified that the only material income that would potentially require adjustment under IFRS 15 was that for patient care provided under Long term Agreements (LTAs) for episodes of care which had started but not concluded as at the end of the financial period;
- demonstrated that the potential amendments to NHS Wales NHS Trust and Local Health Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income for LTA activity is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.3.1 WHSSC/EASC

Neither WHSSC nor EASC hold any statutory responsibility for a resource limit. Services are funded by income from Local Health Boards and based on an agreed financial plan. The committees account for all expenditure on agreed services against the income received as part of their plans. All variances from plan are allocated to Health Boards on the basis of an agreed risk sharing framework and matched by income adjustments consistent with this framework. The net operating cost for the financial year is therefore zero.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the LHB commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the LHBs accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme

The LHB has to offer an alternative pensions scheme for employees not eligible to join the NHS Pensions scheme. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment
Recognition
Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the LHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the LHBs services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales bodies have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2017-18 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure.

From 2015-16, the LHB must comply with IFRS 13 Fair Value Measurement in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the entity or the asset which would prevent access to the market at the reporting date. If the LHB could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, NHS bodies are required to get all All Wales Capital Schemes that are completed in a financial year revalued during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the LHBs business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the LHB; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments
Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the LHB expects to obtain economic benefits or service potential from the asset. This is specific to the LHB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the LHB checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development
Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Local Health Board as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The Local Health Board as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories
Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions
Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs
The Welsh Risk Pool (WRP) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. ***The risk sharing option was /was not implemented in 2018-19***. The WRP is hosted by Velindre NHS Trust.

1.15 Financial Instruments

From 2018-19 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales bodies, will be to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.

1.16 Financial assets
Financial assets are recognised on the Statement of Financial Position when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets

receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

NHS Wales Technical Accounting Group members reviewed the IFRS 9 requirements and determined a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value
Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCNE
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 Financial liabilities are initially recognised at fair value
Financial liabilities are classified as either financial liabilities at fair value through the Statement of Comprehensive Net Expenditure or other financial liabilities.

1.17.2 Financial liabilities at fair value through the Statement of Comprehensive Net Expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax
Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies
Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the LHB has no beneficial interest in them. Details of third party assets are given in Note 29 to the accounts.

1.21 Losses and Special Payments
Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had LHBs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP). The LHB accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is below 50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget
The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32.

The pool is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty
In the application of the LHB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Provisions
The Health Board provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the Health Board or Trust, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision Contingent Liability for all other estimated expenditure.
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of -0.75%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.25 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHBs approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHBs criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the LHB to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs Statement of Financial Position.

Other assets contributed by the LHB to the operator
Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the LHB through the asset being made available to third party users.

1.26 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.
Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.27 Carbon Reduction Commitment Scheme
Carbon Reduction Commitment Scheme allowances are accounted for as government grant funded intangible assets if they are not realised within twelve months and otherwise as current assets. The asset should be measured initially at cost. Scheme assets in respect of allowances shall be valued at fair value where there is evidence of an active market.

1.28 Absorption accounting
Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29 Accounting standards that have been issued but not yet been adopted
The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts (The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.),
IFRS 16 Leases (HMT have confirmed that IFRS 16 Leases, as interpreted and adapted by the FReM is to be effective from 1st April 2020).
IFRS 17 Insurance Contracts,
IFRIC 23 Uncertainty over Income Tax Treatment.

1.30 Accounting standards issued that have been adopted early
During 2018-19 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31 Charities
Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as the LHB is the corporate trustee of the Cwm Taf NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Cwm Taf NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Cwm Taf NHS Charitable Fund within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Cwm Taf NHS Charitable Fund or its independence in its management of charitable funds.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016 -17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	631,729	645,338	687,347	**1,964,414**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(1,181)	(784)	(725)	**(2,690)**
Less revenue consequences of bringing PFI schemes onto SoFP	(111)	(119)	(120)	**(350)**
Total operating expenses	630,437	644,435	686,502	**1,961,374**
Revenue Resource Allocation	630,455	644,458	686,518	**1,961,431**
Under /(over) spend against Allocation	18	23	16	**57**

Cwm Taf LHB has met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2016-17 to 2018-19.

The Health Board did not receive any repayable brokerage during the year.

2.2 Capital Resource Performance

	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	17,748	34,962	27,283	**79,993**
Add: Losses on disposal of donated assets	0	0	0	**0**
Less NBV of property, plant and equipment and intangible assets disposed	(66)	(4)	0	**(70)**
Less capital grants received	0	0	0	**0**
Less donations received	(95)	(64)	(3,115)	**(3,274)**
Charge against Capital Resource Allocation	17,587	34,894	24,168	**76,649**
Capital Resource Allocation	17,592	34,902	24,178	**76,672**
(Over) / Underspend against Capital Resource Allocation	5	8	10	**23**

Cwm Taf LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2016-17 to 2018-19.

2.3 Duty to prepare a 3 year plan

The NHS Wales Planning Framework for the period 2017-18 to 2019-20 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB submitted an Integrated Medium Term Plan for the period 2017-18 to 2019-20 in accordance with NHS Wales Planning Framework.

	2018-19 to 2020-21
The Minister for Health and Social Services approval status	Approved

The LHB has therefore met its statutory duty to have an approved financial plan for the period 2018-19 to 2020-21.

The LHB Integrated Medium Term Plan was approved in 2017-18.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2018-19 Total	2017-18
	£'000	£'000	£'000	£'000
General Medical Services	51,875		**51,875**	48,327
Pharmaceutical Services	17,570	(3,091)	**14,479**	14,512
General Dental Services	17,285		**17,285**	16,214
General Ophthalmic Services	1,133	3,816	**4,949**	4,941
Other Primary Health Care expenditure	4,588		**4,588**	5,050
Prescribed drugs and appliances	54,429		**54,429**	55,809
Total	**146,880**	**725**	**147,605**	144,853

Included within Note 3.1 General Medical Services are staff costs of £7,167m (2017-18 £6.748m).

3.2 Expenditure on healthcare from other providers	**2018-19**	**2018-19**	2017-18	2017-18
	£'000	**£'000**	£'000	£'000
	CT activities		CT activities	
Goods and services from other NHS Wales Health Boards	**29,842**	**409,553**	29,549	387,186
Goods and services from other NHS Wales Trusts	**12,689**	**201,081**	10,932	190,023
Goods and services from Health Education and Improvement Wales (HEIW)	**0**	**0**	0	0
Goods and services from other non Welsh NHS bodies	**1,598**	**133,550**	1,317	133,017
Goods and services from WHSSC / EASC	**69,963**	**0**	64,727	0
Local Authorities	**6,089**	**6,093**	2,749	2,749
Voluntary organisations	**3,451**	**7,002**	3,102	6,733
NHS Funded Nursing Care	**4,867**	**4,867**	5,400	5,400
Continuing Care	**44,242**	**44,242**	34,526	34,526
Private providers	**3,817**	**23,633**	3,426	24,159
Specific projects funded by the Welsh Government	**0**	**0**	0	0
Other	**70**	**70**	70	70
Total	**176,628**	**830,091**	155,798	783,863

3.3 Expenditure on Hospital and Community Health Services

	2018-19 £'000 CT activities	2018-19 £'000	2017-18 £'000 CT activities	2017-18 £'000
Directors' costs	1,948	1,948	1,726	1,726
Staff costs	344,149	349,035	328,317	331,876
Supplies and services - clinical	54,728	55,694	53,359	53,359
Supplies and services - general	5,719	5,719	5,787	5,787
Consultancy Services	349	407	235	351
Establishment	7,000	7,339	6,418	6,590
Transport	711	711	808	808
Premises	15,353	15,798	15,305	15,583
External Contractors	17	17	3	3
Depreciation	15,765	15,765	14,934	14,934
Amortisation	477	477	486	486
Fixed asset impairments and reversals (Property, plant & equipment)	11,569	11,569	(2,811)	(2,811)
Fixed asset impairments and reversals (Intangible assets)	0	0	0	0
Impairments & reversals of financial assets	0	0	0	0
Impairments & reversals of non-current assets held for sale	0	0	0	0
Audit fees	352	401	355	404
Other auditors' remuneration	0	0	0	0
Losses, special payments and irrecoverable debts	3,062	3,062	2,070	2,102
Research and Development	0	0	0	0
Other operating expenses	4,403	4,353	509	509
Total	**465,602**	**472,295**	427,501	431,707

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2018-19 £'000	2017-18 £'000
Increase/(decrease) in provision for future payments:		
Clinical negligence	17,967	20,110
Personal injury	1,115	1,543
All other losses and special payments	307	202
Defence legal fees and other administrative costs	465	954
Gross increase/(decrease) in provision for future payments	**19,854**	**22,809**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	(594)	254
Less: income received/due from Welsh Risk Pool	(16,198)	(20,961)
Total	**3,062**	**2,102**

Personal injury includes £1,694k (2017-18 £53k) in respect of permanent injury benefits.
Clinical Redress arising during the year was £602k (2017-18 £213k)

4. Miscellaneous Income

	2018-19 £'000 CT activities	2018-19 £'000	2017-18 £'000 CT activities	2017-18 £'000
Local Health Boards	39,981	707,913	38,114	678,650
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	7,976	0	8,289	0
NHS trusts	5,791	5,975	5,363	5,381
Health Education and Improvement Wales (HEIW)	15	15	0	0
Other NHS England bodies	623	623	604	604
Foundation Trusts	0	0	0	0
Local authorities	17,248	17,248	6,305	6,305
Welsh Government	4,141	4,141	543	543
Non NHS:				
Prescription charge income	0	0	0	0
Dental fee income	4,124	4,124	4,026	4,026
Private patient income	79	79	81	81
Overseas patients (non-reciprocal)	0	0	0	0
Injury Costs Recovery (ICR) Scheme	1,474	1,474	1,520	1,520
Other income from activities	433	460	545	551
Patient transport services	0	0	0	0
Education, training and research	10,381	10,381	9,834	9,834
Charitable and other contributions to expenditure	142	142	284	284
Receipt of donated assets	3,115	3,115	64	64
Receipt of Government granted assets	0	0	0	0
Non-patient care income generation schemes	537	537	499	499
NHS Wales Shared Services Partnership (NWSSP)	0	0	0	0
Deferred income released to revenue	211	211	169	169
Contingent rental income from finance leases	0	0	0	0
Rental income from operating leases	0	0	0	0
Other income:				
Provision of laundry, pathology, payroll services	1,303	1,303	1,137	1,137
Accommodation and catering charges	2,602	2,602	2,764	2,764
Mortuary fees	281	281	310	310
Staff payments for use of cars	186	186	203	203
Business Unit	0	0	0	0
Other	1,874	1,863	2,198	2,198
Total	**102,517**	**762,673**	82,852	715,123

Injury Cost Recovery (ICR) Scheme income is subject to a provision for impairment of **21.89%** re personal injury claims

5. Investment Revenue

	2018-19	2017-18
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	1	4
Impaired financial assets	0	0
Other financial assets	0	0
Total	1	4

6. Other gains and losses

	2018-19	2017-18
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	44	40
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	44	40

7. Finance costs

	2018-19	2017-18
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	1	3
Interest on obligations under PFI contracts		
main finance cost	69	69
contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	70	72
Provisions unwinding of discount	4	10
Other finance costs	0	0
Total	74	82

8. Operating leases

LHB as lessee

The lease information below relates to lease agreements for buildings, vehicles and equipment.
There are no significant leasing arrangements that require further disclosure.

Payments recognised as an expense	**2018-19**	2017-18
	£000	£000
Minimum lease payments	**2,320**	2,163
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**2,320**	2,163

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**2,225**	2,184
Between one and five years	**5,468**	5,686
After 5 years	**5,722**	6,668
Total	**13,415**	14,538

Number of operating leases expiring	**Land & Buildings**	**Vehicles**	**Equipment**	**Total**
Not later than one year	**0**	**47**	**26**	**73**
Between one and five years	**5**	**79**	**21**	**105**
After 5 years	**4**	**0**	**0**	**4**
Total	**9**	**126**	**47**	**182**
Charged to the income statement (£000)	**0**	**0**	**0**	**0**

There are no future sublease payments expected to be received

LHB as lessor

Rental revenue	**£000**	£000
Rent	**0**	0
Contingent rents	**0**	0
Total revenue rental	**0**	0

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**0**	0
Between one and five years	**0**	0
After 5 years	**0**	0
Total	**0**	0

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other	Total	2017-18
	£000	£000	£000	£000	£000	£000
Salaries and wages	274,715	622	12,837	12,342	**300,516**	287,325
Social security costs	29,459	34	0	0	**29,493**	27,048
Employer contributions to NHS Pension Scheme	36,135	43	0	0	**36,178**	34,909
Other pension costs	49	0	0	0	**49**	19
Other employment benefits	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	**0**	0
Total	340,358	699	12,837	12,342	**366,236**	349,301
Charged to capital					**894**	1,008
Charged to revenue					**365,342**	348,293
					366,236	349,301
Net movement in accrued employee benefits (untaken staff leave accrual included above)					108	(76)

Following categories of costs are included within the 'Other' heading:

1) Medacs/Retinue contracted staff.
2) IR35 applicable staff.
3) GP out of hours staff.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other	Total	2017-18
	Number	Number	Number		Number	Number
Administrative, clerical and board members	1,462	7	23	6	**1,498**	1,487
Medical and dental	645	1	34	113	**793**	788
Nursing, midwifery registered	2,276	0	130	0	**2,406**	2,378
Professional, Scientific, and technical staff	258	0	0	0	**258**	254
Additional Clinical Services	1,313	0	11	0	**1,324**	1,310
Allied Health Professions	436	0	11	0	**447**	446
Healthcare Scientists	158	0	4	0	**162**	165
Estates and Ancilliary	737	0	0	0	**737**	733
Students	6	0	0	0	**6**	2
Total	**7,291**	**8**	**213**	**119**	**7,631**	7,563

9.3. Retirements due to ill-health

During 2018-19 there were 8 early retirements from the LHB agreed on the grounds of ill-health (18 in 2017-18 - £1,068,008) The estimated additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) wi ll be £155,589.

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)	2018-19 Number of compulsory redundancies	2018-19 Number of other departures	2018-19 Total number of exit packages	2018-19 Number of departures where special payments have been made	2017-18 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	2
£25,000 to £50,000	0	0	0	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	3

Exit packages cost band (including any special payment element)	2018-19 Cost of compulsory redundancies	2018-19 Cost of other departures	2018-19 Total cost of exit packages	2018-19 Cost of special element included in exit packages	2017-18 Total cost of exit packages
	£'s	£'s	£'s	£'s	£'s
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	37,289
£25,000 to £50,000	0	0	0	0	48,515
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	85,804

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.

No applications for VERS were made and/or agreed during 2018/19.

9.6 Remuneration Relationship

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

The banded remuneration of the highest-paid director in the LHB in the financial year 2018-19 was £180,000 - £185,000 (2017-18, £175,000 - £180,000). This was 6.4 times (2017-18, 6.4) the median remuneration of the workforce, which was £28,442 (2017-18, £27,889).

In 2018-19, 5 (2017-18, 9) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £183,001 to £210,000 (2017-18 £177,001 to £253,000).

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

9.7 Pension costs

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 5% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 2% of this. The legal minimum level of contribution level is due to increase to 8% in April 2019.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,032 and £46,350 for the 2018-19 tax year (2017-18 £5,876 and £45,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2018-19	**2018-19**	2017-18	2017-18
NHS	**Number**	**£000**	Number	£000
Total bills paid	**6,094**	**339,651**	6,312	715,706
Total bills paid within target	**4,898**	**329,766**	5,096	706,430
Percentage of bills paid within target	**80.4%**	**97.1%**	80.7%	98.7%
Non-NHS				
Total bills paid	**152,781**	**291,031**	136,835	290,997
Total bills paid within target	**146,830**	**278,973**	130,585	280,586
Percentage of bills paid within target	**96.1%**	**95.9%**	95.4%	96.4%
Total				
Total bills paid	**158,875**	**630,682**	143,147	1,006,703
Total bills paid within target	**151,728**	**608,739**	135,681	987,016
Percentage of bills paid within target	**95.5%**	**96.5%**	94.8%	98.0%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2018-19	2017-18
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	21,046	331,811	2,631	27,289	65,555	119	21,721	6,839	**477,011**
Indexation	50	1,198	21	0	0	0	0	0	**1,269**
Additions									
- purchased	0	5,868	0	9,087	4,609	53	4,220	2	**23,839**
- donated	0	0	0	3,003	94	0	18	0	**3,115**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	550	18,138	0	(18,688)	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	371	1,707	0	0	0	0	0	0	**2,078**
Impairments	0	(13,850)	0	0	0	0	0	0	**(13,850)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,160)	(7)	(10)	(37)	**(3,214)**
At 31 March 2019	22,017	344,872	2,652	20,691	67,098	165	25,949	6,804	**490,248**
Depreciation at 1 April 2018	0	49,797	447	0	44,357	118	14,370	4,954	**114,043**
Indexation	0	84	1	0	0	0	0	0	**85**
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	0	0	0	0	0	0	0	**0**
Impairments	0	(203)	0	0	0	0	0	0	**(203)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,160)	(7)	(10)	(37)	**(3,214)**
Provided during the year	0	8,625	80	0	4,342	0	2,262	456	**15,765**
At 31 March 2019	0	58,303	528	0	45,539	111	16,622	5,373	**126,476**
Net book value at 1 April 2018	21,046	282,014	2,184	27,289	21,198	1	7,351	1,885	**362,968**
Net book value at 31 March 2019	22,017	286,569	2,124	20,691	21,559	54	9,327	1,431	**363,772**
Net book value at 31 March 2019 comprises :									
Purchased	21,135	284,894	2,124	17,542	21,452	54	9,283	1,424	**357,908**
Donated	882	1,675	0	3,149	106	0	21	7	**5,840**
Government Granted	0	0	0	0	1	0	23	0	**24**
At 31 March 2019	22,017	286,569	2,124	20,691	21,559	54	9,327	1,431	**363,772**
Asset financing :									
Owned	21,777	284,715	918	20,691	21,556	54	9,327	1,431	**360,469**
Held on finance lease	0	479	0	0	3	0	0	0	**482**
On-SoFP PFI contracts	240	1,375	1,206	0	0	0	0	0	**2,821**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	22,017	286,569	2,124	20,691	21,559	54	9,327	1,431	**363,772**

The net book value of land, buildings and dwellings at 31 March 2019 comprises :

	£000
Freehold	**310,231**
Long Leasehold	**0**
Short Leasehold	**479**
	310,710

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institutie of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set ou t in IAS 16 and value its capital assets to fair vvalue. Fair value is defined by IAS 16 as the amount for whih as asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	21,705	307,658	2,444	14,557	59,479	119	18,641	6,613	**431,216**
Indexation	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	0	3,276	0	19,013	8,967	0	3,332	286	**34,874**
- donated	0	0	0	51	13	0	0	0	**64**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	5,562	0	(6,332)	830	0	0	(60)	**0**
Revaluations	(39)	11,908	163	0	0	0	0	0	**12,032**
Reversal of impairments	61	6,859	24	0	0	0	0	0	**6,944**
Impairments	(681)	(3,452)	0	0	0	0	0	0	**(4,133)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,734)	0	(252)	0	**(3,986)**
At 31 March 2018	21,046	331,811	2,631	27,289	65,555	119	21,721	6,839	**477,011**
Depreciation at 1 April 2017	0	41,411	368	0	43,822	118	12,848	4,524	**103,091**
Indexation	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	41	0	0	(41)	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,730)	0	(252)	0	**(3,982)**
Provided during the year	0	8,386	79	0	4,224	0	1,774	471	**14,934**
At 31 March 2018	0	49,797	447	0	44,357	118	14,370	4,954	**114,043**
Net book value at 1 April 2017	21,705	266,247	2,076	14,557	15,657	1	5,793	2,089	**328,125**
Net book value at 31 March 2018	21,046	282,014	2,184	27,289	21,198	1	7,351	1,885	**362,968**
Net book value at 31 March 2018 comprises :									
Purchased	20,181	280,297	2,184	27,143	21,138	1	7,309	1,866	**360,119**
Donated	865	1,717	0	146	54	0	7	17	**2,806**
Government Granted	0	0	0	0	6	0	35	2	**43**
At 31 March 2018	21,046	282,014	2,184	27,289	21,198	1	7,351	1,885	**362,968**
Asset financing :									
Owned	20,811	280,082	954	27,289	21,195	1	7,351	1,885	**359,568**
Held on finance lease	0	488	0	0	3	0	0	0	**491**
On-SoFP PFI contracts	235	1,444	1,230	0	0	0	0	0	**2,909**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	21,046	282,014	2,184	27,289	21,198	1	7,351	1,885	**362,968**

The net book value of land, buildings and dwellings at 31 March 2018 comprises :

	£000
Freehold	**304,758**
Long Leasehold	**0**
Short Leasehold	**487**
	305,245

11. Property, plant and equipment (continued)

1) Assets totalling £3.115m were purchased with donated funds:

	£'000
RGH Palliative Care Unit	3003
Imaging equipment	48
Automated Pharmacy Cabinets	46
Artificial Intelligence (AI) research equipment	10
Interactive therapy & activities package	8

2) Assets are restated to current value annually, using indicies provided by the District Valuer via Welsh Government. At five yearly intervals an independent professional valuation is undertaken of land and buildings.

The last valuation was carried out as at 1st April 2017.

The valuation was carried out by the Valuation Office Agency

The basis of the valuation for specialised operational assets where there is not market-based evidence is fair value, estimated using a depreciated replacement cost approach, subject to the assumption of continuing use. For non-specialised operational assets existing use value is used.

3) During 2018/19 the following impairments arose:

	£'000
National Imaging Academy (NIAD)	899
Ysbyty George Thomas Dementia Hub	324
PCH Neonatal	6202
PCH Ground and First Floor Refurbishment - Phase 1A	6222
Reversal of impairments	(2,077)
Total Impairments	11,570

The impairments arose as a result of bringing the assets into use.

4) IFRS 13 Fair value measurement

No assets currently meet the criteria for valuation under IFRS13

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2018	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2019	0	0	0	0	0	**0**
Balance brought forward 1 April 2017	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2018	0	0	0	0	0	**0**

12. Intangible non-current assets

2018-19

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	458	0	2,161	0	0	0	**2,619**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- purchased	**0**	**0**	**329**	**0**	**0**	**0**	**329**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(42)**	**0**	**0**	**0**	**0**	**0**	**(42)**
Gross cost at 31 March 2019	**416**	**0**	**2,490**	**0**	**0**	**0**	**2,906**
Amortisation at 1 April 2018	385	0	1,173	0	0	0	**1,558**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	**6**	**0**	**471**	**0**	**0**	**0**	**477**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(42)**	**0**	**0**	**0**	**0**	**0**	**(42)**
Amortisation at 31 March 2019	**349**	**0**	**1,644**	**0**	**0**	**0**	**1,993**
Net book value at 1 April 2018	**73**	**0**	**988**	**0**	**0**	**0**	**1,061**
Net book value at 31 March 2019	**67**	**0**	**846**	**0**	**0**	**0**	**913**
At 31 March 2019							
Purchased	**52**	**0**	**846**	**0**	**0**	**0**	**898**
Donated	**15**	**0**	**0**	**0**	**0**	**0**	**15**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2019	**67**	**0**	**846**	**0**	**0**	**0**	**913**

12. Intangible non-current assets
2017-18

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	443	0	2,161	0	0	0	**2,604**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	24	0	0	0	0	0	**24**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(9)	0	0	0	0	0	**(9)**
Gross cost at 31 March 2018	**458**	**0**	**2,161**	**0**	**0**	**0**	**2,619**
Amortisation at 1 April 2017	329	0	752	0	0	0	**1,081**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	65	0	421	0	0	0	**486**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(9)	0	0	0	0	0	**(9)**
Amortisation at 31 March 2018	**385**	**0**	**1,173**	**0**	**0**	**0**	**1,558**
Net book value at 1 April 2017	**114**	**0**	**1,409**	**0**	**0**	**0**	**1,523**
Net book value at 31 March 2018	**73**	**0**	**988**	**0**	**0**	**0**	**1,061**
At 31 March 2018							
Purchased	50	0	988	0	0	0	**1,038**
Donated	23	0	0	0	0	0	**23**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2018	**73**	**0**	**988**	**0**	**0**	**0**	**1,061**

Additional disclosures re Intangible Assets

In year, £0.329m of intangible assets were acquired relating to software licences.

Software and licences are allocated a useful life of five years

13 . Impairments

	2018-19 Property, plant & equipment £000	2018-19 Intangible assets £000	2017-18 Property, plant & equipment £000	2017-18 Intangible assets £000
Impairments arising from :				
Loss or damage from normal operations	**0**	**0**	0	0
Abandonment in the course of construction	**0**	**0**	0	0
Over specification of assets (Gold Plating)	**0**	**0**	0	0
Loss as a result of a catastrophe	**0**	**0**	0	0
Unforeseen obsolescence	**0**	**0**	0	0
Changes in market price	**0**	**0**	1,116	0
Others (specify)	**13,647**	**0**	3,294	0
Reversal of Impairments	**(2,077)**	**0**	(6,944)	0
Total of all impairments	**11,570**	**0**	(2,534)	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	**11,570**	**0**	(2,811)	0
Charged to Revaluation Reserve	**0**	**0**	277	0
	11,570	**0**	(2,534)	0

The following impairment losses were incurred for assets brought into use during the year:

	£'000
National Imaging Academy (NIAD)	899
Ysbyty George Thomas Dementia Hub	324
PCH Neonatal	6,202
PCH Ground and First Floor Refurbishment - Phase 1A	6,222
	13,647
Reversal of impairments as a result of indexation on assets previously impaired	**(2,077)**

14.1 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	1,706	1,705
Consumables	2,487	2,594
Energy	98	73
Work in progress	0	0
Other	0	0
Total	4,291	4,372
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	47	58
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	47	58

15. Trade and other Receivables

Current	**31 March 2019 £000 CT activities**	**31 March 2019 £000**	31 March 2018 £000 CT activities	31 March 2018 £000
Welsh Government	**2,884**	**2,884**	627	627
WHSSC / EASC	**612**	**0**	1,125	0
Welsh Health Boards	**4,256**	**13,603**	2,948	13,938
Welsh NHS Trusts	**1,330**	**1,784**	1,871	1,892
Health Education and Improvement Wales (HEIW)	**250**	**250**	0	0
Non - Welsh Trusts	**38**	**426**	20	707
Other NHS	**115**	**115**	153	153
Welsh Risk Pool	**60,516**	**60,516**	39,448	39,448
Local Authorities	**8,271**	**8,271**	3,523	3,523
Capital debtors	**0**	**0**	0	0
Other debtors	**7,349**	**7,351**	6,628	6,633
Provision for irrecoverable debts	**(3,045)**	**(3,045)**	(2,494)	(2,494)
Pension Prepayments	**0**	**0**	0	0
Other prepayments	**3,111**	**3,147**	2,826	2,887
Other accrued income	**893**	**893**	658	658
Sub total	**86,580**	**96,195**	57,333	67,972
Non-current				
Welsh Government	**0**	**0**	0	0
WHSSC / EASC	**0**	**0**	0	0
Welsh Health Boards	**0**	**0**	0	0
Welsh NHS Trusts	**0**	**0**	0	0
Health Education and Improvement Wales (HEIW)	**0**	**0**	0	0
Non - Welsh Trusts	**0**	**0**	0	0
Other NHS	**0**	**0**	0	0
Welsh Risk Pool	**38,617**	**38,617**	47,956	47,956
Local Authorities	**0**	**0**	0	0
Capital debtors	**0**	**0**	0	0
Other debtors	**0**	**0**	0	0
Provision for irrecoverable debts	**0**	**0**	0	0
Pension Prepayments	**0**	**0**	0	0
Other prepayments	**117**	**117**	131	131
Other accrued income	**0**	**0**	0	0
Sub total	**38,734**	**38,734**	48,087	48,087
Total	**125,314**	**134,929**	105,420	116,059
Receivables past their due date but not impaired				
By up to three months	**1,255**	**1,255**	1,111	1,201
By three to six months	**107**	**107**	288	288
By more than six months	**50**	**52**	73	73
	1,412	**1,414**	1,472	1,562

Expected Credit Losses (ECL) / Provision for impairment of receivables				
Balance at 31 March 2018	**(2,494)**	**(2,494)**		
Adjustment for Implementation of IFRS 9	**(763)**	**(763)**		
Balance at 1 April 2018	**(3,257)**	**(3,257)**	(2,211)	(2,211)
Transfer to other NHS Wales body	**0**	**0**	0	0
Amount written off during the year	**0**	**0**	1	1
Amount recovered during the year	**293**	**293**	146	146
(Increase) / decrease in receivables impaired	**(81)**	**(81)**	(430)	(430)
Bad debts recovered during year	**0**	**0**	0	0
Balance at 31 March	**(3,045)**	**(3,045)**	(2,494)	(2,494)

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	**0**	**0**	0	0
Other	**991**	**991**	1,093	1,093
Total	**991**	**991**	1,093	1,093

16. Other Financial Assets

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	22	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**22**	**0**	**0**

17. Cash and cash equivalents

	2018-19	**2018-19**	2017-18	2017-18
	£000	**£000**	£000	£000
	CT activities		CT activities	
Balance at 1 April	**(289)**	**11,285**	421	4,568
Net change in cash and cash equivalent balances	**605**	**(2,328)**	(710)	6,717
Balance at 31 March	**316**	**8,957**	(289)	11,285
Made up of:				
Cash held at GBS	**273**	**8,914**	**0**	**11,574**
Commercial banks	**24**	**24**	**29**	**29**
Cash in hand	**19**	**19**	**17**	**17**
Current Investments	**0**	**0**	**0**	**0**
Cash and cash equivalents as in Statement of Financial Position	**316**	**8,957**	46	11,620
Bank overdraft - GBS	**0**	**0**	(335)	(335)
Bank overdraft - Commercial banks	**0**	**0**	0	0
Cash and cash equivalents as in Statement of Cash Flows	**316**	**8,957**	(289)	11,285

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities £27k
PFI liabilities £163k

The movement relates to cash, no comparative information is required by IAS 7 in 2018-19.

18. Trade and other payables

Current	**31 March 2019 £000 CT activities**	**31 March 2019 £000**	31 March 2018 £000 CT activities	31 March 2018 £000
Welsh Government	**0**	**0**	**0**	**0**
WHSSC / EASC	**1,170**	**0**	**405**	**0**
Welsh Health Boards	**2,183**	**10,669**	**2,212**	**10,737**
Welsh NHS Trusts	**2,195**	**3,062**	**1,202**	**1,727**
Health Education and Improvement Wales (HEIW)	**0**	**0**	**0**	**0**
Other NHS	**2,112**	**20,425**	**1,640**	**23,584**
Taxation and social security payable / refunds	**0**	**51**	**0**	**42**
Refunds of taxation by HMRC	**0**	**0**	**0**	**0**
VAT payable to HMRC	**0**	**0**	**48**	**48**
Other taxes payable to HMRC	**3,225**	**3,225**	**2,447**	**2,447**
NI contributions payable to HMRC	**673**	**724**	**53**	**54**
Non-NHS creditors	**3,994**	**5,002**	**4,788**	**5,044**
Local Authorities	**5,202**	**5,202**	**6,364**	**6,364**
Capital Creditors	**5,070**	**5,070**	**3,658**	**3,658**
Overdraft	**0**	**0**	**0**	**0**
Rentals due under operating leases	**0**	**0**	**0**	**0**
Obligations under finance leases, HP contracts	**5**	**5**	**27**	**27**
Imputed finance lease element of on SoFP PFI contracts	**152**	**152**	**165**	**165**
Pensions: staff	**5,171**	**5,171**	**4,983**	**4,983**
Accruals	**52,201**	**54,525**	**38,907**	**41,906**
Deferred Income:				
Deferred Income brought forward	**422**	**422**	**338**	**338**
Deferred Income Additions	**310**	**310**	**253**	**253**
Transfer to / from current/non current deferred income	**0**	**0**	**0**	**0**
Released to SoCNE	**(211)**	**(211)**	**(169)**	**(169)**
Other creditors	**15,023**	**15,023**	**8,368**	**8,368**
PFI assets –deferred credits	**0**	**0**	**0**	**0**
Payments on account	**0**	**6**	**0**	**6**
Total	**98,897**	**128,833**	75,689	109,582
Non-current				
Welsh Government	**0**	**0**	0	0
WHSSC / EASC	**0**	**0**	0	0
Welsh Health Boards	**0**	**0**	0	0
Welsh NHS Trusts	**0**	**0**	0	0
Health Education and Improvement Wales (HEIW)	**0**	**0**	0	0
Other NHS	**0**	**0**	0	0
Taxation and social security payable / refunds	**0**	**0**	0	0
Refunds of taxation by HMRC	**0**	**0**	0	0
VAT payable to HMRC	**0**	**0**	0	0
Other taxes payable to HMRC	**0**	**0**	0	0
NI contributions payable to HMRC	**0**	**0**	0	0
Non-NHS creditors	**0**	**0**	0	0
Local Authorities	**0**	**0**	0	0
Capital Creditors	**0**	**0**	0	0
Overdraft	**0**	**0**	0	0
Rentals due under operating leases	**0**	**0**	0	0
Obligations under finance leases, HP contracts	**2**	**2**	7	7
Imputed finance lease element of on SoFP PFI contracts	**1,464**	**1,464**	1,614	1,614
Pensions: staff	**0**	**0**	0	0
Accruals	**0**	**0**	0	0
Deferred Income :				
Deferred Income brought forward	**0**	**0**	0	0
Deferred Income Additions	**0**	**0**	0	0
Transfer to / from current/non current deferred income	**0**	**0**	0	0
Released to SoCNE	**0**	**0**	0	0
Other creditors	**0**	**0**	0	0
PFI assets –deferred credits	**0**	**0**	0	0
Payments on account	**0**	**0**	0	0
Total	**1,466**	**1,466**	1,621	1,621

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	**31 March 2019 £000**	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2018	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2019
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	**28,937**	0	(5,757)	21,737	11,934	(8,556)	(6,753)	0	**41,542**
Personal injury	**1,677**	0	(243)	(1,219)	2,422	(727)	(1,307)	0	**603**
All other losses and special payments	**0**	0	0	0	307	(307)	0	0	**0**
Defence legal fees and other administration	**1,829**	0	0	226	1,071	(621)	(831)		**1,674**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**149**			141	67	(208)	(12)	0	**137**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**2,303**		(69)	2,036	1,727	(547)	(1,447)		**4,003**
Total	**34,895**	**0**	**(6,069)**	22,921	17,528	(10,966)	(10,350)	**0**	**47,959**
Non Current									
Clinical negligence	**47,447**	0	0	(21,737)	12,786	(532)	0	0	**37,964**
Personal injury	**3,042**	0	0	1,219	0	0	0	3	**4,264**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**948**	0	0	(226)	230	(23)	(5)		**924**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**360**			(141)	0	0	0	1	**220**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**2,036**		0	(2,036)	0	0	0		**0**
Total	**53,833**	**0**	**0**	**(22,921)**	**13,016**	**(555)**	**(5)**	**4**	**43,372**
TOTAL									
Clinical negligence	**76,384**	**0**	**(5,757)**	**0**	**24,720**	**(9,088)**	**(6,753)**	**0**	**79,506**
Personal injury	**4,719**	**0**	**(243)**	**0**	**2,422**	**(727)**	**(1,307)**	**3**	**4,867**
All other losses and special payments	**0**	**0**	**0**	**0**	**307**	**(307)**	**0**	**0**	**0**
Defence legal fees and other administration	**2,777**	**0**	**0**	**0**	**1,301**	**(644)**	**(836)**	**0**	**2,598**
Pensions relating to former directors	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Pensions relating to other staff	**509**			**0**	**67**	**(208)**	**(12)**	**1**	**357**
Restructuring	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Other	**4,339**		**(69)**	**0**	**1,727**	**(547)**	**(1,447)**	**0**	**4,003**
Total	**88,728**	**0**	**(6,069)**	**0**	**30,544**	**(11,521)**	**(10,355)**	**4**	**91,331**

Expected timing of cash flows:

	In year to 31 March 2020	Between 1 April 2020 31 March 2024	Thereafter	Total £000
Clinical negligence	41,541	37,964	0	**79,505**
Personal injury	603	1,151	3,113	**4,867**
All other losses and special payments	0	0	0	**0**
Defence legal fees and other administration	1,675	924	0	**2,599**
Pensions relating to former directors	0	0	0	**0**
Pensions relating to other staff	137	220	0	**357**
Restructuring	0	0	0	**0**
Other	4,003	0	0	**4,003**
Total	**47,959**	**40,259**	**3,113**	**91,331**

The expected timing of cashflows are based on best available information; but they could change on the basis of individual ca se changes.

The Legal & Risk Service (part of the NHS Wales Shared Service Partnership) provide details of Clinical Negligence and person al Injury cases including estimated settlement amounts and the timing of the cashflow.

The provision for Permanent Injury Benefit is supplied by NHS Pensions Agency.

Other provisions include £1,629k for Continuing Healthcare Claims (2017-18: £3,185k) and £937k for Continuing Healthcare - Judicial Review.

The Health Board estimates that it will receive £80,305k from the Welsh Risk Pool in respect of losses and special payments c ases (including Clinical Negligence, Redress and Personal Injury). In addition to the provisions shown above, contingent liabilities are given in Note 21.1 Contingent Liabilities.

20. Provisions (continued)

	At 1 April 2017	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2018
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	32,516	(4,858)	0	256	17,711	(7,865)	(8,823)	0	**28,937**
Personal injury	764	0	(54)	166	1,909	(742)	(366)	0	**1,677**
All other losses and special payments	0	0	0	0	203	(202)	(1)	0	**0**
Defence legal fees and other administration	2,365	0	0	(377)	1,608	(829)	(938)		**1,829**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	172			124	41	(213)	25	0	**149**
Restructuring	0			0	0	0	0	0	**0**
Other	1,625		0	0	928	(250)	0		**2,303**
Total	**37,442**	**(4,858)**	**(54)**	**169**	**22,400**	**(10,101)**	**(10,103)**	**0**	**34,895**
Non Current									
Clinical negligence	33,248	0	0	(256)	16,080	(1,625)	0	0	**47,447**
Personal injury	3,200	0	0	(166)	0	0	0	8	**3,042**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	320	0	0	377	310	(33)	(26)		**948**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	482			(124)	0	0	0	2	**360**
Restructuring	0			0	0	0	0	0	**0**
Other	1,087		0	0	1,632	0	(683)		**2,036**
Total	**38,337**	**0**	**0**	**(169)**	**18,022**	**(1,658)**	**(709)**	**10**	**53,833**
TOTAL									
Clinical negligence	65,764	(4,858)	0	0	33,791	(9,490)	(8,823)	0	**76,384**
Personal injury	3,964	0	(54)	0	1,909	(742)	(366)	8	**4,719**
All other losses and special payments	0	0	0	0	203	(202)	(1)	0	**0**
Defence legal fees and other administration	2,685	0	0	0	1,918	(862)	(964)		**2,777**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	654			0	41	(213)	25	2	**509**
Restructuring	0			0	0	0	0	0	**0**
Other	2,712		0	0	2,560	(250)	(683)		**4,339**
Total	**75,779**	**(4,858)**	**(54)**	**0**	**40,422**	**(11,759)**	**(10,812)**	**10**	**88,728**

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2018-19 £'000**	2017-18 £'000
Legal claims for alleged medical or employer negligence	**132,774**	148,659
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**1,875**	2,116
Continuing Health Care costs	**2,361**	4,811
Other	**0**	0
Total value of disputed claims	**137,010**	155,586
Amounts (recovered) in the event of claims being successful	**(132,424)**	(147,868)
Net contingent liability	**4,586**	7,718

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims ca nnot be determined and no provision has been made for them.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the N HS Pensions Agency could arise due to known incidents.

Liabilities for continuing healthcare costs continue to be a significant financial issue for the LHB. The 31st July 2014 deadline for the submission of any claims for continuing healthcare costs dating back to 1st April 2003 resulted in a large increase in the number of claims which have been recognised in the 2018/19 provision assessment.

Cwm Taf LHB is responsible for post 1st April 2003 costs and the financial statements include the following amounts relating to those uncertain continuing healthcare costs:

Note 20 sets out the £1.629m provision made for probable continuing care costs relating to 77 claims received.

Note 21.1 sets out the £2.361m contingent liability for possible continuing care costs relating to 63 claims received.

21.2 Remote Contingent liabilities

	2018-19	2017-18
	£'000	£'000
Please disclose the values of the following categories of remote contingent liabilities :		
Guarantees	0	0
Indemnities	1,025	1,050
Letters of Comfort	0	0
Total	**1,025**	**1,050**

21.3 Contingent assets

	2018-19	2017-18
	£'000	£'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2018-19	2017-18
	£'000	£'000
Property, plant and equipment	30,491	8,461
Intangible assets	0	0
Total	**30,491**	8,461

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out or written-off during the financial year

	Amounts paid out during period to 31 March 2019		Approved to write-off to 31 March 2019	
	Number	£	Number	£
Clinical negligence	141	14,869,081	126	13,815,895
Personal injury	55	970,797	36	410,054
All other losses and special payments	197	306,953	183	55,733
Total	393	16,146,831	345	14,281,682

Analysis of cases which exceed £300,000 and all other cases

Cases exceeding £300,000	Case type	Amounts paid out in year £	Cumulative amount £	Approved to write-off in year £
03RRSPI0020	Personal Injury	46,246	681,679	0
05RRSMN0039	Clinical Negligence	0	680,800	0
07RRSMN0006	Clinical Negligence	0	3,024,130	3,024,130
08RVEMN0013	Clinical Negligence	4,650,000	5,550,000	0
09RVEMN0017	Clinical Negligence	0	944,619	0
10RYLMN0030	Clinical Negligence	0	3,193,767	3,193,767
10RYLMN0092	Clinical Negligence	0	343,000	0
11RYLMN0068	Clinical Negligence	397,750	416,000	0
12RYLMN0004	Clinical Negligence	260,000	1,680,000	0
12RYLMN0031	Clinical Negligence	0	742,500	742,500
12RYLMN0075	Clinical Negligence	0	541,511	541,511
12RYLMN0100	Clinical Negligence	0	328,860	328,860
13RYLMN0080	Clinical Negligence	0	502,190	502,190
13RYLMN0131	Clinical Negligence	0	800,000	0
14RYLMN0010	Clinical Negligence	137,500	451,156	0
14RYLMN0062	Clinical Negligence	1,044,000	1,050,000	0
14RYLMN0127	Clinical Negligence	1,094,000	1,194,000	0
14RYLMN0133	Clinical Negligence	0	786,646	786,646
14RYLMN0200	Clinical Negligence	620,000	1,645,880	0
14RYLMN0208	Clinical Negligence	335,020	370,020	0
14RYLPI0055	Personal Injury	296,060	361,722	0
15RYLMN0010	Clinical Negligence	0	1,907,205	0
15RYLMN0018	Clinical Negligence	370,550	380,550	0
16RYLMN0078	Clinical Negligence	890,000	900,000	0
16RYLMN0170	Clinical Negligence	14,500	322,450	322,450
17RYLMN0185	Clinical Negligence	687,284	687,284	0
Sub-total		**10,842,910**	**29,485,969**	**9,442,054**
All other cases		5,303,921	12,130,787	4,839,628
Total cases		**16,146,831**	**41,616,756**	**14,281,682**

24. Finance leases

24.1 Finance leases obligations (as lessee)

There are no other significant leasing arrangements which require further disclosure.

Amounts payable under finance leases:

Land	**31 March 2019 £000**	31 March 2018 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Finance leases obligations (as lessee) continue

Amounts payable under finance leases:

Buildings	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**4**	27
Between one and five years	**0**	4
After five years	**0**	0
Less finance charges allocated to future periods	**0**	(1)
Minimum lease payments	**4**	30
Included in:		
Current borrowings	**4**	26
Non-current borrowings	**0**	4
	4	30
Present value of minimum lease payments		
Within one year	**4**	26
Between one and five years	**0**	4
After five years	**0**	0
Present value of minimum lease payments	**4**	30
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**2**	2
Between one and five years	**2**	3
After five years	**0**	0
Less finance charges allocated to future periods	**1**	(1)
Minimum lease payments	**5**	4
Included in:		
Current borrowings	**1**	1
Non-current borrowings	**2**	3
	3	4
Present value of minimum lease payments		
Within one year	**1**	1
Between one and five years	**2**	3
After five years	**0**	0
Present value of minimum lease payments	**3**	4
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Finance leases obligations (as lessor) continued

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2019	31 March 2018
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The Local Health Board 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 2019	31 March 2018
	£000	£000
Total payments due within one year	0	0
Total payments due between 1 and 5 years	0	0
Total payments due thereafter	0	0
Total future payments in relation to PFI contracts	0	0
Total estimated capital value of off-SoFP PFI contracts	0	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	£000
Staff Residences - Royal Glamorgan Hospital	1,446
Contract start date:	09/10/1998
Contract end date:	21/09/2028

Scheme Description

The staff residences scheme covers the design, build, financing and operation of staff accommodation on the Royal Glamorgan Hospital site. The Health Board entered into a project agreement with Charter Housing Association on the 9th October 1998.

	£000
Combined Heat and Power Plant-Prince Charles Hospital	1,375
Contract start date:	01/04/2004
Contract end date:	31/03/2029

The contract is for the installation, operation, maintenance and ownership of a Combined Heat and Power plant and the complete management and operation of a central boiler plant installation, light fittings and building management system on the Prince Charles Hospital site. The contract includes performance guarantees for the supply of hot water and electricity. The charging structure requires the Health Board to pay for the heat (in the form of hot water) created from the electricity generated by the Combined Heat and Power plant being supplied free of charge to the Health Board.

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2019	31 March 2019	31 March 2019
	£000	£000	£000
Total payments due within one year	152	47	406
Total payments due between 1 and 5 years	661	133	1,626
Total payments due thereafter	803	46	1,829
Total future payments in relation to PFI contracts	1,616	226	3,861

	On SoFP PFI Capital element	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2018	31 March 2018	31 March 2018
	£000	£000	£000
Total payments due within one year	165	52	391
Total payments due between 1 and 5 years	639	155	1,563
Total payments due thereafter	975	71	2,149
Total future payments in relation to PFI contracts	1,779	278	4,103

Total present value of obligations for on-SoFP PFI contracts 0

25.3 Charges to expenditure	2018-19	2017-18
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	399	391
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	399	391

The LHB is committed to the following annual charges

PFI scheme expiry date:	31 March 2019 £000	31 March 2018 £000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	406	388
Total	406	388

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	2	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	
Staff residences, Royal Glamorgan Hospital	On
Combined heat and power plant, Prince Charles Hospital	On

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

	2018-19 £000 CT activities	2018-19 £000	2017-18 £000 CT activities	2017-18 £000
(Increase)/decrease in inventories	**81**	**81**	(365)	(365)
(Increase)/decrease in trade and other receivables - non-current	**9,353**	**9,353**	(14,758)	(14,758)
(Increase)/decrease in trade and other receivables - current	**(29,247)**	**(28,223)**	744	(3,994)
Increase/(decrease) in trade and other payables - non-current	**(155)**	**(155)**	(177)	(177)
Increase/(decrease) in trade and other payables - current	**23,208**	**19,251**	6,659	18,758
Total	**3,240**	**307**	(7,897)	(536)
Adjustment for accrual movements in fixed assets - creditors	**(1,412)**	**(1,412)**	(2,115)	(2,115)
Adjustment for accrual movements in fixed assets - debtors	**0**	**0**	0	0
Other adjustments	**(573)**	**(573)**	156	156
	1,255	**(1,678)**	(9,856)	(2,495)

28. Other cash flow adjustments

	2018-19 £000 CT activities	2018-19 £000	2017-18 £000 CT activities	2017-18 £000
Depreciation	**15,765**	**15,765**	14,934	14,934
Amortisation	**477**	**477**	486	486
(Gains)/Loss on Disposal	**(44)**	**(44)**	(40)	(40)
Impairments and reversals	**11,569**	**11,569**	(2,811)	(2,811)
Release of PFI deferred credits	**0**	**0**	0	0
Donated assets received credited to revenue but non-cash	**(3,115)**	**(3,115)**	(64)	(64)
Government Grant assets received credited to revenue but non-cash	**0**	**0**	0	0
Non-cash movements in provisions	**17,137**	**17,137**	24,665	24,759
Total	**41,789**	**41,789**	37,170	37,264

29. Third Party assets

The LHB held £9,038 cash at bank and in hand at 31 March 2019 (31 March 2018, £16,425) which relates to monies held by the LHB on behalf of patients. Cash held in Patient's Investment Accounts amounted to £nil at 31 March 2019 (31 March 2018, £nil). This has been excluded from the Cash and Cash equivalents figure reported in the Accounts.

30. Events after the Reporting Period

The Cabinet Secretary for Health and Social Services announced on 14 June 2018 that from 1 April 2019, the responsibility for providing healthcare services for the people in the Bridgend County Borough Council (BCBC) area will move from Abertawe Bro Morgannwg UHB to Cwm Taf UHB.

The Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 transfers the principal local government area of Bridgend from Abertawe Bro Morgannwg UHB to Cwm Taf UHB. The Order also changes the health board names to Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board. In accordance with the Local Health Boards (Area Change) (Transfer of Staff, Property and Liabilities) (Wales) Order 2019 made on 19th March 2019 and effective on 1 April 2019 assets and liabilities relating to Bridgend services will transfer from Swansea Bay UHB to Cwm Taf Morgannwg UHB on 1 April 2019.

The transfer will be accounted for as a 'Transfer by Absorption' in accordance with the Government Financial Reporting Manual. The recorded amounts of net assets will be brought into the financial statements of Cwm Taf Morgannwg UHB from the 1 April 2019.

The impact of the transfer for Cwm Taf Morgannwg UHB is estimated to increase the expenditure and associated funding by 44% for future financial years.

31. Related Party Transactions

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with the Local Health Board.

The Welsh Government is regarded as a related party. During the year Cwm Taf University Local Health Board has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body namely,

	2018-19 Payments to related party £000	2018-19 Receipts from related party £000	2018-19 Amounts owed to related party £000	2018-19 Amounts due from related party £000
Welsh Assembly Government	9	692,255	0	2,884
WHSSC (see below)	69,991	7,987	1,170	612
NHS Trusts				
Public Health Wales NHS Trust	702	2,487	271	331
Velindre University NHS Trust	19,951	4,270	1,920	979
Welsh Ambulance Services Trust	1,309	79	4	19
Local Health Boards				
ABMU	5,894	7,721	641	1,972
Aneurin Bevan	1,194	21,832	332	761
Betsi Cadwaladwr	245	147	169	34
Cardiff & Vale	23,914	8,771	752	1,145
Hywel Dda	445	529	87	76
Powys	197	2,268	202	267
Health Education and Improvement Wales (HEIW)	0	3,510	0	250
TOTAL	123,851	751,856	5,548	9,330

31. Related Party Transactions(cont.)

Welsh Health Specialised Services and Emergency Ambulance Services

WHSSC and EASC are sub-committees of each of the 7 Local Health Boards in Wales. Therefore, any related transactions would form part of each LHB's statutory financial statements.
Whilst the committees have executive teams these are not executive directors and they are employed by Cwm Taf UHB as the host organisation.
During 2018/2019, the Joint Committees adopted a risk sharing approach which is applied to all financial transactions.
In accordance with the Standing Orders, the Joint Committees must agree a total budget to plan and secure the relevant services delegated to them. The Joint Committees must also agree the appropriate contribution of funding required from each LHB.

Each LHB will be required to make available to the Joint Committees the level of funds outlined in the annual plan.

The risk sharing income received from each LHB during 2018/2019 as per Note 4,
Expenditure incurred by WHSSC and EASC with providers of tertiary and specialist services is as follows as per Note 3.2 and analysed in the Segmental Analysis in Note 33.

	Income (Note 4) £000's	Expenditure (Note 3.2) £000's	Debtor (Note 15) £000's	Creditor (Note 18) £000's
Cardiff and Vale LHB	121,693	221,532	1,121	5,964
Aneurin Bevan LHB	136,775	8,172	2,303	47
Betsi Cadwalladr LHB	166,474	40,590	3,835	349
Abertawe Bro Morgannwg LHB	123,239	107,321	650	1,982
Cwm Taf UHB	69,991	7,601	1,171	612
Hywel Dda LHB	85,495	2,096	1,148	95
Powys Teaching HB	34,256		289	49
Public Health Wales NHS Trust	55		4	
Velindre NHS Trust	129	40,709	24	855
Welsh Ambulance Services NHS Trust		147,683	426	12
	738,107	**575,704**	**10,971**	**9,965**

Members of the Joint Committees for 2018/2019

LHB Chief Executives have voting rights on the committee while Trust Chief Executives are associate members only
During 2018/2019 WHSSC and EASC have entered into material transactions with the organisations represented as listed above

Mrs Judith Paget	Member		Chief Executive Aneurin Bevan UHB
Mrs Carol Shillabeer	Member		Chief Executive Powys Teaching HB
Mr Gary Doherty	Member		Chief Executive Betsi Cadwalladr UHB
Mrs Allison Williams	Member		Chief Executive Cwm Taf UHB
Mr Len Richards	Member		Chief Executive Cardiff and Vale UHB
Mr Steve Moore	Member		Chief Executive Hywel Dda UHB
Mrs Tracy Myhill	Member		Chief Executive Abertawe Bro Morgannwg UHB

The following are Associate Members of the Joint Committees and therefore have no voting rights on the Joint Committee

Dr Tracey Cooper	Associate Member		Chief Executive Public Health Wales NHS Trust (WHSSC & EASC)
Mr Steve Ham	Associate Member		Chief Executive Velindre NHS Trust (WHSSC only)
Mrs Patsy Roseblade	Associate Member	to Oct 2018	Interim Chief Executive, Welsh Ambulance Services NHS Trust (EASC only)
Jason Killens	Associate Member	from Oct 2018	Chief Executive, Welsh Ambulance Services NHS Trust (EASC only)
Prof John Williams	Independent Member		Chair of the Wales Renal Clincial Network (WHSSC only)
Mr Charles Janczewski	Independent Member		Chair of the Quality and Patient Safety Committee (WHSSC only)

Members With a Declared Interest

Prof Vivienne Harpwood	Chair	Chair, Powys Teaching HB (WHSSC only)
Mr Charles Janczewski	Independent Member	Independent Board Member, Cardiff and Vale UHB (WHSSC only)
Mrs Lyn Meadows	Independent Member	Independent Board Member, Betsi Cadwalladr UHB (WHSSC only)
Mr Chris Turner	Independent Member and Chair of EASC	Independent Board Member, Cwm Taf UHB (WHSSC only & EASC)

Apart from the transactions listed above, no Member or Associate Member of the Joint Committees has declared an interest in any other party that transacts with either WHSSC or EASC.

32. Pooled budgets

Rhondda Cynon Taf, Bridgend and Merthyr Tydfil Integrated Community Equipment Service

The Health Board has entered into a pooled budget with

Rhondda Cynon Taf County Borough Council
Merthyr Tydfil County Borough Council
Bridgend County Borough Council
Abertawe Bro Morgannwg University Local Health Board

Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an Intergrated Community Equipment Service. The service is to enable children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live life as fully as possible. The equipment provided can include, but is not limited to

- Community home nursing equipment
- Equipment for daily living
- Physiotherapy living
- Static Seating

A memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by Rhondda Cynon Taf County Borough Council. The financial operation of the pool is governed by a pooled budget agreement between the aboved named organisations and the Health Board. The Health Board accounts for its share of contributions to the budget in expenditure. Contributions are based on each individual organisations forecast activities. Assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Funding	2018-19 £'000
Rhondda Cynon Taf County Borough Council	1,223
Merthyr Tydfil County Borough Council	213
Bridgend County Borough Council	594
Abertawe Bro Morgannwg University Local Health Board	362
Cwm Taf University Local Health Board	355
Total Partners Funding	2,747
I.C.F Funding	33
Other Income Received	51
Total Funding	2,831
Expenditure	
Provision of community equipment services within Rhondda Cynon Taf, Bridgend and Merthyr Tydfil County Boroughs.	2,712
Pooled Budget surplus carried forward to 2019-20	119

32. Pooled budgets(cont)

Cwm Taf Care Home Accommodation

The Health Board has entered into a pool fund arrangement with Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council.

The Agreement for the CWM TAF CARE HOME ACCOMMODATION POOLED FUND is made under The Social Services and Well-being (Wales) Act 2014 (the 'Act') and the Partnership Arrangements (Wales) Regulations 2015 (the 'Regulations').

The Agreement provides for the establishment of the CWM TAF CARE HOME ACCOMMODATION POOLED FUND which will undertake the following functions on behalf of the Parties.

- The functions of a local authority under sections 35 and 36 of the Act, where it has been decided to meet the adult's needs by providing or arranging to provide accommodation in a care home;
- The functions of a Local Health Board under section 3 of the National Health Service (Wales) Act 2006 in relation to an adult, in cases where:
    - The adult has a primary need for health care and it has been decided to meet the needs of the adult by arranging the provision of accommodation in a care home, or
    - The adult does not have a primary need for health care but the adult's needs can only be met by the local authority arranging for the provision of accommodation together with nursing care

A memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by Rhondda Cynon Taf County Borough Council. The financial operation of the pool is governed by a pooled budget agreement between the aboved named organisations and the Health Board. The Health Board accounts for its share of contributions to the budget in expenditure. Contributions are based on each individual organisations forecast activities. Assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Funding	2018-19 £'000
Rhondda Cynon Taf County Borough Council	20,972
Merthyr Tydfil County Borough Council	4,495
Cwm Taf University Local Health Board	12,203
Total Partners Funding	37,670
Other Income Received	10
Total Funding	37,680
Expenditure	
Provision of paying care fees to to homes for the provision of residential & nursing care within the Rhondda Cynon Taf and	37,674

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

The following information segments the results of Cwm Taf Local Health Board by:
- Healthcare activities
- Welsh Health Specialised Services Committee (WHSSC)
- Emergency Ambulance Services Joint Committee (EASC)

Operating Costs 2018-19

	Healthcare activities	WHSSC	EASC	Inter-segment transactions	Cwm Taf LHB Total
	£'000	£'000	£'000	£'000	£'000
Expenditure on primary healthcare services	147,605	0	0	0	147,605
Expenditure on healthcare from other providers	176,628	579,738	151,289	(77,564)	830,091
Expenditure on hospital and community health services	465,600	4,302	2,805	(414)	472,293
	789,833	584,040	154,094	(77,978)	1,449,989
Less: Miscellaneous Income	(102,517)	(584,040)	(154,094)	77,978	(762,673)
losses	687,316	0	0	0	687,316
Investment Income	(1)	0	0	0	(1)
Other (Gains) / Losses	(44)	0	0	0	(44)
Finance costs	70	0	0	0	70
Net operating costs for the financial year	687,341	0	0	0	687,341

Net Assets 2018-19

	£'000	£'000	£'000	£'000	£'000
Total non-current assets	403,419	0	0	0	403,419
Total current assets	91,187	18,723	1,315	(1,782)	109,443
Total current liabilities	(146,694)	(30,565)	(1,315)	1,782	(176,792)
Total non-current liabilities	(44,838)	0	0	0	(44,838)
Total assets employed	303,074	(11,842)	0	0	291,232
Total taxpayers' equity	303,074	(11,842)	0	0	291,232

Operating Costs 2017-18

	Healthcare activities	WHSSC	EASC	Inter-segment transactions	Cwm Taf LHB Total
	£'000	£'000	£'000	£'000	£'000
Expenditure on primary healthcare services	144,853	0	0	0	144,853
Expenditure on healthcare from other providers	155,798	560,774	139,935	(72,644)	783,863
Expenditure on hospital and community health services	427,501	3,255	1,241	(290)	431,707
	728,152	564,029	141,176	(72,934)	1,360,423
Less: Miscellaneous Income	(82,852)	(564,029)	(141,176)	72,934	(715,123)
losses	645,300	0	0	0	645,300
Investment Income	(4)	0	0	0	(4)
Other (Gains) / Losses	(40)	0	0	0	(40)
Finance costs	82	0	0	0	82
Net operating costs for the financial year	645,338	0	0	0	645,338

Net Assets 2017-18

	£'000	£'000	£'000	£'000	£'000
Total non-current assets	389,311	0	0	0	389,311
Total current assets	84,243	23,547	196	(1,530)	106,456
Total current liabilities	(133,593)	(35,389)	(196)	1,530	(167,648)
Total non-current liabilities	(32,283)	0	0	0	(32,283)
Total assets employed	307,678	(11,842)	0	0	295,836
Total taxpayers' equity	307,678	(11,842)	0	0	295,836

34. Other Information

Cwm Taf University Health Board

IFRS15

Work was undertaken by the TAG IFRS sub group, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15. It was determined that the following types of consideration received from customers for goods and services (hereon referred to as income) fell outside the scope of the standard, as the body providing the income does not contract with the body to receive any direct goods or services in return for the income flow.

- Charitable Income and other contributions to Expenditure.
- Receipt of Donated Assets.
- WG Funding without direct performance obligation (e.g. SIFT/SIFT®/Junior Doctors & PDGME Funding).

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB & WHSCC LTA Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- ICR Income ;
- Training & Education income ;
- Accommodation & Catering income

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded (FCE's), as at period end, e.g. 31 March.

When calculating the income generated from these episodes, it was determined that it was appropriate to use length of stay as the best proxy for the attributable Work In Progress (WIP) value. In theory, as soon as an episode is opened, income is due. Under the terms and conditions of the contract this will only ever be realised on episode closure so the average length of stay would be the accepted normal proxy for the work in progress value.

For Cwm Health Board, the following methodology was applied to assess the value of the unaccounted WIP.

1. For 2016/17, income for inpatient activity recorded on a completed spell basis was £21.6m (total income from LTA's, including WHSSC, Welsh Health Boards and Non Welsh Commissioners, was £41m).
2. This related to circa 11,500 episodes, with an estimated average unit cost of £1,900.
3. Contracts are set on a range of marginal rates and the calculation below is based on an average of 60%.
4. As such, £1,140 per spell is the derived estimate for a WIP calculation.
5. Using available Business Intelligence/ Costing Information, the total open episodes at year-end and the average length of stay (ALoS) were identified.
6. This provided assumptions of a 4 day ALoS (with 50% completed) and circa 129 spells attributable to contracts at year-end, which lead to an adjustment calculation to align revenue recognised to the requirements of the standard:

   £1,140 / 4 days x 2 days x 129 spells = £73,530

34. Other Information (continued)

Cwm Taf University Health Board

IFRS 9

For consistency across Wales, the practical expedient provision matrix was used to estimate expected credit losses (ECLs) based on the 'age' of receivables as follows:

- Receivables were segregated into appropriate groups

- Each group, was analysed:

a) age-bands

1-30 days (including current)
31-60 days
61-90 days
91-180 days
181- 365 days
> 1 year

b) at historical back-testing dates (data points)

- For each age-band, at each back-testing date the following were determined:
  a) the gross receivables
  b) the amounts ultimately collected/written-off. If material, adjustments should be made to exclude the effect of non-collections for reasons other than credit loss (e.g. credit notes issued for returns, short-deliveries or as a commercial price concession)

- The average historical loss rate by age-band was calculated, and adjusted where necessary e.g. to take account of changes in:
  a) economic conditions
  b) types of customer
  c) credit management practices

- Consideration was given as to whether ECLs should be estimated individually for any period-end receivables, e.g. because information was available specific debtors.

- Loss rate estimates were applied to each age-band for the other receivables.

- The percentages calculated have been applied to those invoices outstanding as at 31st March 2018 (which don't already have a specific provision against them) to recalculate the value of the HB non-specific provision under IFRS9.

- The application of the above methodology resulted in overall increase in bad debt

2017/18 - Bad Debt Provision					IFRS 9 Impact					Change In Provision
Specific		General		Total	Specific		General		Total	
NHS	Non-NHS	NHS	Non-NHS		NHS	Non-NHS	NHS	Non-NHS		
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
114	1,541	0	0	1,655	114	1,541	171	592	2,418	763

34. Other Information (continued)

Welsh Health Specialised Services and Emergency Ambulance Services

IFRS15

Work was undertaken across NHS Wales, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15.

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB LTA Income
- WHSCC/EASC Risk Shared Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- NHS Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- Training & Education income ;

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded as at period end.

As WHSSC/ EASC are not direct providers of healthcare and so have no income of the nature described above, this assessment was not relevant.

A review, also consistent with the portfolio approach detailed above, was undertaken by the committees, which identified that WHSSC and EASC do not control the services that underpin their income flows. As such, under the terms of IFRS 15, the risk share principles of the committees which allow then to act on behalf of the LHBs when commissioning specialised services, could be deemed an agent v's principle relationship and is therefore outside the scope of the standard.

Taking this into account it can be demonstrated that the potential amendments to WHSSC/EASC Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework, due consideration must be given to the users of the accounts and the cost restraint of compliance, reporting and production of financial reporting. Given the income for WHSSC/EASC risk sharing is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales, it was considered reasonable to continue recognising in accordance with those established terms, on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

IFRS 9

For consistency across Wales, the practical expedient provision matrix was used to estimate expected credit losses (ECLs) based on the 'age' of receivables as follows:

- Receivables were segregated into appropriate groups
- Each group, was analysed:

a) age-bands

1-30 days (including current)
31-60 days
61-90 days
91-180 days
181- 365 days
> 1 year

b) at historical back-testing dates (data points)

- For each age-band, at each back-testing date the following were determined:

a) the gross receivables

b) the amounts ultimately collected/written-off. If material, adjustments should be made to exclude the effect of non-collections for reasons other than credit loss (e.g. credit notes issued for returns, short-deliveries or as a commercial price concession)

In line with the requirements of IFRS 9, WHSSC has assessed the age and profile of individual outstanding debtors and has concluded that the impact of IFRS 9 is immaterial in this financial year. Therefore no provision for bad debts has been deemed necessary Further information regarding WHSSC debtors and the aged profile is provided in note 15.

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

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

		Agenda Item	
Meeting Title	**Audit Committee**	Meeting Date	13/05/2019
Report Title	Report on the Draft Unaudited Financial Statements 2018/19		
Author (Job title)	Financial Accountant		
Executive Lead (Job title)	Director of Finance	~~Public~~ / In Committee	In Committee

Purpose	To brief the Audit Committee on the WHSSC Financial Statements for the financial year ended 31st March 2019.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Audit Committee	Meeting Date	13/05/2019
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **NOTE** the WHSSC Draft Unaudited Financial Statements for 2018/2019		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare			Institute for HealthCare Improvement Triple Aim			Quality, Safety & Patient Experience		
Resources Implications			Risk and Assurance	✓		Evidence Base		
Equality and Diversity			Population Health			Legal Implications	✓	

1.0 Situation

To provide an update to the Audit Committee on the WHSSC draft and unaudited financial statements for the financial year ended 31st March 2019. A more detailed analytical review will be provided to committee members for the sign off of the final post audit financial statements which has been timetabled for 30th May 2019.

Members need to be aware that this template is still in the draft format as supplied by WG and has a number of protected cells and formats which remain uncorrected at this time. WG have agreed to remove the cell protection to allow us to correct the formats, once the final audited statements have been released.

2.0 Background

As in previous years the WHSSC end of year accounting process was completed under a very strict and very tight timescale. In effect, as a result of the timing of the Easter holiday which coincided with the submission of the WHSSC accounts, the time table produced by WG for all NHS Wales bodies was reduced by 3 days

In order to allow Cwm Taf sufficient time to consolidate the WHSSC position into its own accounts, WHSSC must provide the same full set of financial statements, in the same WG format as each of the LHBs, but must complete this work one week earlier than the rest of Wales. This obviously produces its own unique challenges for the Financial Accounting team at WHSSC. This year WHSSC presented the draft accounts on the 18th April 2019.

There were no end of year disputes with any NHS Wales organisation. End of year debtor and creditor, income and expenditure balances were agreed with 7 LHBs and 3 NHS Trusts.

3.0 Key Themes

In order to appropriately brief Audit Committee members, each of the key financial statements and supporting notes will be discussed in the order that they present in the WG format. This paper is intended to direct members to the key issues of note and to highlight areas of significant estimate. A fuller, more detailed analytical review, taking account of any post audit adjustments will be provided for the formal sign off meeting on 30th May 2019.

Statement of Comprehensive Net Expenditure (Page 2)

As in previous years this indicates that at 31st March 2019, WHSSC broke even as required under the terms of the risk sharing agreement. This means there

was neither a surplus nor a deficit and that all LHBs agreed to their share of the WHSSC out turn position.

Overall Expenditure on Healthcare has increased by 4.3% on the 2017/18 position. This increase, which amounts to £30m is mostly attributable to the additional funding secured through the 2018/19 annual plan, which amounted to £28.2m, topped up with a further £12.3m of specifically directed WG allocations and a further £7.6m reduction on the end of year risk sharing position.

Unlike LHBs, there is no requirement to disclose achievement of operational balance. This is because, unlike LHBs, WHSSC does not receive a resource allocation directly from WG. All WHSSC funding, including the risk sharing income, is classed as Miscellaneous Income under the WG rules and is declared on Page 24, Note 4.0

Key adjustments to funding in 2018/19 were as follows:

	£m's
Annual Plan and provider inflation funding	28.171
WG allocations specific to WAST	5.998
HRG 4+ settlement allocation	2.731
Transfer of services - angiography	-1.098
Transfer of services – Renal ICU support	-0.957
Transfer of services – Bleeding disorders	0.877
Winter pressures and unscheduled care	1.369
Genomics for precision medicine	1.388
Communication aids for ALAS	0.852
Movement on Final Risk Sharing Outcome	-7.643
Other funding movements	1.220

Statement of Financial Position or Balance Sheet (Page 4)

It is usual among commissioning organisations to have a negative balance sheet total. This was the case for many of the original 22 individual Local Health Boards. Such organisations are unlikely to have substantial fixed assets to fall back on and, as they are not income generating, they do not build up large debtor balances with which to augment cash flow, but they do incur large creditor balances as a result of outstanding end of year provision for services provided but not paid for.

This negative balance also represents the underlying deficit inherited from the predecessor organisation, and will continue indefinitely because of the risk sharing requirement to break even every year.

Statement of Changes in Taxpayers Equity (Page 5)

This can be demonstrated in the Statement of Changes in Taxpayers Equity which for WHSSC / EASC does not change from year to year. However, for

2018-19 this is the section where LHBs are required to disclose the financial impact of their implementation of IFRS 9, Financial Instruments. As noted on page 5, the age and profile of individual outstanding debtors has been assessed and has been considered immaterial in this financial year. Hence no provision for bad debts has been deemed necessary for this year only. Going forward, each financial year will need to be assessed individually. Further information regarding IFRS 9 is detailed in Note 15, accounting policies 1.15 and 1.16 and on page 63a.

Statement of Cash Flows (Page 7)

Additional Notes to the Cash Flow can be found on Page 57, Note 27.

Cash flows relating to operating costs will always equal zero as long as WHSSC is funded through the risk sharing agreement, whereby all funding received will equal all expenditure out, in the absence of any direct allocation.

Current WG rules do not stipulate a maximum cash tolerance level for LHBs. Organisations are, however, required to maintain operational cash balances at a minimum.

Further information regarding end of year cash balances is provided later in this document.

Notes to the Accounts (Pages 8 to 19)

While the bulk of the notes to the accounts are prescriptive and laid down by WG and HM Treasury, there are 2 notable exceptions that are specific only to WHSSC.

Committee members are asked to direct attention to Note 1.3 Income and Funding, which describes the nature of the WHSSC Risk Sharing Agreement which provides WHSSC with substantially all of its funding. This note also provides an assessment of IFRS 15, Revenue from Contracts with Customers. As the WHSSC/ EASC risk share funding is unique within NHS Wales, this interpretation is very different to that used by LHBs and has been specifically agreed with both WG and with the WAO technical team.

Note 1.22 Critical Accounting Judgements describes the key areas of estimation uncertainty within the WHSSC Statements.

Moving on to the year to year movements within the key supporting financial schedules.

Note 3.2 Expenditure on Healthcare – Other Providers (Page 22)

Taking each main heading in turn the main movement are described in the following tables

NHS Wales Health Boards 5.95% increase	
Additional investment to LTA Baselines	£10.77m
Activity Payments to LTAs	£ 6.08m
Transfer of Services	-£3.97m
IPFR – Enzyme Replacement Therapy	£ 1.45m
IPFR - Eculizumab	£ 0.87m
Approved New Developments	£ 6.30m
Other Funded Adjustments	£ 0.20m

NHS Wales Trusts 5.19% increase	
Additional Investment - Cancer Drugs	£1.50m
Additional Investment – WAST Annual Plan	£2.80m
Additional Investment – WAST WG Directed	£5.00m

Non Welsh Bodies 0.19% increase	
Write back of 17-18 HRG4+ and LTA accrual accrual as per settlement agreements with NHS England	-£6.50m
Cost of Activity Increases	£4.60m
Increase in High Secure Mental Health placements including price increase.	£1.01m
Increase in Renal Transplant numbers in Liverpool for N Wales population	£0.55m
Approved New Developments	£0.52m
Other Expenditure Movements	£0.07m

Voluntary Organisations 2.2% decrease	
Reduction in IPFR approvals relating to Centre for Young Epilepsy	-£0.12m
Increase in CAMHS placements plus price increases	£0.06m
Other Expenditure Movements	-£0.02m

Private Sector 4.42% decrease	
IPFR - Eculizumab	-£0.47m
IPFR – Home Parenteral Nutrition	£0.93m
IPFR – Other movements relating to reduced use of the private sector	-£0.54m
Increase in referrals to Cardiff University PET scanner	£0.34m
Decrease in Medium Secure Placements	-£1.20m
Other Expenditure Movements	£0.02m

Note 3.3 Expenditure on Hospital & Community Services (Page 23)

Members are asked to note the following exceptional expenditure items which occurred during 2017/18 and which did not re-occur in 2018/19

Previously, 2017/18 saw a substantial increase in the planned usage of consultancy services across both WHSSC and EASC. In 2018/19, this spend reduced by almost half to £58k. Of this £33k related to the EASC commissioned amber review of WAST.

Elsewhere in this note there were significant material increases across a number of lines. Of most note is the £1.417m increase in staffing establishment. During 2018/19 both WHSSC and EASC made efforts to fill gaps in their staffing provision. Within WHSSC this included the planned creation of the new Gender Identity and Quality Assurance teams and within EASC the creation of the Invest to Save team. These accounted for about £200k of the overall increase.

For the first time since its inception WHSSC was fully and permanently up to establishment regarding its medical staffing. All AMD posts were filled and the MD post was filled as a part time job share. In EASC the equivalent clinical lead posts were filled. The 2018/19 cost impact of these appointments was approximately £300k.

In September 2018 NHS Wales rolled out the agreed staff wage award which was backdated to April 2018, while NHS Consultants received a 2% pay increase. The cost effect of this which was funded by Welsh Government was approximately £100k.

During 2018/19 a significant effort was made to bring into use the new WHSSC information reporting tool, "MAIR". In order to upload and validate over £1m individual patient data records, WHSSC employed an agency database developer for several months during 2018. The work is almost complete, the data base is available and ready for use and has been presented across Wales to the Heads of Information and several LHB boards.

Similarly WHSSC needed to employ additional resource within the finance team to undertake a piece of work surrounding the impact on WHSSC commissioned services and the risk sharing agreement as a result of the Bridgend boundary change.

The spend relating to these temporary agency staff can be evidenced in Note 9.1 on page 27.

In line with the 2017-18 WAO audit comments, and the 2018-19 WG Manual for Accounts, WHSSC has adjusted the staff expenditure to include the gross costs of staff on outward secondment, which would have previously been reduced in line with the income received. The impact of this required adjustment is £293k.

Regarding the increase in expenditure related to establishment associated costs, an additional £115k was spent on attendance at conferences by both the gender identity team and EASC. This expenditure was paid for out of funding for these specific Welsh Government initiatives.

Regarding the increase in premises costs, this almost wholly relates to the non capital refurbishment works being undertaken by EASC at the Charnwood Court site.

Committee members will be aware that 2017/18 was the first financial year that WHSSC has had to complete note 3.4 related to losses and special payments. As previously reported to committee, WHSSC wrote off 3 bad debt invoices worth a total of £4k, approved one member of staff to take advantage of the 2017-2018 VER scheme, at a release cost of £22k, and made on ex-gratia patient payment of £5k to re-imburse costs incurred. There have been no such payments made in 2018/19.

Note 4.0 Miscellaneous Income (Page 24)

As stated earlier, key adjustments to funding in 2018/19 were as follows:

	£m's
Annual Plan and provider inflation funding	28.171
WG allocations specific to WAST	5.998
HRG 4+ settlement allocation	2.731
Transfer of services - angiography	-1.098
Transfer of services – Renal ICU support	-0.957
Transfer of services – Bleeding disorders	0.877
Winter pressures and unscheduled care	1.369
Genomics for precision medicine	1.388
Communication aids for ALAS	0.852
Movement on Final Risk Sharing Outcome	-7.643
Other funding movements	1.220

Members are directed to Note 31 Related Parties on Page 60, which provides further analysis of Risk Sharing contributions by LHB.

Movements in Other Income are due to an accommodation re-charge from EASC to Velindre NHS Trust

Notes 9.1, 9.2 Staff Costs and Average Staff Numbers (Page 27)

Expenditure on the staffing resource required to support the Joint Committees has increased by 37.5% on the 2017/18 position.

As mentioned earlier, during 2018/19 both WHSSC and EASC made efforts to fill gaps in their staffing provision. Within WHSSC this included the planned creation of the new Gender Identity and Quality Assurance teams and within EASC the creation of the Invest to Save team. For the first time since its inception WHSSC was fully and permanently up to establishment regarding its medical staffing, while in September 2018 NHS Wales rolled out the agreed staff wage award which was backdated to April 2018. The required adjustment to account for outward staff recharges and secondments was undertaken.

The committee is asked to be aware that the Average Staff Numbers are calculated according to a formula dictated by WG, so these changes might not be immediately apparent in the statistics presented in Note 9.2.

Note 10.1 Public Sector Payment Policy (Page 32)

The WG requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The WG has set a target for every Health Board to pay 95% of the number of non NHS creditors within 30 days of receipt of a valid invoice at the correct site.

While that target was only reached by value and not by number during 2018/19, being 95% and 94% respectively, during the same period the overall volume of invoices processed and paid by the WHSSC team increased by 7.2%.

WHSSC budget holders have been reminded of the important of authorising valid invoices in good time to ensure the payment target is met.

The target had been met in full during the previous year.

Note 15 Trade and Other Receivables (Page 42)

NHS Wales Health Boards 7.71% decrease	
Risk sharing movement from over to under performance	-£4.45m
Late WG allocation for HRG4+ 18-19 agreement	£2.70m
Increased provider under performance BCU, ABMU and Cwm Taf	£0.95m

The most notable movement in receivables has resulted from the year to year movement in the WHSSC risk sharing position which moved from a risk sharing debtor of £4.45m in 2017-18 to a risk sharing creditor in 2018-19.

The ongoing HRG4+ issue with NHS England was resolved for 2018-19 as a settlement for NHS Wales was brokered by Welsh Government. From a cash and debtor perspective the allocation that backed this deal came through too late for the cash to be transferred and remained unpaid at 31st March 2019.

2018-19 saw a significant increase in the value of the debtor with NHS Wales Trusts. This is solely in relation to the agreed end of year under performance by WAST on their provider LTA with EASC.

Regarding other prepayments, in all previous years WHSSC usually made an early full year payment to Caerphilly Council for the rates invoice for the Caerphilly Business Park premises. As a result of the planned office relocation the rates invoice has not been paid early and therefore there is no prepayment for this in 2018-19.

Note 18 Trade and Other Payables (Page 44)

NHS Wales Health Boards 5.73% decrease	
C&V reduction in outstanding non contract invoices	-£0.31m
Outstanding risk share under performance	£0.23m
Renal Immunosuppression charges 18-19 BCU	-£0.43m
Other creditor movements	-£0.04m

NHS Wales Trusts 65.1% increase	
Provider Over Performance at Velindre	£0.37m
Other creditor movements	-£0.03m

Non Welsh Bodies 16.55% decrease	
IPFR non contract creditors – North Bristol Trust non contract invoices cleared	-£1.30m
IPFR non contract creditors – General non contract and emergency	£1.00m
LTA performance creditors paid in year (Manchester, Walton)	-£1.80m
LTA performance creditors reduced activity and lower end of year accrual (LHCH, GOSH)	-£2.40m
Other creditor movements	£0.90m

Non NHS Providers (creditors & accruals)	
Other creditor movements	£0.07.m

- To note that non NHS creditors and accruals have been analysed as a total to remove the impact of timing differences from invoices being received later in 2017-18, as a result of the early Easter break in that year.

Note 17 Cash Balances (Page 43)

Please refer to earlier commentary regarding the Statement of Cash Flow and associated notes.

Under recent changes to WG rules there is no longer a maximum cash tolerance level for LHBs. Organisations are, however, required to maintain operational cash balances at a minimum.

As noted previously in 2017-18 WHSSC held considerable creditors related to NHS England organisations. We have noted that the impact of HRG4+ on the WHSSC creditor balances as a result of LTA contracts that were not paid in that year was circa £5m. This resulted in WHSSC carrying significantly higher cash balances at that year end than ever before. WG are aware of the issue and the impact on the WHSSC 2017-18 financial statements as a result.

The cash balance held at 31st March 2019 is £8.6m and has returned to a more reasonable level in line with years prior to 2017-18.

Note 31 Related Party Transactions (Page 60)

After considerable discussion with the Wales Audit Office, in the years since the inception of WHSSC in 2010, this note is now in a format that is deemed acceptable to all.

In the context of the Joint Committee, related parties are considered to be anyone who can influence the financial or planning agenda of WHSSC to the benefit of another related party or organisation. In this case this would result in a Joint Committee member, through their commissioning role, being able to influence the provider LTA for an organisation with which they have a related role, be that a contract of employment or a Non Executive position.

Note 33 Operating Segments (Page 62)

This note provides further separate analysis of the activities of each committee.

Items to note which are specific to the EASC committee are

- New targeted Welsh Government income allocations for spend to save initiatives and WAST targeted unscheduled care programmes which can also be evidenced by expenditure increases for NHS Wales Trusts.
- A transfer of commissioning responsibility from WHSSC to EASC of the Emergency Medial Retrieval and Transfer Service.
- Late allocations issued by WG have caused an increase in the debtor with Welsh Heath boards as there was insufficient time to make the cash transactions.
- Provider underperformance by WAST has increased the EASC NHS Wales Trusts debtor.
- For the first time there is a separate commissioner risk sharing under performance which has increased the EASC Welsh Health Boards creditor.
- Outstanding accruals relate to invoices received late in the accounts process from a supplier of lifting devices relating to a WG spend to save initiative. These were unpaid at 31st March 2019. On advice from NHS Wales Shared Services Procurement the associated spend has been disclosed as Clinical Supplies and Services.

4.0 Recommendations

Members of are asked to**:-**

- **NOTE** the draft unaudited financial statements for the financial year ended 31st March 2019.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	**None**
Health and Care Standards	Governance, Leadership and Accountability Effective Care Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Improving Patient Experience (including quality and Satisfaction) Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	No specific impact
Resources Implications	The financial statements highlight the resources received by the committees and the use of those resources for the financial year 2018-19 in accordance with WG requirements.
Risk and Assurance	This is a key element of the overall governance and assurance process for all financial matters.
Evidence Base	WG Manual for Accounts 2018-19 HM Treasury Financial Reporting Manual UK Generally Accepted Accounting Principles UK Financial Reporting Standards International Financial Reporting Standards
Equality and Diversity	No Specific Impact
Population Health	No Specific Impact
Legal Implications	Legal requirement to produce a set of financial statements for each financial year, to be consolidated by Cwm Taf into their published Statutory Annual Accounts.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Choose an item.		
Choose an item.		

Welsh Health Specialised Services and Emergency Ambulance Services Committees

FOREWORD

These accounts have been prepared 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

Welsh Health Specialised Services Committee

The Welsh Health Specialised Services Committee was established on 1 April 2010 and is hosted by Cwm Taf University Local Health Board. It is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales.

Performance Management and Financial Results

In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009 no 35), LHB's are required to establish a Joint committee for the purpose of jointly exercising its Delegated Functions and providing Relevant Services from 1st April 2010.

The Welsh Health Specialised Services committee (WHSSC) (Wales) Regulations 2009 (SI 2009 no 3097) make provision for the constitution of the "Joint Committee" including its procedures and administrative arrangements.

In accordance with the Emergency Ambulance Services Committee (Wales) Directions 2014 (2014 no 8), LHBs are required to establish a Joint committee for the purpose of jointly exercising its Delegated Functions and providing Relevant Services from 1st April 2014.

The Emergency Ambulance Services Committee (Wales) Regulations 2014 make provision for the constitution of the "Joint Committee" including its procedures and administrative arrangements.

The delegated functions of the Emergency Ambulance Services Committee include the planning and commissioning of Emergency Ambulance Services across Wales, as provided by the Wales Ambulance Services NHS Trust.

The Committees do not hold any statutory responsibility for a resource limit. Services are funded from income from Local Health Boards and accounts for all expenditure on agreed services against the income received.

The Committees must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable. As a result the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure. This shows the net operating cost incurred by the Committees which is funded by Local Health Boards in Wales.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	**2018-19 £'000**	2017-18 £'000
Expenditure on Primary Healthcare Services	3.1	**0**	0
Expenditure on healthcare from other providers	3.2	**731,027**	700,720
Expenditure on Hospital and Community Health Services	3.3	**7,107**	4,485
		738,134	705,205
Less: Miscellaneous Income	4	**(738,134)**	(705,205)
LHB net operating costs before interest and other gains and losses		**0**	0
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**0**	0
Finance costs	7	**0**	0
Net operating costs for the financial year		**0**	0

The notes on pages 8 to 63 form part of these accounts

Other Comprehensive Net Expenditure

	2018-19	2017-18
	£'000	£'000
Net (gain) / loss on revaluation of property, plant and equipment	**0**	0
Net (gain) / (loss) on revaluation of intangibles	**0**	0
Net (gain) / loss on revaluation of available for sale financial assets	**0**	0
(Gain) / loss on other reserves	**0**	0
Impairment and reversals	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Other comprehensive net expenditure for the year	**0**	0
Total comprehensive net expenditure for the year	**0**	0

Statement of Financial Position as at 31 March 2019

	Notes	31 March 2019 £'000	31 March 2018 £'000
Non-current assets			
Property, plant and equipment	11	**0**	0
Intangible assets	12	**0**	0
Trade and other receivables	15	**0**	0
Other financial assets	16	**0**	0
Total non-current assets		**0**	0
Current assets			
Inventories	14	**0**	0
Trade and other receivables	15	**11,397**	12,169
Other financial assets	16	**0**	0
Cash and cash equivalents	17	**8,641**	11,574
		20,038	23,743
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**20,038**	23,743
Total assets		**20,038**	23,743
Current liabilities			
Trade and other payables	18	**(31,718)**	(35,423)
Other financial liabilities	19	**0**	0
Provisions	20	**(162)**	(162)
Total current liabilities		**(31,880)**	(35,585)
Net current assets/ (liabilities)		**(11,842)**	(11,842)
Non-current liabilities			
Trade and other payables	18	**0**	0
Other financial liabilities	19	**0**	0
Provisions	20	**0**	0
Total non-current liabilities		**0**	0
Total assets employed		**(11,842)**	(11,842)
Financed by :			
Taxpayers' equity			
General Fund		**(11,842)**	(11,842)
Revaluation reserve		**0**	0
Total taxpayers' equity		**(11,842)**	(11,842)

The financial statements on pages 2 to 7 were approved by the Audit Committee on 30th May 2019 and signed on its behalf by:

Managing Director of Specialised Services…… Date ……
for balances relating to WHSSC

Chief Ambulance Services Commissioner…….. Date ……
For balances relating to EASC

The notes on pages 8 to 63 form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2019

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2018-19			
Balance as at 31 March 2018	-11,842	0	**-11,842**
Adjustment for Implementation of IFRS 9	**	0	**0**
Balance at 1 April 2018	-11,842	0	-11,842
Net operating cost for the year	0		**0**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	0	0	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2018-19	0	0	**0**
Net Welsh Government funding	0		**0**
Balance at 31 March 2019	(11,842)	0	**(11,842)**

The notes on pages 8 to 63 form part of these accounts

** In line with the requirements of IFRS 9, the committees have assessed the age and profile of individual outstanding debtors and has concluded that the impact of IFRS 9 is immaterial in this financial year. Therefore no provision for bad debts has been deemed necessary
Further information regarding debtors and the aged debt profile is provided in note 15 and accounting policies 1.15 and 1.16.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2018

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2017-18			
Balance at 31 March 2017	(11,842)	0	**(11,842)**
Net operating cost for the year	0		**0**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	0	0	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2017-18	0	0	**0**
Net Welsh Government funding	0		**0**
Balance at 31 March 2018	(11,842)	0	**(11,842)**

The notes on pages 8 to 63 form part of these accounts

Statement of Cash Flows for year ended 31 March 2019

		2018-19	2017-18
		£'000	£'000
Cash Flows from operating activities	notes		
Net operating cost for the financial year		**0**	0
Movements in Working Capital	27	**(2,933)**	7,361
Other cash flow adjustments	28	**0**	94
Provisions utilised	20	**0**	(28)
Net cash outflow from operating activities		**(2,933)**	7,427
Cash Flows from investing activities			
Purchase of property, plant and equipment		**0**	0
Proceeds from disposal of property, plant and equipment		**0**	0
Purchase of intangible assets		**0**	0
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**0**	0
Net cash inflow/(outflow) before financing		**(2,933)**	7,427
Cash Flows from financing activities			
Welsh Government funding (including capital)		**0**	0
Capital receipts surrendered		**0**	0
Capital grants received		**0**	0
Capital element of payments in respect of finance leases and on-SoFP		**0**	0
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**0**	0
Net increase/(decrease) in cash and cash equivalents		**(2,933)**	7,427
Cash and cash equivalents (and bank overdrafts) at 1 April 2018		**11,574**	4,147
Cash and cash equivalents (and bank overdrafts) at 31 March 2019		**8,641**	11,574

The notes on pages 8 to 63 form part of these accounts

Notes to the Accounts

1. Accounting policies

The Cabinet Secretary for Health and Social Services has directed that the financial statements of Local Health Boards in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2018-19 Manual for Accounts. The accounting policies contained in that manual follow the European Union version of the International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances for the purpose of giving a true and fair view has been selected. The particular policies adopted 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

Neither WHSSC nor EASC hold any statutory responsibility for a resource limit. Services are funded by income from Local Health Boards and based on an agreed finanical plan. The committees account for all expenditure on agreed services against the income received as part of their plans. All variances from plan are allocated to Health Boards on the basis of an agreed risk sharing framework and matched by income adjustments consistent with this framework. The net operating cost for the financial year is therefore zero.

Under the establishment agreements for the committees, the host body, Cwm Taf Local Health Board, is held harmless for all costs with the exception of their own share which reflects their population usage of specialised and emergency ambulance services.

All allocations for services flow from the Welsh Assembly Government through the Local Health Boards. There are no direct allocations to either WHSSC or EASC. Income received from LHBs transacting with other NHS Wales bodies is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers is applied, as interpreted and adapted for the public sector, in the Financial Reporting Manual (FReM). It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. Upon transition the accounting policy to retrospectively restate in accordance with IAS 8 has been withdrawn. All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.
A review consistent with the portfolio approach was undertaken by the NHS Technical Accounting Group members, which

- identified that WHSSC and EASC do not control the services provided by the LHBs and as such are an agent for the LHBs and therefore are not subject to the provisions of IFRS 15;
- demonstrated that the potential amendments to WHSSC/EASC Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income from the WHSSC and EASC risk sharing is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.
Only non-NHS income may be deferred.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the WHSSC commits itself to the retirement, regardless of the method of payment.

No employees are members of the Local Government Superannuation Scheme.

NEST Pension Scheme

LHBs have to offer an alternative pensions scheme for employees not eligible to join the NHS Pensions scheme. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

The committees DO NOT HOLD ANY ASSETS. The following is to outline the principles that may be used in this situation.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the provision of services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales bodies have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2017-18 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure.

From 2015-16, LHBs must comply with IFRS 13 Fair Value Measurement in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the entity or the asset which would prevent access to the market at the reporting date. If LHBs 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

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, NHS bodies are required to get all All Wales Capital Schemes that are completed in a financial year revalued during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the LHBs business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to LHBs; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments
Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the LHB expects to obtain economic benefits or service potential from the asset. This is specific to the LHB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, LHBs must check whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development
Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Local Health Board as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The Local Health Board as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories
Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions
Provisions are recognised when there is a present legal or constructive obligation as a result of a past event, it is probable that the committees 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 there is 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 a detailed formal plan for the restructuring has been developed and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs
The Welsh Risk Pool (WRP) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The WRP is hosted by Velindre NHS Trust.

1.15 Financial Instruments

From 2018-19 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales bodies, will be to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.

1.16 Financial assets
Financial assets are recognised on the Statement of Financial Position when the 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.

NHS Wales Technical Accounting Group members reviewed the IFRS 9 requirements and determined a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS9 to construct a provision matrix.

In line with the requirements of IFRS 9, WHSSC has assessed the age and profile of individual outstanding debtors and has concluded that the impact of IFRS 9 is immaterial in this financial year. Therefore no provision for bad debts has been deemed necessary Further information regarding WHSSC debtors and the aged profile is provided in note 15.

1.16.1 Financial assets are initially recognised at fair value
Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCNE
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the committees assess whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

1.17 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the 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 Statement of Comprehensive Net Expenditure or other financial liabilities.

1.17.2 Financial liabilities at fair value through the Statement of Comprehensive Net Expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax
Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies
Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the LHB has no beneficial interest in them. Details of third party assets are given in Note 29 to the accounts.

1.21 Losses and Special Payments
Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had LHBs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The committees account for all losses and special payments gross (including assistance from the WRP). The committees accrue or provide for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is below 50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget
Neither WHSSC or EASC have any pooled budgets.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty
In the application of these 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.

For WHSSC, the critical accounting judgements and estimates within these accounts are contained within the cross border tertiary and quaternary contractual agreements with NHS England organisations. This involves a financial evaluation of the uncertainties surrounding the end of year contract flow of funds. In doing so management is required to predict performance trends for a number of low volume but exceptionally high cost procedures and treatments.

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 Private Finance Initiative (PFI) transactions
The committes DO NOT HOLD ANY PFI ASSETS. The following is to outline the principles that may be used in this situation.

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHBs approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHBs criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed 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 Statement of Financial Position.

Other assets contributed to the operator
Assets contributed (e.g. cash payments, surplus property) 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 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 through the asset being made available to third party users.

1.25 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 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 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.

1.26 Carbon Reduction Commitment Scheme
Carbon Reduction Commitment Scheme allowances are accounted for as government grant funded intangible assets if they are not realised within twelve months and otherwise as current assets. The asset should be measured initially at cost. Scheme assets in respect of allowances shall be valued at fair value where there is evidence of an active market.

WHSSC and EASC are exempt from the requirements of the Carbon Reduction Scheme as the capacity of the premises occupied and the numbers of staff employed are below the de minimis threshold.

1.27 Absorption accounting
Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.28 Accounting standards that have been issued but not yet been adopted
The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts (The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.),
IFRS 16 Leases, HMT have confirmed that IFRS 16 Leases, as interpreted and adapted by the FReM is to be effective from 1st April 2020.
IFRS 17 Insurance Contracts,
IFRIC 23 Uncertainty over Income Tax Treatment.

1.29 Accounting standards issued that have been adopted early
During 2018-19 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	0	0	**0**	**0**
Less general ophthalmic services expenditure and other non-cash limited expenditure	0	0	**0**	**0**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	**0**	**0**
Total operating expenses	0	0	0	**0**
Revenue Resource Allocation	0	0	**0**	**0**
Under /(over) spend against Allocation	0	0	**0**	**0**

2.2 Capital Resource Performance

	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	0	0	**0**	**0**
Add: Losses on disposal of donated assets	0	0	**0**	**0**
Less: NBV of property, plant and equipment and intangible assets disposed	0	0	**0**	**0**
Less: capital grants received	0	0	**0**	**0**
Less: donations received	0	0	**0**	**0**
Charge against Capital Resource Allocation	0	0	**0**	**0**
Capital Resource Allocation	0	0	**0**	**0**
(Over) / Underspend against Capital Resource Allocation	0	0	**0**	**0**

2.3 Duty to prepare a 3 year plan

The WHSSC Joint Committee of Health Boards have agreed an Integrated Medium Term Plan, a provisional version of which was submitted to Welsh Government on 22nd January 2019 and was subsequently approved.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £'000	Non-cash limited £'000	2018-19 Total £'000	2017-18 £'000
General Medical Services	0		**0**	0
Pharmaceutical Services	0	0	**0**	0
General Dental Services	0		**0**	0
General Ophthalmic Services	0	0	**0**	0
Other Primary Health Care expenditure	0		**0**	0
Prescribed drugs and appliances	0		**0**	0
Total	**0**	**0**	**0**	0

3.2 Expenditure on healthcare from other providers

	2018-19 £'000	2017-18 £'000
Goods and services from other NHS Wales Health Boards	**387,312**	365,565
Goods and services from other NHS Wales Trusts	**188,392**	179,091
Goods and services from Health Education and Improvement Wales (HEIW)	**0**	0
Goods and services from other non Welsh NHS bodies	**131,952**	131,700
Goods and services from WHSSC / EASC	**0**	0
Local Authorities	**4**	0
Voluntary organisations	**3,551**	3,631
NHS Funded Nursing Care	**0**	0
Continuing Care	**0**	0
Private providers	**19,816**	20,733
Specific projects funded by the Welsh Government	**0**	0
Other	**0**	0
Total	**731,027**	700,720

3.3 Expenditure on Hospital and Community Health Services

	2018-19 £'000	2017-18 £'000
Directors' costs	0	0
Staff costs	5,194	3,777
Supplies and services - clinical	966	0
Supplies and services - general	0	0
Consultancy Services	58	108
Establishment	343	182
Transport	0	0
Premises	476	316
External Contractors	0	0
Depreciation	0	0
Amortisation	0	0
Fixed asset impairments and reversals (Property, plant & equipment)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	49	49
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	0	32
Research and Development	0	0
Other operating expenses	21	21
Total	**7,107**	4,485

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2018-19 £'000	2017-18 £'000
Clinical negligence	0	0
Personal injury	0	0
All other losses and special payments	0	28
Defence legal fees and other administrative costs	0	0
Gross increase/(decrease) in provision for future payments	**0**	**28**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	0	4
Less: income received/due from Welsh Risk Pool	0	0
Total	**0**	**32**

During 2018/2019 WHSSC did not make any payments against personal injury claims or benefits.
Expenditure on clinical supplies and services relates to the direct provision of services by EASC to support emergency winter pressures.

4. Miscellaneous Income

	2018-19 £'000	2017-18 £'000
Local Health Boards	737,923	705,181
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	0	0
NHS trusts	184	18
Health Education and Improvement Wales (HEIW)	0	0
Other NHS England bodies	0	0
Foundation Trusts	0	0
Local authorities	0	0
Welsh Government	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	0	0
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	0	0
Other income from activities	27	6
Patient transport services	0	0
Education, training and research	0	0
Charitable and other contributions to expenditure	0	0
Receipt of donated assets	0	0
Receipt of Government granted assets	0	0
Non-patient care income generation schemes	0	0
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	0	0
Other income:		
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
Total	**738,134**	705,205

Other income includes:

	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0

5. Investment Revenue

	2018-19	2017-18
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	**0**	0
contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue :		
Bank accounts	**0**	0
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total	**0**	0

6. Other gains and losses

	2018-19	2017-18
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**0**	0
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	**0**	0

7. Finance costs

	2018-19	2017-18
	£000	£000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts		
main finance cost	**0**	0
contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**0**	0
Provisions unwinding of discount	**0**	0
Other finance costs	**0**	0
Total	**0**	0

8. Operating leases

LHB as lessee

The WHSSC lease on Unit 3a Caerphilly Business Park terminated on 31st March 2018. Continued occupation of the building is on a month by month rental basis only.	**EASC Unit 1 Charnwood Court 10 years from 23rd March 2017**

Payments recognised as an expense	**2018-19**	2017-18
	£000	£000
Minimum lease payments	56	137
Contingent rents	0	0
Sub-lease payments	0	0
Total	56	137

Total future minimum lease payments Payable	**£000**	£000
Not later than one year	56	47
Between one and five years	300	234
After 5 years	225	250
Total	581	531

LHB as lessor

Rental revenue	**£000**	£000
Rent	**0**	0
Contingent rents	**0**	0
Total revenue rental	**0**	0

Total future minimum lease payments Receivable	**£000**	£000
Not later than one year	**0**	0
Between one and five years	**0**	0
After 5 years	**0**	0
Total	**0**	0

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	£000	£000	£000	£000	£000	£000
Salaries and wages	3,755	320	138	17	**4,229**	3,327
Social security costs	401	36	0	0	**437**	371
Employer contributions to NHS Pension Scheme	483	46	0	0	**528**	454
Other pension costs	0	0	0	0	**0**	0
Other employment benefits	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	**0**	0
Total	4,638	401	138	17	**5,194**	4,152
Charged to capital					**0**	0
Charged to revenue					**5,194**	4,152
					5,194	4,152
Net movement in accrued employee benefits (untaken staff leave accrual included above)					0	0

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	63	7	2	0	**73**	63
Medical and dental	4	1	0	0	**5**	2
Nursing, midwifery registered	6	0	0	0	**6**	6
Professional, Scientific, and technical staff	1	0	0	0	**1**	1
Additional Clinical Services	0	0	0	0	**0**	0
Allied Health Professions	0	0	0	0	**0**	0
Healthcare Scientists	0	0	0	0	**0**	0
Estates and Ancilliary	0	0	0	0	**0**	0
Students	0	0	0	0	**0**	0
Total	**74**	**8**	**2**	**0**	**84**	72

9.3. Retirements due to ill-health

9.4 Employee benefits

WHSSC does not have an employee benefit scheme.

Additional information regarding Note 9.1 - average number of employees	Total	2017-18
WHSSC (excluding following areas)	**63**	**51**
Neonatal & CAMHS/ED Networks (half year values)		
EASC - QAIT reporting element	**17**	**13**
EASC - EASC reporting element	**5**	**4**
	84	68

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2018-19 Number of compulsory redundancies	2018-19 Number of other departures	2018-19 Total number of exit packages	2018-19 Number of departures where special payments have been made	2017-18 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	1
£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	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**1**

Exit packages cost band (including any special payment element)	2018-19 Cost of compulsory redundancies	2018-19 Cost of other departures	2018-19 Total cost of exit packages	2018-19 Cost of special element included in exit packages	2017-18 Total cost of exit packages
	£'s	£'s	£'s	£'s	£'s
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	22
£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	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**22**

No redundancy or exit packages were agreed or paid in 2018-19

9.6 Remuneration Relationship

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

WHSSC and EASC are not statutory bodies and hold no statuory responsibility. The directors of WHSSC and EASC are directors in name only and are not directors of any statutory body.

The statutory reporting body is the host organisation, Cwm Taf Health Board. The directors of WHSSC and EASC are not recognised as directors within the organisational structure of Cwm Taf Health Board.

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 in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 5% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 2% of this. The legal minimum level of contribution level is due to increase to 8% in April 2019.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,032 and £46,350 for the 2018-19 tax year (2017-18 £5,876 and £45,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2018-19	**2018-19**	2017-18	2017-18
NHS	**Number**	**£000**	Number	£000
Total bills paid	**2,076**	**717,017**	1,928	666,497
Total bills paid within target	**1,923**	**713,112**	1,850	663,265
Percentage of bills paid within target	**92.6%**	**99.5%**	96.0%	99.5%
Non-NHS				
Total bills paid	**4,967**	**24,897**	4,289	25,134
Total bills paid within target	**4,648**	**23,548**	4,219	23,981
Percentage of bills paid within target	**93.6%**	**94.6%**	98.4%	95.4%
Total				
Total bills paid	**7,043**	**741,914**	6,217	691,631
Total bills paid within target	**6,571**	**736,660**	6,069	687,246
Percentage of bills paid within target	**93.3%**	**99.3%**	97.6%	99.4%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2018-19	2017-18
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	0	0	0	0	0	0	0	0	**0**
Indexation	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	0	0	0	0	0	0	0	0	**0**
- donated	0	0	0	0	0	0	0	0	**0**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2018	0	0	0	0	0	0	0	0	**0**
Indexation	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	0	0	0	0	0	0	0	0	**0**
Net book value at 1 April 2018	0	0	0	0	0	0	0	0	**0**
Net book value at 31 March 2019	0	0	0	0	0	0	0	0	**0**
Net book value at 31 March 2019 comprises :									
Purchased	0	0	0	0	0	0	0	0	**0**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	0	0	0	0	0	0	0	0	**0**
Asset financing :									
Owned	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	0	0	0	0	0	0	0	0	**0**

The net book value of land, buildings and dwellings at 31 March 2019 comprises :

	£000
Freehold	**0**
Long Leasehold	**0**
Short Leasehold	**0**
	0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for whih as asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2017-18

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	0	0	0	0	0	0	0	0	**0**
Indexation	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	0	0	0	0	0	0	0	0	**0**
- donated	0	0	0	0	0	0	0	0	**0**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2017	0	0	0	0	0	0	0	0	**0**
Indexation	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	0	0	0	0	0	0	0	0	**0**
Net book value at 1 April 2017	0	0	0	0	0	0	0	0	**0**
Net book value at 31 March 2018	0	0	0	0	0	0	0	0	**0**
Net book value at 31 March 2018 comprises :									
Purchased	0	0	0	0	0	0	0	0	**0**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	0	0	0	0	0	0	0	0	**0**
Asset financing :									
Owned	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	0	0	0	0	0	0	0	0	**0**

The net book value of land, buildings and dwellings at 31 March 2018 comprises :

	£000
Freehold	**0**
Long Leasehold	**0**
Short Leasehold	**0**
	0

11. Property, plant and equipment (continued)

Neither WHSSC nor EASC hold any property, plant or equipment. Any necessary equipment purchases are made through Cwm Taf UHB as the host organisation and are capttalised, managed and held on its asset register on behalf of the Joint Committees.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2018	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2019	0	0	0	0	0	**0**
Balance brought forward 1 April 2017	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2018	0	0	0	0	0	**0**

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	0	0	0	0	0	0	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gross cost at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1 April 2018	0	0	0	0	0	0	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 1 April 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2019							
Purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	0	0	0	0	0	0	**0**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Gross cost at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1 April 2017	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Amortisation at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 1 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2018							
Purchased	0	0	0	0	0	0	**0**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Additional disclosures re Intangible Assets

13 . Impairments

	2018-19		2017-18	
	Property, plant & equipment £000	**Intangible assets £000**	Property, plant & equipment £000	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)	**0**	0	**0**	0
Reversal of impairments	**0**	0	**0**	0
Total of all impairments	**0**	0	**0**	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	**0**	0	**0**	0
Charged to Revaluation Reserve	**0**	0	**0**	0
	0	0	**0**	0

14.1 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	**0**	0
Consumables	**0**	0
Energy	**0**	0
Work in progress	**0**	0
Other	**0**	0
Total	**0**	0
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2019 £000	31 March 2018 £000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**0**	**0**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	**0**
Welsh Health Boards	**10,517**	**11,395**
Welsh NHS Trusts	**454**	**21**
Health Education and Improvement Wales (HEIW)	**0**	**0**
Non - Welsh Trusts	**388**	**687**
Other NHS	**0**	**0**
Welsh Risk Pool	**0**	**0**
Local Authorities	**0**	**0**
Capital debtors	**0**	**0**
Other debtors	**2**	**5**
Provision for irrecoverable debts	**0**	**0**
Pension Prepayments	**0**	**0**
Other prepayments	**36**	**61**
Other accrued income	**0**	**0**
Sub total	**11,397**	12,169
Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
Welsh Risk Pool	**0**	0
Local Authorities	**0**	0
Capital debtors	**0**	0
Other debtors	**0**	0
Provision for irrecoverable debts	**0**	0
Pension Prepayments	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**0**	0
Total	**11,397**	12,169
Receivables past their due date but not impaired		
By up to three months	**0**	90
By three to six months	**0**	0
By more than six months	**2**	0
	2	90

Provision for impairment of receivables		
Balance at 31 March 2018	0	0
Adjustment for Implementation of IFRS 9	**0**	0
Balance at 1 April 2018	0	**0**
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	**0**	**0**
Bad debts recovered during year	**0**	**0**
Balance at 31 March	**0**	0

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	**0**	0
Other	**0**	0
Total	**0**	0

16. Other Financial Assets

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**

17. Cash and cash equivalents

	2018-19	2017-18
	£000	£000
Balance at 1 April	**11,574**	4,147
Net change in cash and cash equivalent balances	**(2,933)**	7,427
Balance at 31 March	**8,641**	11,574
Made up of:		
Cash held at GBS	**8,641**	11,574
Commercial banks	**0**	0
Cash in hand	**0**	0
Current Investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**8,641**	11,574
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**8,641**	11,574

18. Trade and other payables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**0**	**0**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	**0**
Welsh Health Boards	**9,098**	**9,650**
Welsh NHS Trusts	**867**	**525**
Health Education and Improvement Wales (HEIW)	**0**	**0**
Other NHS	**18,313**	**21,944**
Taxation and social security payable / refunds	**51**	**42**
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	**51**	**1**
Non-NHS creditors	**1,008**	**256**
Local Authorities	**0**	**0**
Capital Creditors	**0**	**0**
Overdraft	**0**	**0**
Rentals due under operating leases	**0**	**0**
Obligations under finance leases, HP contracts	**0**	**0**
Imputed finance lease element of on SoFP PFI contracts	**0**	**0**
Pensions: staff	**0**	**0**
Accruals	**2,324**	**2,999**
Deferred Income:		
Deferred Income brought forward	**0**	**0**
Deferred Income Additions	**0**	**0**
Transfer to / from current/non current deferred income	**0**	**0**
Released to SoCNE	**0**	**0**
Other creditors	**0**	**0**
PFI assets –deferred credits	**0**	**0**
Payments on account	**6**	6
Total	**31,718**	35,423

Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS creditors	**0**	0
Local Authorities	**0**	0
Capital Creditors	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**0**	0
Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Total	**0**	0

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

Amounts falling due more than one year are expected to be settled as follows:	**31-Mar-19 £000**	**31-Mar-18 £000**
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	0	0

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	**31 March 2019 £000**	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2018	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2019
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	**0**	0	0	0	0	0	0	0	**0**
Personal injury	**0**	0	0	0	0	0	0	0	**0**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**0**	0	0	0	0	0	0		**0**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**0**			0	0	0	0	0	**0**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**162**		0	0	0	0	0		**162**
Total	**162**	**0**	**0**	0	0	0	0	**0**	**162**
Non Current									
Clinical negligence	**0**	0	0	0	0	0	0	0	**0**
Personal injury	**0**	0	0	0	0	0	0	0	**0**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**0**	0	0	0	0	0	0		**0**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**0**			0	0	0	0	0	**0**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**0**		0	0	0	0	0		**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL									
Clinical negligence	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Personal injury	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All other losses and special payments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Defence legal fees and other administration	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**
Pensions relating to former directors	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Pensions relating to other staff	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Restructuring	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Other	**162**		**0**	**0**	**0**	**0**	**0**		**162**
Total	**162**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**162**

Expected timing of cash flows:

	In year to 31 March 2020	Between 1 April 2020 31 March 2024	Thereafter	Total
				£000
Clinical negligence	0	0	0	**0**
Personal injury	0	0	0	**0**
All other losses and special payments	162	0	0	**162**
Defence legal fees and other administration	0	0	0	**0**
Pensions relating to former directors	0	0	0	**0**
Pensions relating to other staff	0	0	0	**0**
Restructuring	0	0	0	**0**
Other	0	0	0	**0**
Total	**162**	**0**	**0**	**162**

20. Provisions (continued)

	At 1 April 2017	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2018
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	0	0	0	0	0	0	0	0	**0**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	28	(28)	0	0	**0**
Defence legal fees and other administration	0	0	0	0	0	0	0		**0**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	96		0	0	66	0	0		**162**
Total	**96**	**0**	**0**	**0**	**94**	**(28)**	**0**	**0**	**162**
Non Current									
Clinical negligence	0	0	0	0	0	0	0	0	**0**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	0	0	0	0	0	0	0		**0**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL									
Clinical negligence	0	0	0	0	0	0	0	0	**0**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	28	(28)	0	0	**0**
Defence legal fees and other administration	0	0	0	0	0	0	0		**0**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	96		0	0	66	0	0		**162**
Total	**96**	**0**	**0**	**0**	**94**	**(28)**	**0**	**0**	**162**

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2018-19 £'000**	2017-18 £'000
Legal claims for alleged medical or employer negligence	**0**	0
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**0**	0
Continuing Health Care costs	**0**	0
Other	**0**	0
Total value of disputed claims	**0**	0
Amounts (recovered) in the event of claims being successful	**0**	0
Net contingent liability	**0**	**0**

21.2 Remote Contingent liabilities

	2018-19 £'000	2017-18 £'000
Please disclose the values of the following categories of remote contingent liabilities :		
Guarantees	0	0
Indemnities	0	0
Letters of Comfort	0	0
Total	**0**	**0**

21.3 Contingent assets

	2018-19 £'000	2017-18 £'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2018-19 £'000	2017-18 £'000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	0

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out or written-off during the financial year

	Amounts paid out during period to 31 March 2019		Approved to write-off to 31 March 2019	
	Number	**£**	**Number**	**£**
Clinical negligence	0	0	0	0
Personal injury	0	0	0	0
All other losses and special payments	0	0	0	0
Total	0	0	0	0

Analysis of cases which exceed £300,000 and all other cases

Cases exceeding £300,000	Case type	**Amounts paid out in year** £	**Cumulative amount** £	**Approved to write-off in year** £
		0		0
Sub-total		**0**	**0**	**0**
All other cases		0	0	0
Total cases		**0**	**0**	**0**

24. Finance leases

24.1 Finance leases obligations (as lessee)

Neither WHSSC nor EASC have any Finance Lease Obligations

Amounts payable under finance leases:

Land	**31 March 2019 £000**	31 March 2018 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Finance leases obligations (as lessee) continue

Amounts payable under finance leases:

Buildings	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Finance leases obligations (as lessor) continued

Amounts receivable under finance leases:

	31 March 2019	31 March 2018
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

Neither WHSSC nor EASC have Private Finance Initiative Contracts

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2019	31 March 2018
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Neither WHSSC nor EASC have any Private Finance Initiative Contracts

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element 31 March 2019 £000	**On SoFP PFI Imputed interest 31 March 2019 £000**	**On SoFP PFI Service charges 31 March 2019 £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 31 March 2018 £000	On SoFP PFI Imputed interest 31 March 2018 £000	On SoFP PFI Service charges 31 March 2018 £000
Total payments due within one year	0	0	0
Total payments due between 1 and 5 years	0	0	0
Total payments due thereafter	0	0	0
Total future payments in relation to PFI contracts	0	0	0
Total present value of obligations for on-SoFP PFI contracts	**0**		

25.3 Charges to expenditure	2018-19	2017-18
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	31 March 2019 £000	31 March 2018 £000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract		
	0	0

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. WHSSC and EASC are 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. WHSSC and EASC have 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 committees in undertaking their activities.

Currency risk

WHSSC and EASC are principally domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. WHSSC and EASC, therefore ,have low exposure to currency rate fluctuations.

Interest rate risk

WHSSC and EASC are not permitted to borrow. Therefore, they have low exposure to interest rate fluctuations

Credit risk

Because the majority of the funding for WHSSC and EASC derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

WHSSC and EASC are 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 committees are not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2018-19	2017-18
	£000	£000
(Increase)/decrease in inventories	**0**	0
(Increase)/decrease in trade and other receivables - non-current	**0**	0
(Increase)/decrease in trade and other receivables - current	**772**	(5,602)
Increase/(decrease) in trade and other payables - non-current	**0**	0
Increase/(decrease) in trade and other payables - current	**(3,705)**	12,963
Total	**(2,933)**	7,361
Adjustment for accrual movements in fixed assets - creditors	**0**	0
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**0**	0
	(2,933)	7,361

28. Other cash flow adjustments

	2018-19	2017-18
	£000	£000
Depreciation	**0**	0
Amortisation	**0**	0
(Gains)/Loss on Disposal	**0**	0
Impairments and reversals	**0**	0
Release of PFI deferred credits	**0**	0
Donated assets received credited to revenue but non-cash	**0**	0
Government Grant assets received credited to revenue but non-cash	**0**	0
Non-cash movements in provisions	**0**	94
Total	**0**	94

29. Third Party assets

The committees do not hold any cash balances on behalf of patients or any other 3rd party

30. Events after the Reporting Period

There are none to report

31. Related Party Transactions

Welsh Health Specialised Services and Emergency Ambulance Services

WHSSC and EASC are sub-committees of each of the 7 Local Health Boards in Wales. Therefore, any related transactions would form part of each LHB's statutory financial statements.
Whilst the committees have executive teams these are not executive directors and they are employed by Cwm Taf UHB as the host organisation.
During 2018/2019, the Joint Committees adopted a risk sharing approach which is applied to all financial transactions.
In accordance with the Standing Orders, the Joint Committees must agree a total budget to plan and secure the relevant services delegated to them. The Joint Committees must also agree the appropriate contribution of funding required from each LHB.

Each LHB will be required to make available to the Joint Committees the level of funds outlined in the annual plan.

The risk sharing income received from each LHB during 2018/2019 as per Note 4,
Expenditure incurred by WHSSC and EASC with providers of tertiary and specialist services is as follows as per Note 3.2 and analysed in the Segmental Analysis in Note 33.

	Income (Note 4) £000's	Expenditure (Note 3.2) £000's	Debtor (Note 15) £000's	Creditor (Note 18) £000's
Cardiff and Vale LHB	121,693	221,532	1,121	5,964
Aneurin Bevan LHB	136,775	8,172	2,303	47
Betsi Cadwalladr LHB	166,474	40,590	3,835	349
Abertawe Bro Morgannwg LHB	123,239	107,321	650	1,982
Cwm Taf UHB	69,991	7,601	1,171	612
Hywel Dda LHB	85,495	2,096	1,148	95
Powys Teaching HB	34,256		289	49
Public Health Wales NHS Trust	55		4	
Velindre NHS Trust	129	40,709	24	855
Welsh Ambulance Services NHS Trust		147,683	426	12
	738,107	**575,704**	**10,971**	**9,965**

Members of the Joint Committees for 2018/2019

LHB Chief Executives have voting rights on the committee while Trust Chief Executives are associate members only
During 2018/2019 WHSSC and EASC have entered into material transactions with the organisations represented as listed above

Mrs Judith Paget	Member		Chief Executive Aneurin Bevan UHB
Mrs Carol Shillabeer	Member		Chief Executive Powys Teaching HB
Mr Gary Doherty	Member		Chief Executive Betsi Cadwalladr UHB
Mrs Allison Williams	Member		Chief Executive Cwm Taf UHB
Mr Len Richards	Member		Chief Executive Cardiff and Vale UHB
Mr Steve Moore	Member		Chief Executive Hywel Dda UHB
Mrs Tracy Myhill	Member		Chief Executive Abertawe Bro Morgannwg UHB

The following are Associate Members of the Joint Committees and therefore have no voting rights on the Joint Committee

Dr Tracey Cooper	Associate Member		Chief Executive Public Health Wales NHS Trust (WHSSC & EASC)
Mr Steve Ham	Associate Member		Chief Executive Velindre NHS Trust (WHSSC only)
Mrs Patsy Roseblade	Associate Member	to Oct 2018	Interim Chief Executive, Welsh Ambulance Services NHS Trust (EASC only)
Jason Killens	Associate Member	from Oct 2018	Chief Executive, Welsh Ambulance Services NHS Trust (EASC only)
Prof John Williams	Independent Member		Chair of the Wales Renal Clincial Network (WHSSC only)
Mr Charles Janczewski	Independent Member		Chair of the Quality and Patient Safety Committee (WHSSC only)

Members With a Declared Interest

Prof Vivienne Harpwood	Chair	Chair, Powys Teaching HB (WHSSC only)
Mr Charles Janczewski	Independent Member	Independent Board Member, Cardiff and Vale UHB (WHSSC only)
Mrs Lyn Meadows	Independent Member	Independent Board Member, Betsi Cadwalladr UHB (WHSSC only)
Mr Chris Turner	Independent Member and Chair of EASC	Independent Board Member, Cwm Taf UHB (WHSSC only & EASC)

Apart from the transactions listed above, no Member or Associate Member of the Joint Committees has declared an interest in any other party that transacts with either WHSSC or EASC.

32. Pooled budgets

Neither WHSSC nor EASC have any pooled budgets.

33. Operating segments

	WHSSC			EASC	
	31 March 2019	31 March 2018		**31 March 2019**	31 March 2018
	£000	£000		**£000**	£000
Miscellaneous Income					
Income from Local Health Boards	**583,866**	564,023		**154,057**	**141,158**
Income from Wales NHS Trusts	**147**	0		**37**	**18**
Other Income from Activities	**27**	6			**0**
Total Income	**584,040**	564,029		**154,094**	141,176
Expenditure on Healthcare from Other Providers					
Other NHS Wales LHBS	**383,759**	**365,565**	*	**3,553**	**0**
Other NHS Wales Trusts	**40,686**	**39,146**		**147,706**	**139,945**
Other Non Welsh NHS Bodies	**131,952**	**131,700**			**0**
Local Authorities	**4**				
Voluntary Organisations	**3,551**	**3,630**			**1**
Private Providers	**19,786**	**20,733**		**30**	**0**
Total Expenditure on Healthcare	**579,738**	560,774		**151,289**	139,946
Expenditure on Hospital and Community Services					
Staff costs	**3,840**	**2,783**		**1,354**	**994**
Clinical Supplies & Services	**0**		**	**966**	
Consultancy	**6**	**66**		**52**	**42**
Establishment	**190**	**105**		**153**	**77**
Premises	**200**	**203**		**276**	**113**
Audit Fees	**49**	**49**			**0**
Losses and Special Payments		**32**			**0**
Other Operating Expenses	**17**	**17**		**4**	**4**
Total Expenditure on Hospital and Community Services	**4,302**	3,255		**2,805**	1,230
Net Operating Costs of the Committees	**0**	0		**0**	0

* EASC expenditure with NHS Wales LHBs relates to the transfer from WHSSC to EASC of the commissioning responsibility for the Emergency Medical Retrieval and Transfer Service provided by ABMU LHB.
** Expenditure on clinical supplies and services relates to the direct provision of servcies by EASC to support emergency winter pressures in 2018-19.

Trade and Other Receivables				
Welsh Health Boards	**9,902**	**11,091**	**615**	**304**
Welsh NHS Trusts	**28**	**21**	**426**	**0**
Other NHS	**388**	**684**		**3**
Other Debtors	**2**	**5**		**0**
Other Prepayments	**21**	**46**	**15**	**15**
Total Receivables	**10,341**	11,847	**1,056**	322
Liabilities				
Welsh Government				**0**
Welsh Health Boards	**8,399**	**9,587**	**699**	**63**
Welsh NHS Trusts	**867**	**455**		**70**
Other NHS	**18,313**	**21,944**		**0**
Taxation and social security payable	**51**	**42**		**0**
NI contributions payable to HMRC	**51**	**1**		**0**
Non-NHS creditors	**908**	**255**	**100**	**1**
Accruals	**1,808**	**2,938**	**516**	**61**
Payments on account	**6**	**6**		**0**
Provisions	**162**	**162**		**0**
Total Liabilities	**30,565**	35,390	**1,315**	195
Cash Balances Held	**8,382**	11,701	**259**	(127)
Taxpayer's Equity in the Committees	**(11,842)**	(11,842)	**0**	0

34. Other Information

IFRS15

Work was undertaken across NHS Wales, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15.

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB LTA Income
- WHSCC/EASC Risk Shared Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- NHS Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- Training & Education income ;

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded as at period end.

As WHSSC/ EASC are not direct providers of healthcare and so have no income of the nature described above, this assessment was not relevant.

A review, also consistent with the portfolio approach detailed above, was undertaken by the committees, which identified that WHSSC and EASC do not control the services that underpin their income flows. As such, under the terms of IFRS 15, the risk share principles of the committees which allow then to act on behalf of the LHBs when commissioning specialised services, could be deemed an agent v's principle relationship and is therefore outside the scope of the standard.

Taking this into account it can be demonstrated that the potential amendments to WHSSC/EASC Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework, due consideration must be given to the users of the accounts and the cost restraint of compliance, reporting and production of financial reporting. Given the income for WHSSC/EASC risk sharing is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales, it was considered reasonable to continue recognising in accordance with those established terms, on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

34. Other Information (continued)

IFRS 9

For consistency across Wales, the practical expedient provision matrix was used to estimate expected credit losses (ECLs) based on the 'age' of receivables as follows:

- Receivables were segregated into appropriate groups

- Each group, was analysed:

a) age-bands

1-30 days (including current)
31-60 days
61-90 days
91-180 days
181- 365 days
> 1 year

b) at historical back-testing dates (data points)

- For each age-band, at each back-testing date the following were determined:
  a) the gross receivables
  b) the amounts ultimately collected/written-off. If material, adjustments should be made to exclude the effect of non-collections for reasons other than credit loss (e.g. credit notes issued for returns, short-deliveries or as a commercial price concession)

In line with the requirements of IFRS 9, WHSSC has assessed the age and profile of individual outstanding debtors and has concluded that the impact of IFRS 9 is immaterial in this financial year. Therefore no provision for bad debts has been deemed necessary Further information regarding WHSSC debtors and the aged profile is provided in note 15.

34. Other Information (continued)

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 2019 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 2019 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 2019 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 : Alan Brace 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

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

DRAFT

Annual Governance Statement 2018/19

Contents

1. Scope of Responsibility 4
2. Governance Framework 5
   2.1 The Joint Committee 5
   2.2 Joint Sub-Committees and Advisory Groups 6
      2.2.1 Sub-Committees 6
      2.2.2 Advisory Groups and Networks 7
   2.3 Committees of the Host Organisation 8
      2.3.1 Audit Committee 8
      2.3.2 Quality, Safety and Risk Committee 8
   2.4 Joint Committee and Joint Sub-Committees meetings 9
   2.5 Standards of Behaviour 9
3 The purpose of the system of internal control 13
4 Capacity to handle risk 14
   4.1 Risk Appetite 14
   4.2 Managing Risk 14
   4.3 The Risk and Assurance Framework 14
   4.4 Top Organisational Risks 17
5 The Control Framework 27
   5.1 Integrated Plan for Commissioning Specialised Services 27
      5.1.1 Quality and Performance Escalation Framework 27
      5.1.2 Schemes prioritised by the Joint Clinical impact Advisory Group (CIAG) and Management Group Prioritisation process 27
      5.1.3 Schemes highlighted as exceptional risks for additional funding included within the ICP 27
      5.1.4 Key risks that are expected to emerge in year 28
   5.2 Performance Dashboard 28
      5.2.1 Services in Escalation 29
   5.3 Corporate Governance Code 29
   5.4 Health and Care Standards 29
6 Other elements of control framework 31
   6.1 Equality and Diversity 31
   6.2 National Health Service Non-Statutory Instruments 2018-19 31
   6.3 Information Governance 31
      6.3.1 Data Security 32
   6.4 Counter Fraud 32

DRAFT

7 Review of effectiveness 32
7.1 Internal Audit 32
7.2 External Audit 33
8 Significant Governance Issues 33
9 Conclusion 33

DRAFT

1. SCOPE OF RESPONSIBILITY

In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) and 2014 (2014/9 (w.9)) (the Directions), the Local Health Boards (LHBs) established a joint committee known as the Welsh Health Specialised Services Committee (the Joint Committee or WHSSC), which commenced on 1 April 2010, for the purpose of jointly exercising its Delegated Functions and providing the Relevant Services.

In establishing WHSSC to work on their behalf, the seven LHBs recognised that the most efficient and effective way of planning the Relevant Services was to work together to reduce duplication and ensure consistency.

WHSSC's Aim is to ensure that there is:
Equitable access to safe, effective and sustainable specialist services for the people of Wales, as close to patients' homes as possible, within available resources

In order to achieve this aim, WHSSC works closely with each of the LHBs (in both their commissioner and provider roles) as well as with Welsh NHS Trusts, providers in NHS England and the independent sector.

The commissioning of specialised services is informed through the application of the Prudent Healthcare Principles and the Institute of Healthcare Improvement Triple Aim.

The Welsh Health Specialised Services Committee (WHSSC) (Wales) Regulations 2009 (SI 2009 No 3097) (the Regulations) make provision for the constitution of the Joint Committee including its procedures and administrative arrangements.

The Joint Committee is a statutory committee established under sections 12 (1)(b) and (3), 13(2)(c), (3)(c) and (4)(c) and 203(9) and (10) of the National Health Service (Wales) Act 2006. The LHBs are required to jointly exercise the Relevant Services.

Cwm Taf University Health Board is the identified host organisation. It provides administrative support for the running of WHSSC and has established the Welsh Health Specialised Services Team (WHSST) as per Direction 3(4), Regulation 3(1) (d) and the interpretation sections of both the Directions and the Regulations and the Joint Committee Standing Orders: Statutory Framework and Joint Committee Framework.

DRAFT

2. GOVERNANCE FRAMEWORK

In accordance with regulation 12 of the Regulations, each LHB in Wales must agree Standing Orders for the regulation of Joint Committee proceedings and business. These Joint Committee Standing Orders (Joint Committee SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. Together with the adoption of a scheme of decisions reserved to the Joint Committee; a scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with a Memorandum of Agreement setting out the governance arrangements for the seven LHBs and a hosting agreement between the Joint Committee and Cwm Taf University Health Board, form the basis upon which the Joint Committee's Governance and Accountability Framework is developed. Together with the adoption of a Values and Standards of Behaviour Framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

The Joint Committee reviewed the Governance and Accountability Framework in January 2018. Welsh Government has indicated that it will issue revised Model Standing Orders during 2019/20. On receipt, a review of the Governance and Accountability Framework will be undertaken. The Framework will be presented to the Joint Committee for approval.

On 12 November 2018, the Cabinet Secretary for Health and Social Services wrote, inter alia, to the WHSSC Chair, Chairs of the LHBs and NHS Trusts. The letter directed a change to the criteria for the taking of decisions at Joint Committee meetings with immediate effect:

- All decisions subject to a 2/3 majority of voting members present
- Nominated deputies for LHB Chief Executives to formally contribute to the quorum and have delegated voting rights
- Nominated deputies should be an executive director of the same organisation.

A copy of the WHSSC Joint Committee Governance and Accountability Framework is available at:
http://www.whssc.wales.nhs.uk/opendoc/324413

2.1 The Joint Committee

The Joint Committee was established in accordance with the Directions and Regulations to enable the seven LHBs in NHS Wales to make collective decisions on the review, planning, procurement and performance

DRAFT

monitoring of agreed specialised and tertiary services (Relevant Services) and in accordance with their defined Delegated Functions.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the responsibility of individual LHBs for their residents remains. They are therefore accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

The Joint Committee is accountable for Governance, Risk Management and Internal Control. As Managing Director of Specialised Commissioning, NHS Wales, I have the responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports achievement of the Joint Committee's policies, aims and objectives; and to report the adequacy of these arrangements to the Chief Executive of Cwm Taf University Health Board. Under the terms of the establishment arrangements, Cwm Taf University Health Board is deemed to be held harmless and have no additional financial liabilities beyond its own population.

The membership of the Joint Committee consists of 15 voting members and 3 Associate Members. The voting members include the Chair (appointed by the Minister for Health and Social Services), the Vice Chair (appointed by the Joint Committee from existing non-officer members of the seven LHBs), two other non-officer members (appointed by the Joint Committee from existing non-officer members of the seven LHBs), the LHB Chief Executives and WHSSC Officers.

The Joint Committee is supported by the Committee Secretary, who acts as the guardian of good governance within the Joint Committee.

In accordance with WHSSC Standing Order 3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

DRAFT

2.2 Joint Sub-Committees and Advisory Groups

The Joint Committee structural diagram can be found on page 11.

2.2.1 Sub-Committees

The Joint Committee has established five joint sub-committees in the discharge of its functions:

- All Wales Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee

- Management Group
- Quality and Patient Safety Committee
- Welsh Renal Clinical Network

The **All Wales Individual Patient Funding Request (IPFR) Panel (WHSSC)** holds delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a health board has agreed to routinely provide.

The **Integrated Governance Committee** scrutinises evidence and information brought before it in relation to activities and potential risks which impact on the services provided and provides assurance to the Joint Committee that effective governance and scrutiny arrangements are in place across the organisation.

The **Management Group** is the specialised services commissioning operational body responsible for the implementation of the Specialised Services Strategy. The group underpins the commissioning of specialised services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

The **Quality and Patient Safety Committee** provides assurance to the Joint Committee in relation to the arrangements for safeguarding and improving the quality and safety of specialised healthcare services within the remit of the Joint Committee.

During 2018-19 the Terms of Reference for the Quality and Patient Safety Committee were reviewed and refreshed as part of the ongoing development to strengthen quality performance and reporting within the organisation; this included amendments to the membership and quorum. It is anticipated the changes will result in improved effectiveness of the Committee (including the ability of the Committee to achieve quorate meetings).

The **Welsh Clinical Renal Network** is a vehicle through which specialised renal services are planned and developed on an all Wales basis in an efficient, economical and integrated manner and provides a single decision-making framework with clear remit, responsibility and accountability.

2.2.2 Advisory Groups and Networks

The Joint Committee also established three advisory groups in the discharge of its functions.

- NHS Wales Gender Identity Partnership Group
- All Wales Mental Health and Learning Disability Collaborative Commissioning Group
- All Wales Posture and Mobility Service Partnership Board

DRAFT

The **All Wales Gender Identity Partnership Group**, established in July 2013, supports the development of a future NHS Wales Strategy for Gender Dysphoria services within current NHS Wales' funding parameters and reviews the audit of assessment and surgical services against the quality indicators and key performance indicators. The scope of the Partnership Group extends beyond the services currently commissioned by WHSSC.

The **All Wales Mental Health and Learning Disability Collaborative Commissioning Group** advises the Joint Committee on issues regarding the development of secure mental health services for Wales. The group ensures that there is a co-ordinated approach to secure services across Wales and that the benefits of working collaboratively are realised.

The **All Wales Posture and Mobility Services Partnership Board** monitor the service's delivery against the key performance and quality indicators, in order to provide assurance to the Joint Committee that the service is delivering in line with the All Wales Service Specification and advises the Joint Committee on the commissioning strategy for Posture and Mobility services, including identification of, and supporting opportunities for embedding coproduction as a core principle of the commissioning strategy.

2.3 Committees of the Host Organisation

2.3.1 Audit Committee

The Audit Committee of the Cwm Taf University Health Board, as host organisation, advises and assures the Joint Committee on whether effective arrangements are in place, through the design and operation of the Joint Committee's assurance framework, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Joint Committee's Delegated Functions.

Relevant officers from WHSSC attend Cwm Taf Audit Committee meetings for agenda items concerned with WHSSC business.

2.3.2 Quality, Safety and Risk Committee

The Quality, Safety and Risk Committee of the Cwm Taf University Health Board, as host organisation, advises and assures the Joint Committee on the provision of workplace health & safety within WHSSC.

The Corporate Governance Manager for WHSSC is a member of the Cwm Taf University Health Board, Quality, Safety and Risk Committee.

DRAFT

2.4 Joint Committee and Joint Sub-Committees meetings

The following table indicates the months during which meetings of the Joint Committee and joint sub-committee meetings were held during 2018-19. Meetings where a quorum was not achieved are highlighted in red.

	2018									2019		
	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Joint Committee												
Joint Committee (extraordinary)												
Integrated Governance												
All Wales IPFR Panel												
Management Group												
Quality & Patient Safety												
Welsh Renal Clinical Network												

The membership of the Joint Committee and member's attendance can be found on page 12.

2.5 Standards of Behaviour

The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

> ***"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"***

The Joint Committee is strongly committed to WHSSC being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Joint Committee expects all Independent Members and employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of service users must come first.

The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for WHSSC employees and Independent Members.

The WHSSC Standards of Behaviour Policy, incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship, aims to ensure that arrangements are in place to support employees to act in a manner that

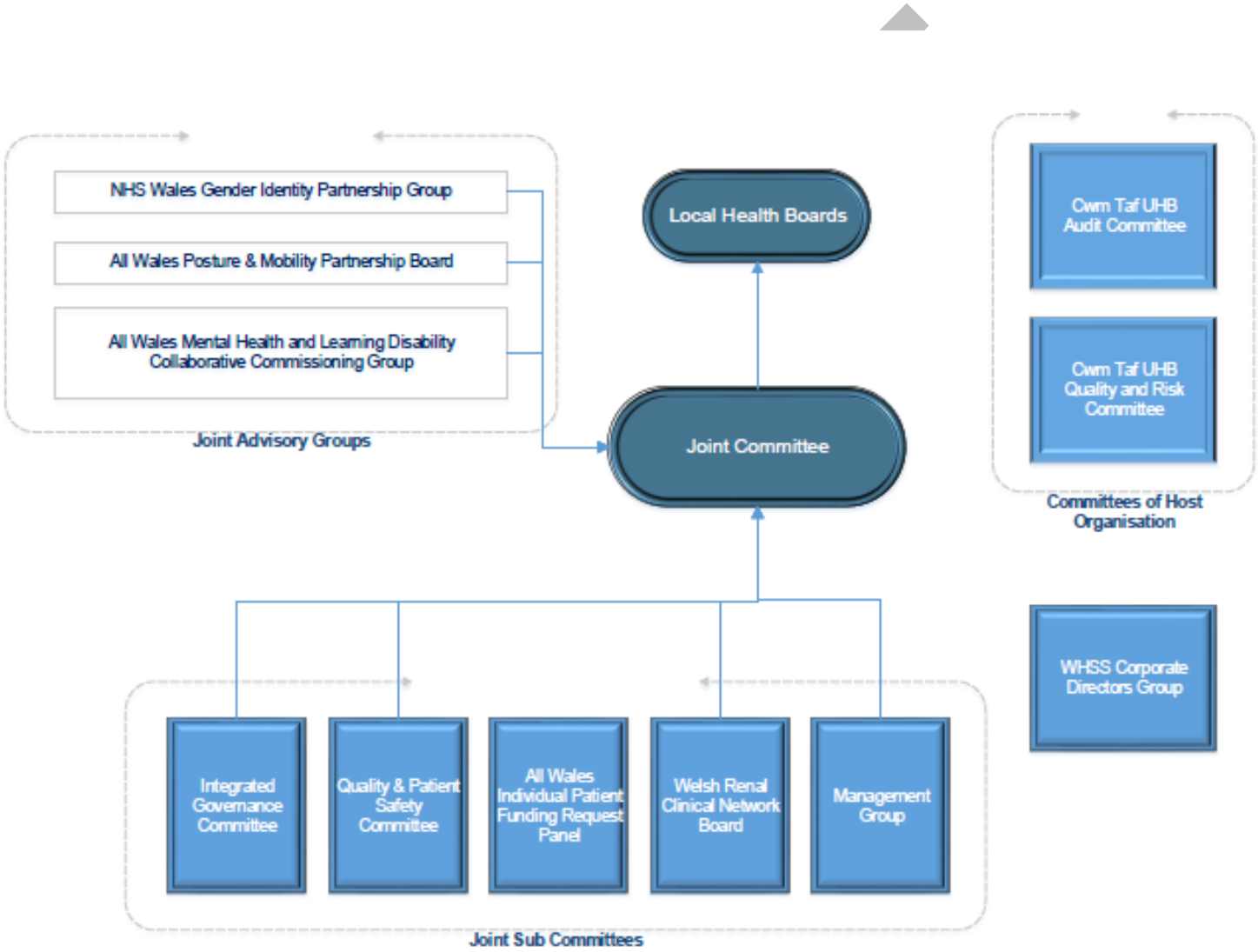
DRAFT

upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that WHSSC can be seen to have exemplary practice in this regard.

A register of interests is maintained and is available on request or through the WHSSC publication scheme.

DRAFT

Joint Committee Structure



The Joint Committee members in post during the financial year 2018-19:

Name	Role	Organisation	Attendance at Meetings 2018-19*
Non Officer Members			
Vivienne Harpwood	Chair	Welsh Health Specialised Services Committee	8/8
Charles Janczewski	Member	Independent Board Member, Cardiff and Vale UHB and Chair of the Quality and Safety Committee	5/8
Lyn Meadows	Member and Vice Chair	Independent Board Member, Betsi Cadwaladr UHB	3/8
Chris Turner	Member and Audit Lead (until 31 December 2018)	Independent Board Member, Cwm Taf UHB	6/6
Chief Executive Members			
Gary Doherty	Member	Chief Executive, Betsi Cadwaladr UHB	5/8
Steve Moore	Member	Chief Executive, Hywel Dda UHB	4/8
Tracy Myhill	Member	Chief Executive, Abertawe Bro Morgannwg UHB	5/8
Judith Paget	Member	Chief Executive, Aneurin Bevan UHB	5/8
Len Richards	Member	Chief Executive, Cardiff and Vale UHB	7/8
Carol Shillabeer	Member	Chief Executive, Powys Teaching HB	8/8
Allison Williams	Member	Chief Executive, Cwm Taf UHB	8/8
Welsh Health Specialised Services Officer Members			
Sian Lewis	Officer Member	Managing Director	8/8
Stuart Davies	Officer Member	Director of Finance	6/8
Jennifer Thomas	Officer Member (from 03 April 2018)	Medical Director	8/8
Carole Bell	Officer Member	Director of Nursing and Quality Assurance	7/8
Associate Members			
Tracey Cooper	Associate Member	Chief Executive, Public Health Wales NHS Trust	0/8
Steve Ham	Associate Member	Chief Executive, Velindre NHS Trust	0/8
Affiliate Members			
John Williams	Affiliate Member	Chair of the Welsh Renal Clinical Network	6/8

*In person or represented by a nominee in accordance with the direction from Welsh Government issued in November 2018

DRAFT

3. 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 was in place for the year ended 31 March 2019 and up to the date of approval of the annual accounts.

As Managing Director for Specialised and Tertiary Services Commissioning, NHS Wales, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aim and objectives and need to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively.

The Joint Committee's joint sub-committees assist in providing these assurances and I am supported by the Head of Internal Audit's annual work, report and opinion on the effectiveness of our system of internal control.

An Independent Member of the Joint Committee is a Member of the Cwm Taf University Health Board Audit Committee. The Director of Finance and Committee Secretary and other members of Welsh Health Specialised Services Team, as required, attend the Audit Committee meetings.

The links with joint sub-committees, previously established through the Integrated Governance Committee, continue. The Integrated Governance Committee is chaired by the Chair of the Joint Committee and the Members include the Chairs of the WHSSC joint sub-committees and advisory groups.

A summary from each Joint Committee meeting is circulated to all LHBs and Trusts for reporting to their Boards. The confirmed minutes of Joint Committee meetings are available on the WHSSC website.

Each joint sub-committee and advisory group is required to submit a Chair's report to the Joint Committee following each meeting, to ensure that an integrated and efficient approach to risk management is maintained within the organisation. The report summarises the issues discussed at the joint sub-committee or advisory group and any items for escalation to the Joint Committee. The Chair's report also provides Joint Committee Members with access to the minutes of the joint sub-committee or advisory group.

DRAFT

4. CAPACITY TO HANDLE RISK

4.1 Risk Appetite

In 2015-16, the Joint Committee agreed to adopt the Good Governance Institute Model Matrix on defining Risk Appetite for Specialised Services.

The Risk Appetite Statement has been reviewed as part of the review of the Integrated Risk Management Framework.

The risk appetite statement is the driver for implementing our priority areas. It provides staff with clear expectations on how risks should be managed and a common acceptance of the importance of continuous management of risk.

4.2 Managing Risk

WHSSC has established an Internal Risk Group which monitors the organisations internal risk processes and where necessary makes recommendations to strengthen systems and gain a consistent understanding across the senior management team and improve the way in which risks are reported and managed within the organisation. The Internal Risks Group continues to lead the ongoing work to develop a system of triangulation between the Corporate Risk and Assurance Framework, the Integrated Commissioning Plan Risk Management Framework (detailed in section 5.1), the WHSSC Escalation Process and Quality reporting.

The WHSST continues to strengthen and test its Business Continuity Plan (BCP).

4.3 The Risk and Assurance Framework

Risk management (for risks other than health and safety) is embedded in the activities of WHSSC through the WHSSC Risk Management Framework and associated operating procedures.

The Corporate Risk and Assurance Framework (CRAF) forms part of the WHSSC's approach to the identification and management of strategic risks. The framework is subject to continuous review by the Executive Director lead, Corporate Directors Group Board, Internal Risk Management Group, Joint Committee and joint sub-committees.

It is for the Joint Committee, through the joint sub-committees, to determine whether there is sufficient assurance in the rigour of internal systems to be confident that there are adequate controls over the management of principal risks to strategic objectives.

DRAFT

The CRAF is informed by risks identified at a Programme, Network, Directorate and Executive level. Each risk is allocated to an appropriate committee for assurance and monitoring purposes, i.e. Joint Committee, Audit Committee, Quality and Patient Safety Committee, and the Cwm Taf Quality, Safety and Risk Committee. The CRAF is received by the joint sub-committees as a standing agenda item. The Joint Committee receives the CRAF twice yearly.

Under the hosting agreement with Cwm Taf University Health Board, WHSSC complies with the Health Board's Risk Management Policy and Risk Assessment Procedure for health and safety risk.

DRAFT

DRAFT

4.4 Top Organisational Risks

There were 58 risks on the CRAF as at 1 February 2019, all of which are Commissioning Risks. This position was reported to the Corporate Directors Group on 12 March 2018.

The top organisational risks (scored 15 and above) are delegated where appropriate to key sub-committees of the Joint Committee and these in summary fall into the following areas:

Risk Reference	Description of risk identified	Current Score JAN 19			Overall Trend	Last Review By Directorate/ Programme Team
		Safe	Sustainable	Effective		
Lung Resection CH/011	Risk to patient o/comes and quality of service due to insufficient capacity in South Wales service	**9**	**16**	**6**	→	21/02/2019
Haemophilia CH/016	There is currently a vacancy for a Haematology Consultant in ABMUHB which has resulted in a temporarily reduced local service to patients (suspension of outreach clinics to Hywel Dda). CVUHB have raised concern with regards to taking OOH patients from ABMUHB which has a knock on effect for other haematology and leukaemia patients.	**12**	**16**	**12**	→	21/02/2019
Plastic Surgery CH/018	Failure to achieve the maximum waiting times target in ABMUHB	**6**	**1**	**15**	→	21/02/2019
Lung cancer CH/020	Excessive lung cancer surgery waiting times	**20**	**12**	**12**	→	21/02/2019

DRAFT

PET – CT POLICY CH/024	Sub-optimal management of cancers excluded by the current commissioning policy Potential for sub-optimal outcomes; Potential for patient receiving unnecessary procedures or procedures of limited benefit Sub-optimal utilisation of scarce healthcare resources The reputation of WHSSC is also at risk as the current PET-CT policy excludes many of the indications included in the NHS England and NHS Scotland policies creating inequity of access across the UK.	**12**	**1**	**20**	→	21/02/2019
NETs CH/028	• Risk to sustainability of the service with respect to its capacity • Clinic capacity insufficient to meet demand • Inability to meet the Task & Finish Group recommendations • Continued inequity between patients in N and S Wales • Failure to meet expectations that WG have made to patient groups • Potential increase in patient complaints	**12**	**15**	**12**	→	21/02/2019
Sarcoma CH/029	Fragility of service (lack of cover) not achieving quality standards	**12**	**15**	**12**	→	21/02/2019
BMT CH/032	The BMT service at UHW is at risk of not gaining JACIE accreditation due to its poor facilities (space; bed numbers; lack of en-suite facilities (adults UHW); small collection area in busy day-care ward (UHW apheresis) and the processing lab (UHW). These concerns were identified at the JACIE inspection in 2013 but to	**16**	**16**	**12**	→	21/02/2019

DRAFT

	date no assurance has been provided to WHSSC that these concerns will be addressed.					
Haemophilia CH/033	Lack of haematology consultant for haemophilia patients in Bangor. Patients have expressed safety concerns. Nurse led service supported by Liverpool	**12**	**16**	**12**	→	21/02/2019
SARCOMA CH/035	Lack of access to CNS in SE Wales. No CNS in south east Wales leading to poor patient experience reported in Macmillan briefing paper which was issued as a follow up to the 2016 Wales Cancer Patient Experience Survey.	**20**	**6**	**20**	→	21/02/2019
SARCOMA CH/036	Sustainability of south Wales soft tissue sarcoma service (single CNS for patients in south west Wales). Sustainable provision of CNS support	**12**	**20**	**20**	→	21/02/2019
SARCOMA CH/038	Clinical governance. Lack of clinical ownership of sarcoma patients in health boards through diagnostic stage of the pathway	**15**	**1**	**15**	→	21/02/2019
BMT CH/040	Sustainability of south Wales soft tissue sarcoma service (single CNS for patients in south west Wales) Sustainable provision of CNS support	**15**	**1**	**16**	→	21/02/2019
GENETICS CH/041	Major genetic laboratory reconfiguration in England leading to inequitable access to genetic tests for patients in Wales as compared to England	**8**	**6**	**15**	→	21/02/2019
Cardiac Ablation CT/013	Limited access to ablation in S. Wales	**16**	**12**	**20**	→	12/02/2019
Interventional Cardiology CT/014	Risk to patients of suffering cardiac arrest whilst waiting for PCI intervention in the tertiary centre due to lack of capacity.	**12**	**12**	**20**	→	12/02/2019

DRAFT

Cardiac surgery TAVI CT/029	WHSSC monitor services against the Welsh Government (WG) RTT targets, various issues have been identified that suggest that waiting times may have been under reported, this creates a risk in terms of the commissioning required for these services.	**10**	**4**	**20**	→	12/02/2019
Cardiac Surgery Pathway CT/030	Risk of under reporting of waiting times for treatment due to incorrect or unidentified Patient pathway start dates.	**10**	**4**	**20**	→	12/02/2019
ACHD CT/032	Delivery and sustainability of ACHD service South Wales.	**16**	**16**	**16**	→	12/02/2019
CYSTIC FIBROSIS CT/036 Formerly (WC/016)	Provision of Adult Cystic Fibrosis services.	**8**	**20**	**16**	→	12/02/2019
CARDIAC SURGERY C&VUHB CT/037 (PREVIOUSLY CT/023)	Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity.	**10**	**9**	**20**	→	12/02/2019
CARDIAC SURGERY ABMUHB CT/038 (PREVIOUSLY CT/023)	Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity.	**10**	**9**	**16**	→	12/02/2019
CARDIAC SURGERY LHCH/BCUHB CT/039 (PREVIOUSLY CT/023)	Commissioning sufficient capacity for cardiac surgery to be delivered within waiting time standards and providers delivering this level of activity.	**10**	**9**	**16**	→	12/02/2019

DRAFT

PAEDIATRIC CHD CT/040	Delivery and sustainability of Paediatric CHD service South Wales.	**16**	**16**	**16**	→	12/02/2019
CAMHS MH/108	Limited current ability to manage funded capacity & case mix following a series of serious incidents and a sentinel event at the unit	**20**	**20**	**20**	→	31/01/2019
Spinal Rehabilitation NC/001	There are significant risks related to delivering a sustainable service that can achieve British Society of Rehabilitation Medicine (BSRM) standards for specialised rehabilitation. Whilst the service is unable to meet staffing levels to the recommended mi	**16**	**16**	**16**	→	31/01/2019
Neuro rehabilitation NC/010	Patients not receiving full service due to low staffing levels against standards	**15**	**16**	**16**	→	31/01/2019
Neurosurgery NC/012	Patients waiting in excess of the agreed waiting times for Neurosurgery.	**10**	**15**	**20**	→	31/01/2019

DRAFT

Interventional Radiology NC/014	Interventional Radiology - Ability of Cardiff & Vale University Health Board to deliver the Interventional Radiology service at University Hospital Wales. A member of the clinical team has resigned. This will increase the pressure on the interventional radiology service, and will also have an impact on other services, and WHSSC will be undertaking work to quantify this impact.	**20**	**20**	**20**	→	31/01/2019
Paediatric Neurosurgery NC/022	NHS England are due to publish the outcomes of their commissioning through evaluation for Selective Dorsal Rhizotomy (SDR) in Spring 2018. There is the potential for a change in policy in light of the reported outcomes that could mean SDR becomes a commissioned service.	**16**	**12**	**12**	→	31/01/2019
Neuro-oncology NC/023	Delays in treatment due to MDT meetings cancellations. Inequitable care between patients in North and South	**9**	**16**	**20**	→	31/01/2019
Prosthetics NC/026	Inability to achieve waiting time targets and provide equitable service to civilian population in BCUHB	**12**	**20**	**12**	→	31/01/2019
Alternative Augmentative Communication NC/028	Lack of funding for AAC equipment across Wales	**20**	**20**	**20**	→	31/01/2019
Spinal Cord Monitoring NC/029	Shortfall in spinal cord monitoring. Risk to spinal functioning mapping and monitoring during surgery.	**20**	**20**	**20**	→	31/01/2019

DRAFT

Ketogenic Diet NC/031	Risk to availability and capacity of specialists in Bristol - figures suggest that capacity is already limited by staffing. UHB do not have the capacity to accept Welsh Paediatric Neurology patients for all but very specialist cases. At present, only telephone consultations with the dietician are available.	**16**	**20**	**12**	→	31/01/2019
Thrombectomy 1 NC/032	Neuroradiology - Service Development - Lack of Neuro-interventional Consultants and the ongoing recruitment difficulties at the Cardiff centre to provide a robust 24/7 service.	**20**	**20**	**20**	→	31/01/2019
Thrombectomy 2 NC/033	Neuroradiology - Service Development - Bed Capacity at the Cardiff centre particularly with the development of the Major Trauma Centre	**20**	**20**	**16**	→	31/01/2019
Thrombectomy 3 NC/034	Neuroradiology - Service Development - Rapid access to appropriate imaging (Non contrast CT scan and CT Angiogram as a minimum)	**20**	**20**	**16**	→	31/01/2019
Thrombectomy 4 NC/035	Neuroradiology - Service Development - Safe and rapid transport to the specialist centre for patients who have been identified for this clinical treatment.	**20**	**20**	**16**	→	31/01/2019
Thrombectomy 5 NC/036	Neuroradiology - Service Development - Post-operative care	**20**	**20**	**16**	→	31/01/2019
Neurosurgery SDR NC/039	Development of SDR surgery. Inequity for Welsh patients as they do not have access to surgery as English children.	**16**	**16**	**16**	↑	31/01/2019

DRAFT

Neurosurgery - Paediatrics NC/040	Waiting times for Paediatrics to receive a MRI is outside the standard. Inequitable service between North and South Wales.	**16**	**16**	**16**	→	31/01/2019
Posture and Mobility Service - Discontinued Wheelchairs - North Wales Service NC/041	Excessive waiting times and requirement to build the wheelchair to meet specific needs could impact patient safety	**9**	**15**	**9**	→	31/01/2019
Major Trauma NC/042	Sustainability of service. To address inequity of the service in South and West Wales and South Powys in line with the NHS England Quality Indicators for Major Trauma.	**20**	**20**	**20**	→	31/01/2019
Fetal Medicine WC/008	Lack of sustainability of South Wales services	**16**	**16**	**12**	→	31/01/2019
IVF WC/009	Excessive waiting times to commence treatment	**6**	**1**	**16**	→	31/01/2019
PICU WC/014	Lack of capacity for tertiary services in South Wales	**20**	**9**	**16**	→	31/01/2019
Cleft Lip & Palate WC/015	Lack of resource for full MDT of CLP service	**8**	**16**	**16**	→	31/01/2019
Neonatal Transport WC/018	Lack of 24/7 dedicated Neonatal transport in South Wales	**12**	**4**	**16**	→	31/01/2019

DRAFT

BAHA and Cochlear WC/019	The BAHA and Cochlear service is managed centrally by C&V however patients are managed at both Bridgend Hospital and UHW. Adult patients are waiting 52 weeks for BAHA and cochlear implants in line with the WHSSC policy, however this does not align with other RTT specialities. The wait for this procedure impacts on social interactions, work, home-life.	**6**	**16**	**12**	→	31/01/2019
Paediatric Endocrinology WC/020	Inequitable service for Endocrinology patients in Wales.	**6**	**20**	**16**	→	31/01/2019
Paediatric Rheumatology WC/022	Limited service in South Wales high risk of unsustainability	**9**	**20**	**16**	→	31/01/2019
Cleft Lip Palate RTT WC/029	Significant waiting times for adult patients waiting for revisional surgery.	**6**	**10**	**20**	→	31/01/2019
Paediatric Surgery WC/036	Risk to the Quality and sustainability of Paediatric Surgery in South Wales	**16**	**20**	**12**	→	31/01/2019
Neonatal Transport WC/037	Significant gaps in documentation kept and there is no clear governance lead which poses significant safety and effective risks. Due to the volume of the service the risk to sustainability is low.	**16**	**4**	**12**	→	31/01/2019
BAHA and Cochlear WC/038	Risk to patients wellbeing and quality of life that cannot have their implant upgraded/maintained as there is no policy in place.	**12**	**6**	**16**	→	31/01/2019
Inherited Metabolic Diseases (IMD) Paediatric Services	Fragility of current paediatric IMD service due to the imminent retirement of sole consultant delivering the service.	**12**	**16**	**9**	→	31/01/2019

DRAFT

WC/039						
Paediatric Oncology - Share care arrangement with Hywel Dda WC/041	Resignation of single handed consultant that delivers paediatric oncology at Hywel Dda	**9**	**16**	**12**	→	31/01/2019

DRAFT

5 THE CONTROL FRAMEWORK

5.1 Integrated Plan for Commissioning Specialised Services

The Integrated Commissioning Plan (ICP) sets out WHSSC's strategy and aim for commissioning specialised services over a three year period.

The ICP for 2018-21 was approved by the Joint Committee on the 27th March 2018. This ICP was developed in greater collaboration with Health Boards than previous plans and was centred on a robust risk assessment model which sought to balance the requirements for quality assurance, reduced risk and improvement to health outcomes for the people of Wales within the constraints of challenging financial pressures.

The ICP focused on a number of key work programmes including:

5.1.1 Quality and Performance Escalation Framework

The Quality and Performance Escalation Framework sets out a clear process for monitoring and managing performance of providers, including various stages of escalation which culminate in decommissioning if the provider is unable to deliver the appropriate level of quality, performance or activity. The details of the services in Escalation is presented to Management Group on a monthly basis and at every Joint Committee meeting through the WHSSC Performance report. Where services are at the highest levels of escalation – level III Commissioning Quality Visit and level IV Escalation Monitoring for which the outcome could be outsourcing or de-commissioning of a service, these issues will be specifically reported to Management Group and Joint Committee.

5.1.2 Schemes prioritised by the Joint Clinical impact Advisory Group (CIAG) and Management Group Prioritisation process

Eight schemes prioritised by the Joint CIAG and Management Group Prioritisation process were included for funding within the 2018-21 ICP.
The funding release for these schemes were scrutinised and approved on an individual basis through the WHSSC Management Group. These schemes included:

- Replacement of obsolete wheelchairs (South Wales)
- New indications for Positron emission tomography CT (All Wales)
- Porphyria service available for advice 24/7 (All Wales)

5.1.3 Schemes highlighted as exceptional risks for additional funding included within the ICP

Two schemes which were considered in the ICP to be exceptional risks and consequently included for funding were:

- Spinal Rehabilitation (South Wales) – this service was extremely fragile, as it was delivered by a single consultant and with relatively

DRAFT

few Units across the UK we know that there would be extreme difficulties in this service being delivered elsewhere for Welsh patients and it would also not be in the best interest of the patients and their families to receive such rehabilitative care further from home.
- Additional PICU capacity (South Wales) – WHSSC was aware of difficulties in accessing PICU beds in the sole Unit in Wales based in the Children's Hospital for Wales, Cardiff and increased refusal of admissions over the last few months.

The mitigation for both these schemes were also presented to Management Group for scrutiny before funding was released.

5.1.4 Key risks that are expected to emerge in year

The 2018-21 ICP highlighted a number of key risks that were likely to present in year and were likely to present a cost pressure. These included:

- Cystic Fibrosis – service was exceeding the number of patients for the size/staffing of its service
- Neonatal Transport- South Wales – service was only available for 12 hours a day, when the majority of neonatal transport services have in place and national guidance recommends, a 24 hour service
- Fetal Medicine – South Wales – in terms of the ability of the service to deliver all necessary diagnostics in the timely manner required

Further work was required on each of these schemes to fully identify the resource requirements and outcomes before presentation to Management Group and Joint Committee. Whilst Cystic Fibrosis and Fetal Medicine received investment in 2018/19, a full review of Neonatal Transport was recommended following an independent case review and is being undertaken in the first half of 2019/20.

5.2 Performance Dashboard

WHSSC has two performance dashboards. An Organisation Performance Report and an Integrated Performance Report.

The Organisation Performance Report is provided to the Corporate Directors Group. It details compliance with management indicators including sickness and absence, performance appraisals and mandatory and statutory training.

The Integrated Performance Report provides an overview on the performance of providers for services commissioned by WHSSC including services in escalation and provider performance. The report is provided to the Corporate Directors Group Board, Management Group and Joint Committee. The services in escalation are also reported through the Corporate Risk and Assurance Framework to Joint Committee and the joint sub-committees.

DRAFT

5.2.1 Services in Escalation

The table below summarised the services in escalation as at January 2019.

5.3 Corporate Governance Code

The WHSST has reviewed its assessment against the main principles of the *Corporate governance code for central government departments: Code of Good Practice 2011*[1], as they relate to an NHS public sector organisation in Wales. The WHSST remains satisfied that it remains compliant with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. No departures from the Code were identified during the year.

5.4 Health and Care Standards

The Health and Care Standards set out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. They set out what the people of Wales can expect when they access health services and what part they themselves can play in promoting their own health and wellbeing.

The Health and Care Standards are focussed around service delivery and therefore a number of areas are not appropriate to the remit of WHSSC. However, WHSST has sought opportunities to ensure consideration of the standards within its work and requires all reports to the Joint Committee and sub-committees to identify which themes within the Health and Care Standards were considered/appropriate when developing those reports.

DRAFT

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220645/corporate_governance_good_practice_july2011.pdf

Specialty	Level of Escalation	Current Position	Movement from Last Month
Cardiac Surgery	2	Performance meetings continue bi-monthly with ABMUHB.	⇨
	3	Monthly performance meetings continue with C&VUHB.	⇨
	2	Performance meetings continue bi-monthly with LHCH.	⇨
Thoracic Surgery	2	Bi-monthly performance meetings continue with ABMUHB and C&VUHB.	⇨
Lymphoma Panel	2	Performance meetings are in place with the All Wales Lymphoma Panel (CVUHB and ABMUHB).	⇨
Bariatric Surgery	2	The bariatric service at ABMUHB was de-escalated from level 3 to 2 in December. Bi-monthly performance meetings are continuing to take place.	⇨
Plastic Surgery	2	Monthly performance meetings continue with ABMUHB	⇨
Neurosurgery	2	The Neurosurgery service has been de-escalated from a level 3 to level 2, as a result of the improvement in the RTT waiting times since February 2018. Although, the service are still not achieving the 36 week target, monthly meetings are continuing to take place to monitor the situation.	⇨
Adult Posture & Mobility	2	Quarterly meetings occur with all three providers however there is closer monitoring of the BC UHB service, as the service is still not meeting the 90% RTT target. However in recent months, the service have demonstrated that the waiting time performance has improved due to the appointment of key staff with the aim to achieve RTT by March 2019.	⇨
CAMHS	3	An action plan has been developed with BCUHB and significant improvements to workforce issues have been made in last 3 months.	⇨
	3	The CAMHS service in South Wales at Ty Llidiard was escalated straight to level 4 following inpatient incident leading to a temporary closure of the unit. Site visit and findings from QAIT report led to unit being reopened to admissions on case by case basis and de-escalated to Level 3 with action plan developed.	⇨
Paediatric Surgery	3	The service remains in escalation stage 3 following the re-visit in October 2018. Two key actions are outstanding and once completed the escalation stage will be reviewed.	⇨
Paediatric Intensive Care	2	The first escalation meeting is scheduled to take place on 23rd April	⇨
BMT	2	The BMT service in south Wales has recently been placed into level 2 escalation to explore further concerns raised.	⇨
IVF Shrewsbury	2	Following the meeting in February additional information has been requested from the Provider along with a further follow up letter detailing the actions required from the service to improve the waiting time performance to mitigate the risk. WHSSC and the provider will work together to agree a performance report, which will be submitted monthly.	⇨
Sarcoma	2	WHSSC has arranged weekly input into MDT from surgeon at Royal Orthopaedic. WHSSC is coordinating discussions with health board leads for cancer and radiology to reach an agreement on the diagnostic pathway in south east Wales.	⇨

6. OTHER ELEMENTS OF CONTROL FRAMEWORK

6.1 Equality and Diversity

WHSSC follows the policies and procedures of the Cwm Taf University Health Board, as the host LHB. All staff have access to the Intranet where these are available. The Hosting Agreement includes provision for specific support around Equality and Diversity and WHSSC has been working with the Equality Officer and the NHS Wales Equality Unit to look at ways of integrating equality and diversity issues into its work.

The Corporate Governance Manager is a member of the Equality Group within Cwm Taf University Health Board and therefore any issues are integrated into this process.

The Welsh Government's Public Sector Equality Duty (PSED) advocates that all public sector organisations publish their Strategic Equality Plan (SEP) no less than every four years. Whilst WHSSC commissions specialised services on behalf of the seven LHBs the responsibility for individual patients remains with the LHB of residence.

In recognition of WHSSC's responsibility to ensure that equality is a key consideration in the commissioning of its services, we aim to develop an equality plan for specialised services. This plan should assist LHBs to ensure that specialised services commissioning for their population is reflected in their individual strategic equality plans.

6.2 National Health Service Non-Statutory Instruments 2018-19

The Welsh Government has issued six non-statutory instruments (NSIs) in 2018-19. None of these NSIs were relevant to WHSSC.

The NSIs are available at the following Welsh Government website:
http://gov.wales/legislation/subordinate/nonsi/nhswales/2018/?lang=en

6.3 Information Governance

The Committee Secretary is the Lead Officer in relation to Information Governance for WHSSC. An agreement has been made that the Medical Director for Cwm Taf University Health Board, as host LHB, will act as Caldicott Guardian for WHSSC with input and assurance from the WHSSC Medical Director.

The Committee Secretary and the Corporate Governance Manager are members of the Cwm Taf University Health Board Information Governance Group.

DRAFT

6.3.1 Data Security

There were no WHSSC specific incidents relating to data security that required reporting to the Information Commissioners Office during 2018-19.

6.4 Counter Fraud

The Counter Fraud Plan was designed to reduce the risk of fraud by reviewing those aspects of WHSSC business that have a residual fraud risk. During the year, the Audit Committee received regular Local Counter Fraud Progress Reports. These provided a summary of the work that had been undertaken by the Local Counter Fraud Services Team to deliver the Counter Fraud Plan.

The plan for the year was to implement systems improvements building on the proactive audits which looked at the supply of home delivered high value drugs.

7. REVIEW OF EFFECTIVENESS

As Managing Director for Specialised and Tertiary Services Commissioning, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within WHSST 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.

7.1 Internal Audit

Internal audit provide me and the Joint Committee, 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 Cwm Taf UHB Audit Committee regularly reviews and consider the work and findings of the internal audit team. The Director of Audit and Assurance and the relevant Heads of Internal Audit have attended each meeting to discuss their work and present their findings. The Audit Committee is satisfied with the liaison and coordination between the external and internal auditors.

DRAFT

The following reviews were completed by Internal Audit during 2018-19:

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
WHSSC					
Prioritisation process review	10	Final	Reasonable	Q1	Final issued 1 September
Governance framework and action plan	10	Final	Reasonable	Q2	Final issued 22 August
Mental Health services	10	Final	Reasonable	Q3	Final issued 8 January
Core financial systems	5	Final	Substantial	Q4	Final issued 4 January

No reports received an assessment rating lower than 'Reasonable assurance'.

For internal audit the Cwm Taf UHB Audit Committee monitored implementation of management actions agreed in response to reported weaknesses. Reports were generally received on time and enabled the Cwm Taf UHB Audit Committee to understand operational and financial risks. In addition, our internal auditors have provided valuable benchmarking information relating to best practice in existence elsewhere across NHS Wales.

7.2 External Audit

As an organisation hosted by Cwm Taf UHB, the work of external audit is monitored by the Cwm Taf UHB Audit Committee through regular progress reports. The recommendations made are relevant and helpful in our overall assurance and governance arrangements and our work on minimising risk. There are clear and open relationships with officers and the reports produced are comprehensive and well presented.

In addition to WHSSC matters, the Cwm Taf UHB Audit Committee has been kept apprised by its external auditors of developments across NHS Wales and elsewhere in the public service. These discussions have been helpful in extending the Audit Committee's awareness of the wider context of our work.

8. SIGNIFICANT GOVERNANCE ISSUES

There were no significant governance issues during 2018-19 to note.

9. CONCLUSION

During 2018-19 no significant internal control or governance issues were identified other than those challenges presented in section 8 of this statement.

DRAFT

As the Managing Director for Specialised and Tertiary Services Commissioning, I will use all reasonable endeavours to ensure that through robust management and accountability frameworks, significant internal control problems do not occur in the future. However, if such situations do arise, swift and robust action will be taken, to manage the event and to ensure that learning is spread throughout the organisation.

Signed:

Dr Sian Lewis
Managing Director of Specialised and Tertiary Services Commissioning

Date:

DRAFT

To: Dr Chris Turner,
Emergency Ambulance Services Committee Chair
Cwm Taf University Health Board (UHB)

cc: Emergency Ambulance Services Committee (EASC) Members

EMERGENCY AMBULANCE SERVICES COMMITTEE ANNUAL GOVERNANCE STATEMENT 2018-2019

1. SCOPE OF RESPONSIBILITY

In accordance with the Emergency Ambulance Services Committee (Wales) Directions 2014 (2014 No.08), the Local Health Boards (LHBs) established a Joint Committee, which commenced on 1 April 2014, for the purpose of jointly exercising its Delegated Functions and providing the Relevant Services.

In establishing the Emergency Ambulance Services Joint Committee (EASC) to work on their behalf, the seven Local Health Boards (LHBs) recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

The Emergency Ambulance Services Committee (EASC) (Wales) Regulations 2014 (SI 2014 No.566 (W.67)[1] make provision for the constitution of the "Joint Committee" including its procedures and administrative arrangements.

The Joint Committee is a statutory committee established under sections 11, 12(3), 13(2) (c) and (4) (c) and 203(9) and (10) of and paragraph 4 of Schedule 2 to the National Health Service (Wales) Act 2006(1). The LHB's are required to jointly exercise the Relevant Services.

[1] The Emergency Ambulance Services Committee (EASC) (Wales) Regulations 2014 (SI 2014 No.566 (W.67)[1]http://www.wales.nhs.uk/sitesplus/documents/1134/Welsh%20Statutory%20Instrument%20for%20EASC%202014%20No%20566%20%28w67%29.pdf

In December 2015, the Welsh Ministers directed the Health Boards under the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8)[2] to be responsible for commissioning Non-Emergency Patient Transport (NEPT) services via the Emergency Ambulance Services Committee from April 2016.

The Cwm Taf University Health Board (UHB) is the identified host organisation. It provides administrative support for the running of EASC in line with the Directions and has established the Emergency Ambulance Services Team (EAST) and appointed the Chief Ambulance Services Commissioner as per Direction 8(4), 3 of the Emergency Ambulance Services Committee and related Regulations.

2. GOVERNANCE FRAMEWORK

In March 2014, the Joint Committee approved the revised Governance and Accountability Framework including the Standing Orders. These were reviewed and updated during 2017/18. In accordance with related Regulations and Directions, each Local Health Board ('LHB') in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee ("Joint Committee") proceedings and business. These Joint Committee Standing Orders (Joint Committee SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them.

Together with the adoption of a scheme of decisions reserved to the Joint Committee; a scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with a Memorandum of Agreement setting out the governance arrangements for the seven LHBs and a hosting agreement between the Joint Committee and Cwm Taf University Health Board LHB ("the Host LHB"), form the basis upon which the Joint Committee's governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

2.1 Quality & Delivery Framework Agreements

The *Quality & Delivery Framework Agreement is* structured to support the following scope of services;

a) responses to emergency calls via 999;

[2] the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8)
http://www.wales.nhs.uk/sitesplus/documents/1134/2016%20No%208%20%28W8%29%20The%20EASC%20%28Wales%29%20%28Amendment%29%20Directions%202016.pdf

b) urgent hospital admission requests from general practitioners;
c) high dependency and inter-hospital transfers;
d) major incident response and urgent patient triage by telephone;
e) NHS Direct Wales Services.

This is in line with the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)), 10th March 2014.

Prior to the formation of the EASC there were inadequate arrangements and documentation in place covering the commissioning of emergency ambulance services between Health Boards and the Welsh Ambulance Services NHS Trust (WAST).

The Emergency Ambulance Services Committee (EASC) at its inaugural meeting in April 2014 sponsored the use of CAREMORE® for the creation of a Commissioning, Quality & Delivery Framework Agreement ('Framework Agreement') for Emergency Ambulance Services.

The Framework Agreement:

- Clarifies the role, responsibilities and outcomes from emergency ambulance services and their partners;
- enables a balance to be achieved between national expectations and local responsiveness to support the delivery of an efficient and effective urgent / emergency care response system;
- improves patient experience, improves patient outcomes, and demonstrates value for money;
- Was fully operational in 2018/19.



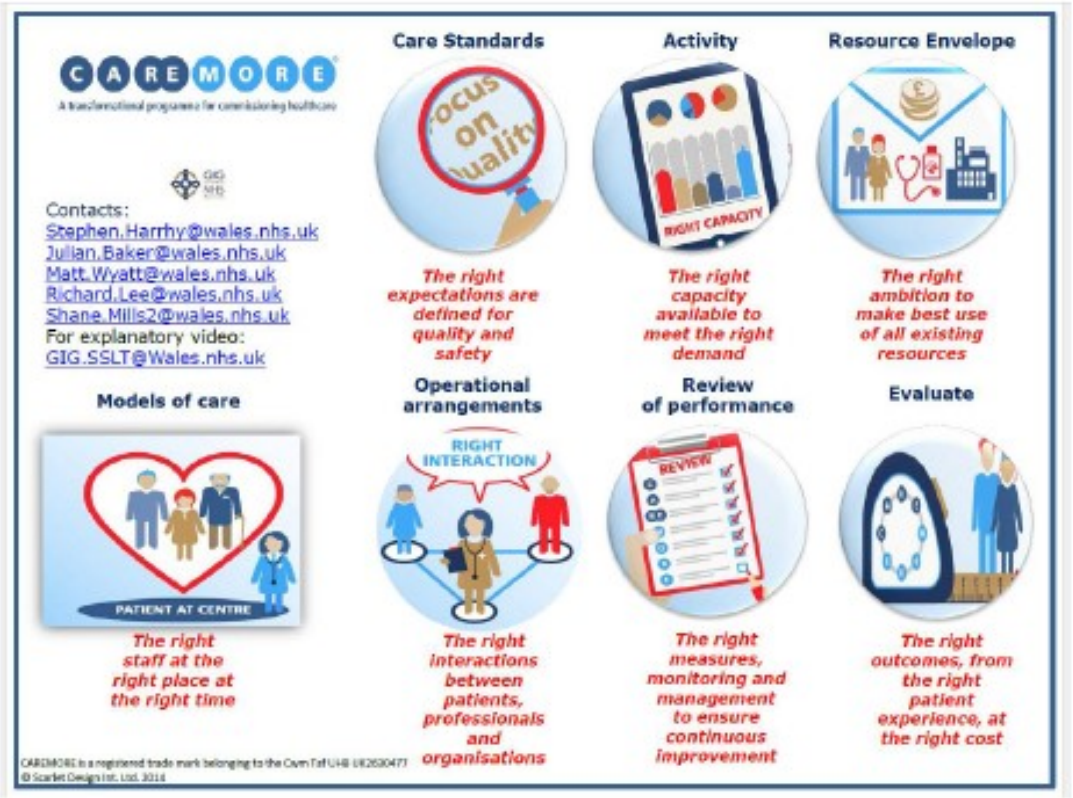
One of the main ambitions of EASC is to encourage and enable patients to access services through other, more appropriate means before their needs become urgent and/or life-threatening, and require a response from the emergency ambulance service. In 2015, EASC developed a new, citizen-centred pathway which describes a five-step process that supports the delivery of emergency ambulance services within Wales. The Ambulance Patient Care Pathway (referred to as the five-step model) is set out in Figure 1 below:

Figure 1 - CAREMORE® 5 Step Model



To support the development of the Framework Agreement, EASC sponsored the use of the CAREMORE® model5 which had successfully been used to commission other services previously. The CAREMORE® model defines the expected care standards to be met for each of the five steps of the Ambulance Patient Care Pathway; as well as setting out activity, performance and resource management information available for each of the steps of the pathway. It also details the outcomes required in pursuit of improving patient experience; improving patient's clinical outcomes and demonstrating value for money. The principles of the CAREMORE® model are set out in Figure 2 below:

Figure 2 – Principles of the CAREMORE®



2.2 The Joint Committee

The Joint Committee has been established in accordance with the Directions and Regulations to enable the seven LHB's in NHS Wales to make collective decisions on the review, planning, procurement and performance monitoring of Emergency Ambulance Services (relevant Services), Emergency Medical Retrieval & Transfer Service (EMRTS) and Non-Emergency Patient Transport Service and in accordance with their defined Delegated Functions.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the responsibility of individual LHBs for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of Emergency Ambulance Services; Emergency Medical Retrieval & Transfer Service and Non-Emergency Patient Transport Services.

The Joint Committee is accountable for internal control. As Chief Ambulance Services Commissioner NHS Wales, I have the responsibility for maintaining a sound system of internal control that supports achievement of the Joint Committee's policies, aims and objectives and to report the adequacy of these arrangements to the Chief Executive of Cwm Taf University Health Board University Health Board (UHB).

Health Boards and NHS Trusts in Wales have collaborated over the operational arrangements for the provision of the emergency ambulance services and have agreed the terms of a Memorandum of Understanding to ensure that the arrangements are introduced and operate effectively by collective decision making, in accordance with the policy and strategy set out above determined by the EASC.

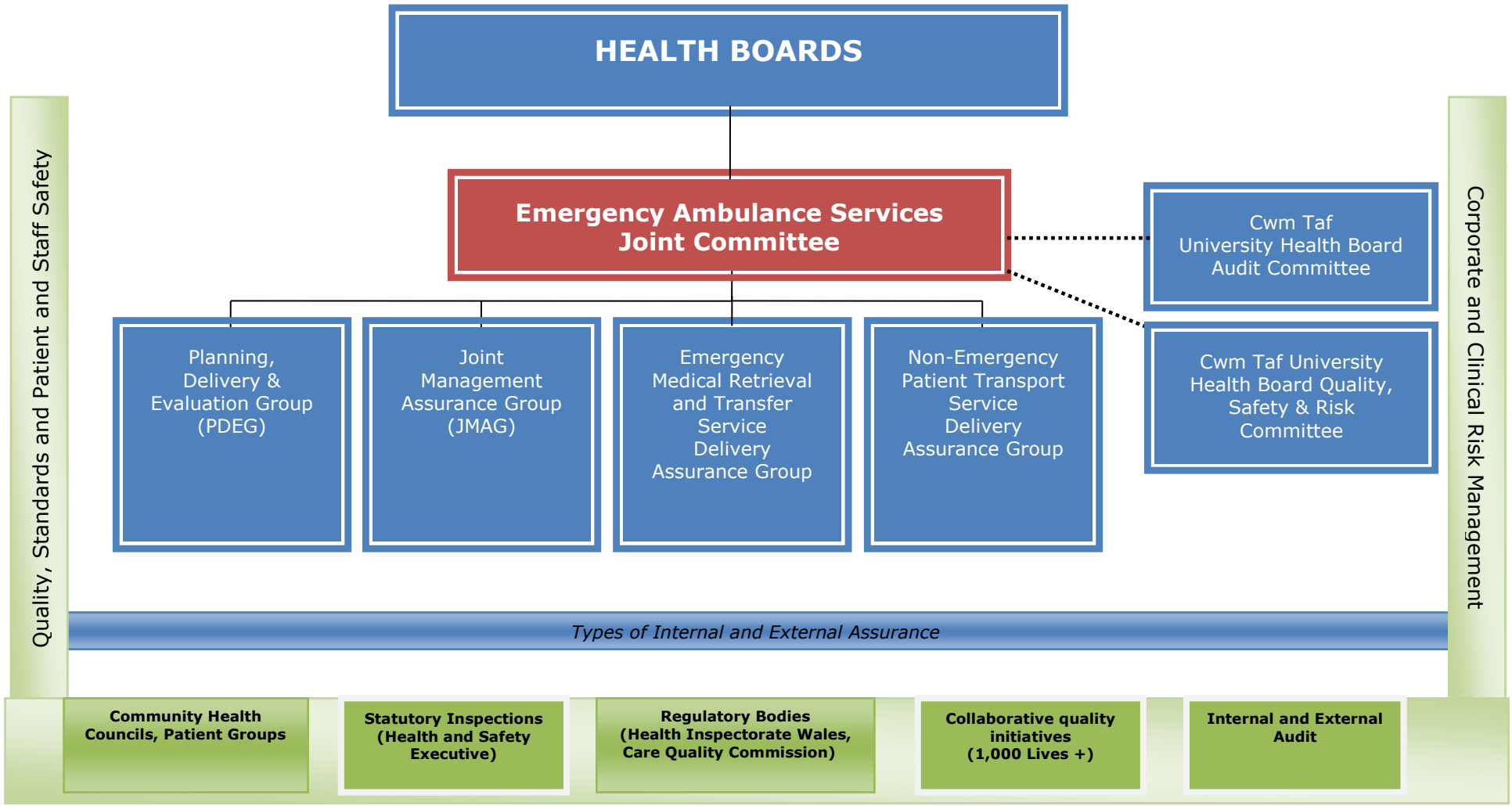
Whilst the EASC acts on behalf of the Health Boards and NHS Trusts in undertaking its functions, the responsibility for the exercise of the emergency ambulance functions is a shared responsibility of all NHS bodies in Wales.

Under the terms of the establishment arrangements, Cwm Taf University Health Board (UHB) is deemed to be held harmless and have no additional financial liabilities beyond their own resident population.

The Joint Committee is supported by a Board/Committee Secretary, who acts as the guardian of good governance within the Joint Committee.

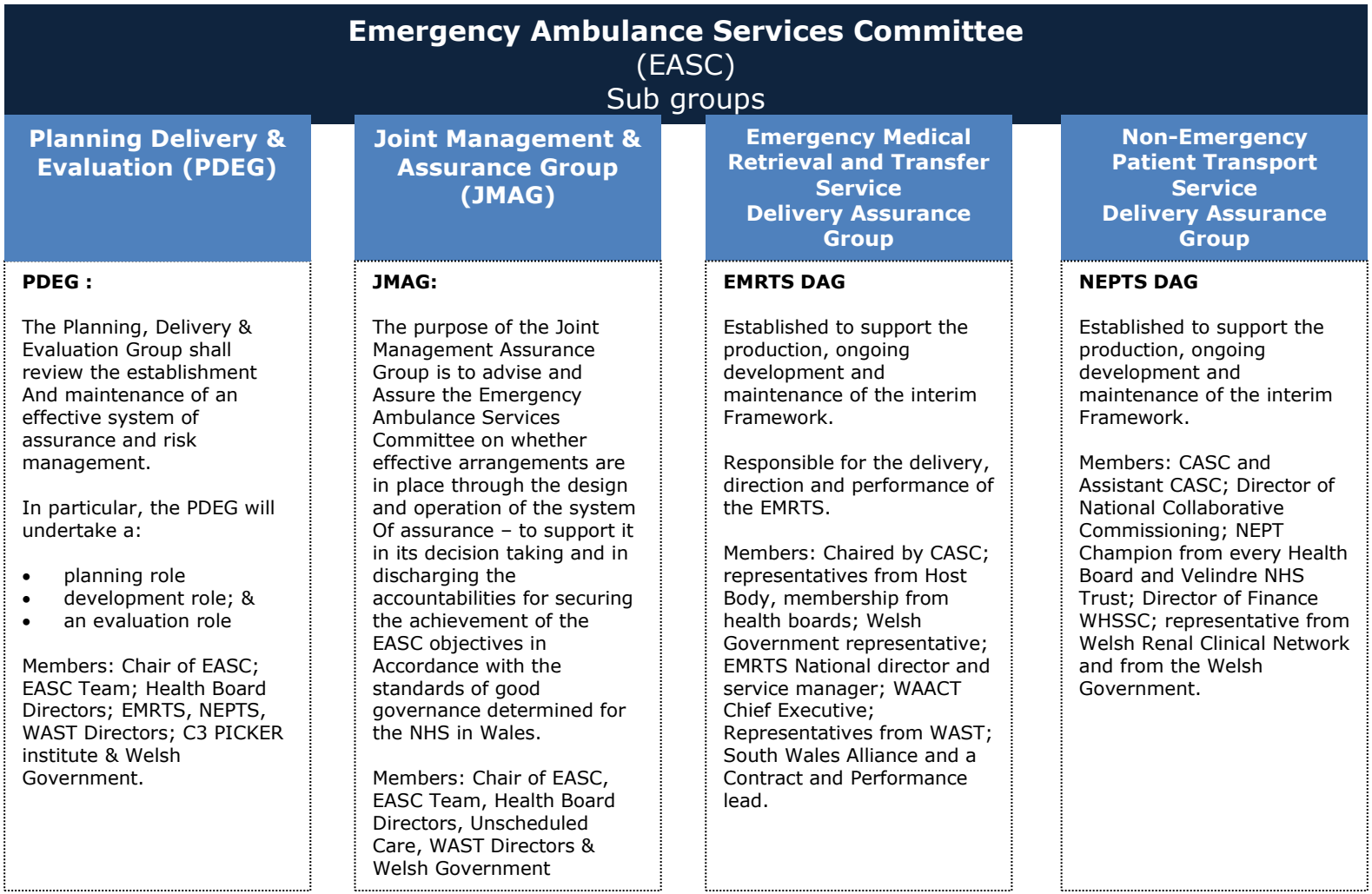
The Governance framework for the operation of EASC is presented in Figures 3 and a flowchart outlining the supporting sub groups is outlined in Figure 4.

Figure 3 - Governance Framework for EASC



It should be noted that the subcommittee structure will change in 2019/20 with the amalgamation of both PDEG and JMAG into a single management group reporting to the EASC Joint Committee.

Figure 4 – Sub Groups of the EASC



The EASC has in place a robust Governance and Accountability Framework including:

- Standing Orders
- A Hosting Agreement
- Memorandum of Understanding

The above documents set out the governance arrangements for the NHS Wales organisations and form the basis upon which the Joint Committee's Governance and Accountability Framework is developed. Together with the Cwm Taf University Health Board "Values and Standards of Behaviour framework" this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

The table in Figure 5 below outlines the Composition of the Joint Committee during the financial year 2017-2018.

Figure 5 – Composition of the EASC Committee 2018-2019

Name	**Role**	**Organisation**
Dr. Chris Turner	Chair (Nov 2018)	Emergency Ambulance Services Committee
Mr Stephen Harrhy	Chief Ambulance Services Commissioner	Emergency Ambulance Services Committee
Mrs. Allison Williams	Chair (March 2018-Oct 2018) Member (Vice Chair)	Chief Executive, Cwm Taf University Health Board UHB
Mr. Len Richards	Member	Chief Executive, Cardiff & Vale UHB
Mr Steve Moore	Member	Chief Executive, Hywel Dda UHB
Mrs. Judith Paget	Member	Chief Executive, Aneurin Bevan UHB
Mr. Gary Doherty	Member	Chief Executive, Betsi Cadwaladr UHB
Mrs. Tracy Myhill	Member	Chief Executive, Abertawe Bro Morgannwg UHB
Mrs. Carol Shillabeer	Member	Chief Executive, Powys Teaching HB
Ms Tracey Cooper	Associate Member	Chief Executive, Public Health Wales NHS Trust
Mr. Steve Ham	Associate Member	Chief Executive, Velindre NHS Trust
Mr. Jason Killens	Associate Member	Chief Executive, Welsh Ambulance Services NHS Trust

In accordance with the EASC Standing Orders, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

The purpose of the Joint Committee is to jointly exercise those functions relating to the commissioning of emergency ambulance services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of emergency ambulance services for residents within their area.

The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance non-emergency patient transport services and Emergency Medical Retrieval and Transfer Services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance service;
- Produce an Integrated Medium Term Plan (IMTP), including a balanced Medium Term Financial Plan for agreement by the Committee following the publication of individual LHB's Integrated Medium Term Plans (IMTPs), which should also make reference to the EASC commissioning intentions;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the EASC Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance, non-emergency patient transport services and Emergency Medical Retrieval and Transfer Services and take appropriate action.

The EASC monitors performance on a quarterly basis against the key performance indicators. For any indicators assessed as being below target, reasons for current performance are identified and included in the report along with any remedial actions to improve performance.

The Joint Committee ensures that the principles of good governance applicable to NHS organisations are followed consistently, including the oversight and development of systems and processes for financial control, organisational control, governance and risk management. The EASC assesses strategic and corporate risks through the Risk Register.

2.2.1 Joint Committee Meetings

The table in Figure 6 outlines dates of Joint Committee meetings held during 2018-2019 and attendance by Members. All meetings held were quorate.

Figure 6 – EASC Committee Attendance 2018-2019

Health Board	May	Jul	Oct	Nov	Feb	Mar
Committee Members						
Chair	Awaiting appointment			√	√	√
CASC	√	√	√	√	√	√
Aneurin Bevan UHB	√	√	√	√	√(VC)	√
Abertawe Bro Morgannwg UHB	√	√	X**	√	X*	X
Betsi Cadwaladr UHB	X	√(VC)	X	√	X*	X**
Cardiff & Vale UHB	√	√	X	X*	X*	X
Cwm Taf University Health Board UHB	√ (Chair)	√ (Chair)	√ (Chair)	√	√	√
Hywel Dda UHB	√	√	√	X*	X*	√
Powys THB	√	√	X	√	X*	X**
Associate Committee Members						
WAST	√	√	√	√	√	√
Public Health Wales	X	X	X	X	X	X
Velindre NHS Trust	X	X	X	X	X	X

X * denotes not present but sent a nominated Executive Director
X ** denotes not present but sent a representative (not Executive) to attend.
(I) denotes 'interim CEO'
(VC) denotes by Video Conference

The Chair of the Committee routinely emphasises the importance of attendance at the Joint Committee and escalates any matters of member non-attendance, as appropriate, with Members and/or Chairs of NHS organisations. The issue of non-attendance of organisation representatives at sub-group meetings has also been raised by the Chair and the CASC and discussed with Members at Joint Committee meetings. Dr Andrew Goodall, Director General / Chief Executive NHS Wales has also written out to Chief Executive Officers to remind them of their responsibilities in this regard.

2.2.1 Joint Committee Performance and Self-Assessment

During 2018-2019 the Emergency Ambulance Services Committee approved an annual forward plan of business, including:

Standing items

- Chair's report
- Chief Ambulance Services Commissioner (CASC) report,
- Finance Report
- Provider issues by exception
- Forward Plan of Business
- AMBER Review (Standing item from February)

Planned items received on a regular basis

- Ambulance Quality Indicators Report (in line with quarterly reporting)
- AMBER Review
- EASC Governance Updates including quarterly risk register reporting
- Emergency Medical Retrieval and Transport Services (EMRTS) including the business case

Other items included:

- 'A Healthier Wales' Commissioning allocation
- Demand and Capacity Review
- EASC Integrated Medium Term Plan (IMTP)
- EASC Integrated Medium Term Plan (IMTP) (Chair's action)
- Emergency Medical Service - Quality Delivery Framework
- Final version of the EASC Governance Statement
- Integrated Performance Report
- Opportunities for joint initiatives based and IMTP's and key Schemes
- Planning, Development and Evaluation Group (PDEG) Approved Action Notes 13 March 2018
- Updated Summary on role, function and membership of sub groups well as the progress on the work with WAST on the Clinical Governance Plan.
- Wales Audit Office Review of Emergency Ambulance Services Commissioning Arrangements update and closure report.

Reports from EASC Sub Groups

- Emergency Medical Retrieval and Transport Service Delivery Assurance Group
- Non-Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG)
- Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG)
- Joint Management Assurance Group (JMAG).

2.3 Sub Committees and Advisory Groups

2.3.1 The Audit Committee of the Cwm Taf University Health Board

The primary role of the Cwm Taf University Health Board Audit Committee is to review and report upon the adequacy and effective operation of EASC's overall governance and internal control system.

This includes risk management, operational and compliance controls, together with the related assurances that underpin the delivery of EASC's objectives. This role is set out clearly in the Audit Committee's terms of reference which were revised in 2017 to ensure these key functions were embedded within the standing orders and governance arrangements.

The Audit Committee reviews the effective local operation of internal and external audit, as well as the Counter Fraud Service. In addition, it ensures that a professional relationship is maintained between the external and internal auditors so that reporting lines can be effectively used.

The Audit Committee supports the Joint Committee in discharging its accountabilities for securing the achievement of the EASC objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Cwm Taf University Health Board Audit Committee attendees during 2018-2019 comprised 4 Independent Members supported by representatives of both Internal and External Audit and Senior Officers of Cwm Taf University Health UHB.

Where necessary, relevant officers are in attendance for the EASC components of the Cwm Taf University Health Board Audit Committee, and it is recognised that as the EASC continues to evolve and mature as a Joint Committee, there will be an increasing level of audit related activity.

The attendance for the Cwm Taf University Health Board Audit Committee for 2018-2019 is presented at Figure 7 for information:

Figure 7 - Composition of the Cwm Taf University Health Board UHB Audit Committee 2018-2019

Name	Position	From/To	Attendance
Chris Turner	Chair Independent Member	Apr 2018 – Oct 2018	5/5
Paul Griffiths	Independent Member Chair from January 2019	April 2018 - March 2019	7/7
Maria Thomas	Independent Member	April 2018 - March 2019	7/7
Jayne Sadgrove (née Dowden)	Independent Member	April 2018 - March 2019	6/7
Dilys Jouvenat	Independent Member	Oct 2018 – March 2019	3/3

The Audit Committee met formally on 6 occasions during the year with the majority of members attending regularly and all meetings were quorate. Minutes of the meeting were reported to the Health Board.

2.3.2 Planning, Delivery and Evaluation Group (PDEG)

The purpose of the Planning, Delivery & Evaluation Group is to review the establishment and maintenance of an effective system of assurance and risk management.

In 2017 the Wales Audit Office (WAO) undertook a review of Emergency Ambulance Services Commissioning arrangements, including EASC and in July 2017 they published the WAO Report "Review of Emergency Ambulance Services Commissioning Arrangements".
The report provides positive assurance on EASC's strategic intent and made recommendations to strengthen and develop existing processes, including:

> *R4 "..... review the structures, roles and memberships of its three subgroups to ensure they are mutually exclusive, have a clear purpose and appropriately support the work of EASC."*

Consequently, the original terms of reference for the Planning, Delivery and Evaluation Group (PDEG)" were reviewed and the new draft terms of reference were discussed at the September 2017 Joint Committee meeting, following on from the recommendations outlined within the WAO Report. The new terms of reference for the newly structured "Planning, Delivery

and Evaluation Group (PDEG)" were approved at the November 2017 Joint Committee meeting.

The EASC standing orders have been reviewed and the updated terms of reference for the PDEG have been included in the document.

2.3.3 Joint Management Assurance Group (JMAG)

The purpose of the Joint Management Assurance Group (JMAG) is to advise and Assure the Emergency Ambulance Services Committee (EASC) on whether effective arrangements are in place through the design and operation of the system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the EASC objectives in accordance with the standards of good governance determined for the NHS in Wales.

Consequently, the original terms of reference for the "Joint Management Assurance Group (JMAG)" were reviewed and the new draft terms of reference were discussed at the September 2017 meeting following on from the recommendations outlined within the WAO Report. The new terms of reference for the newly structured "Joint Management Assurance Group (JMAG)" were approved at the November 2017 meeting.

The EASC standing orders have been reviewed and the updated terms of reference for the JMAG have been included in the document.

2.3.4 Emergency Medical Retrieval & Transfer Service (EMRTS)

The EMRTS is commissioned by the Emergency Ambulance Service Committee (EASC) and is hosted by Abertawe Bro Morgannwg (ABMU). The organisational governance structure consists of an EMRTS Delivery Assurance Group (DAG) which reports to the Chief Ambulance Service Commissioner and through to the EASC Joint Committee. The EASC Joint Committee delegates responsibility to the DAG for the delivery, direction and performance of the EMRTS. The Chief Ambulance Services Commissioner is a member of the ABMU EMRTS Clinical Governance sub group.

The National Director is accountable to the DAG for the delivery and performance of the EMRTS and to the ABMU Chief Executive for organisational and clinical governance. There are a number of supporting agreed documents which underpin the organisational governance of the service as follows:

1. Memorandum of Agreement between ABMU and EASC.
2. Terms of reference for the EMRTS Delivery Assurance Group.
3. Collaborative agreement between AB ABMU MUHB, the Wales Air Ambulance Charity Trust (WAACT) and the Welsh Ambulance Service Trust (WAST).

4. Memorandum of Understanding between ABMU and other Welsh LHB's/NHS Trusts.
5. Service level agreement between EMRTS and ABMU for accessing supporting services.
6. Terms of Reference for the EMRTS Clinical and Operational Board.

The Emergency Medical Retrieval and Transfer Service went live on the 27 April 2015. The service was commissioned "to provide advanced decision making & critical care for life or limb threatening emergencies that require transfer for time critical specialist treatment at an appropriate facility." The service represents a joint partnership between NHS Wales, The Wales Air Ambulance Charity Trust (WAACT) and Welsh Government. The service was initially commissioned by the Welsh Health Specialised Services Committee; however, this function transferred to the Emergency Ambulance Services Committee on the 1 April 2016.

2.3.5 Non-Emergency Patient Transport Service (NEPTS)

The diagram in Figure 8 below provides a schematic in relation to the Interim Quality & Delivery Framework Agreement for the Non-Emergency Patient Transport Service (NEPTS).

Figure 8 – Assurance Framework Between EASC & Health Boards,WHSCC and Velindre NHS Trust

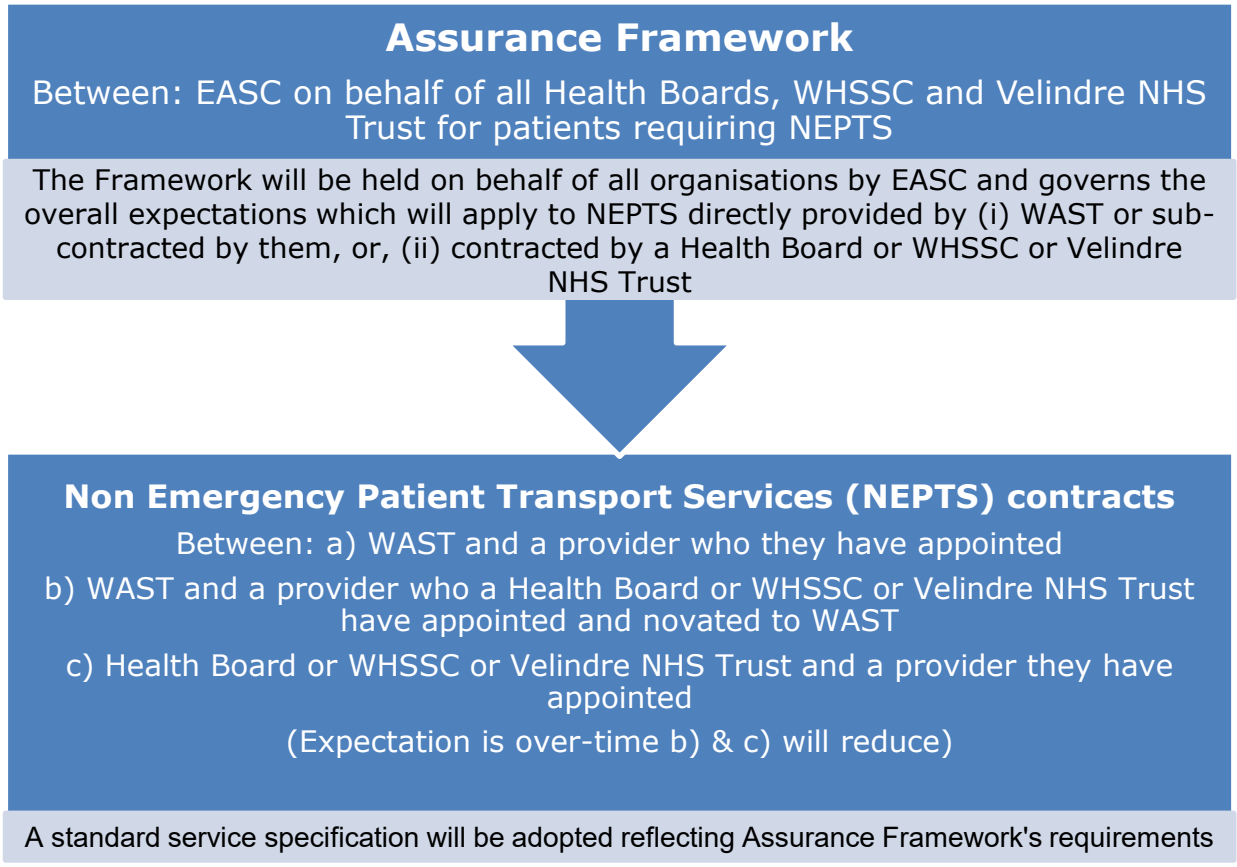
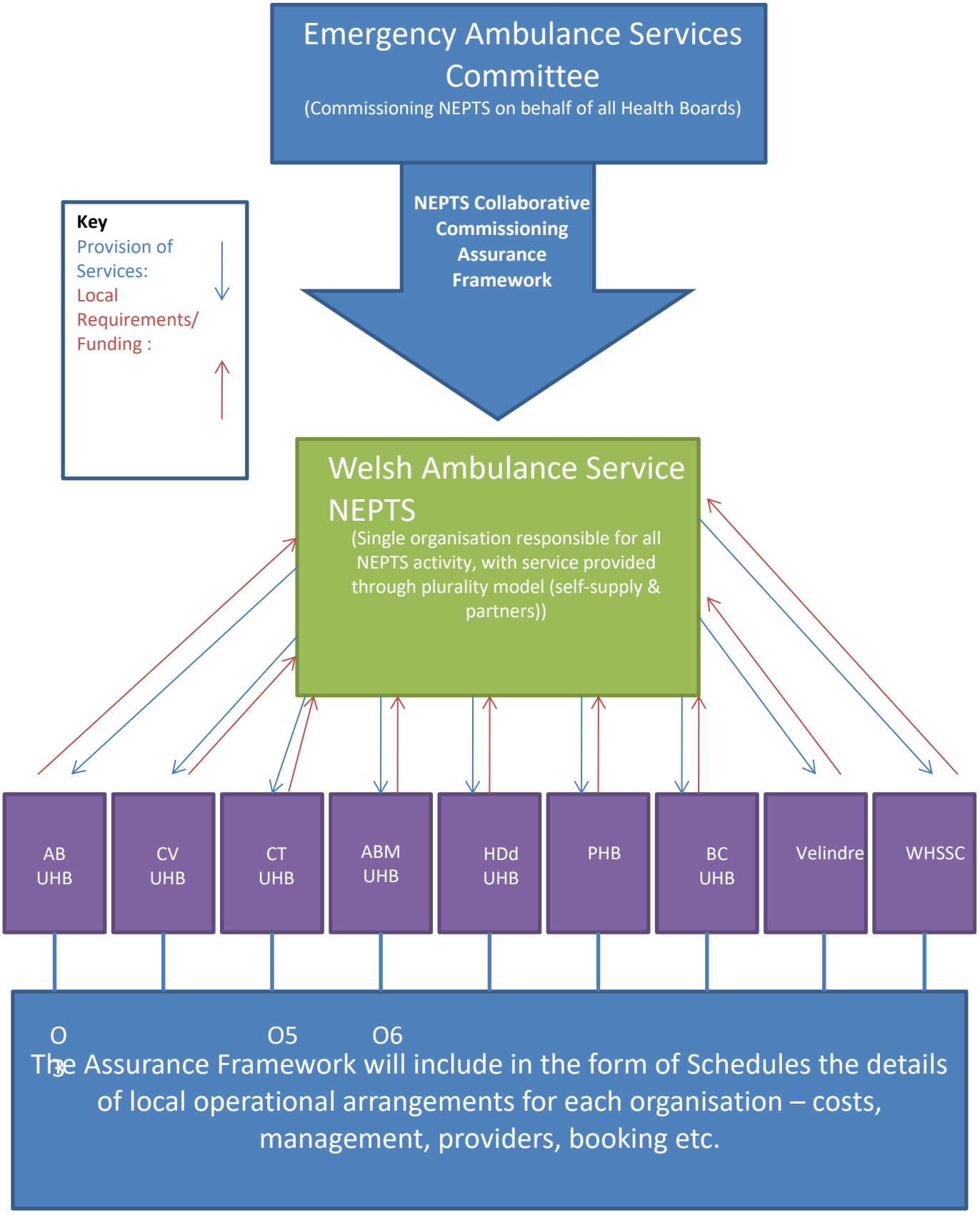


Figure 9 - Diagrammatic Presentation of the Commissioning Model



Following the submission of a business case, in January 2016, the Deputy Minister for Health announced the future plans for Non-Emergency Patient Transport Services and responsibility for commissioning NEPTS transferred to the Emergency Ambulance Services Committee (EASC) from April 2016.

The Joint Committee approved the establishment of the NEPTS Commissioning and Delivery Assurance Group which required the NEPTS also to utilise the functions of the Quality Assurance and Improvement Panel.

The agreed business case required that NEPTS became a distinct and separate entity within WAST. The implementation of the business case and the agreed commissioning arrangements for NEPTS would be undertaken within the existing financial envelope.

As commissioning was previously undertaken by a range of organisations, EASC members have requested clarity on the resources used for NEPTS.

The arrangements should enable the EASC Team to:

- challenge providers & commissioners to ensure outcomes are delivered as specified within the Framework Agreement;
- enable openness & transparency about system wide performance issues between Health Boards and the NEPTS;
- ensure positive relationships are maintained and promoted between commissioners and providers to continuously improve performance;
- ensure commissioned services are being delivered safely & effectively; with positive patient outcomes and experience; demonstrating that services delivered are evidence-based and effective, whilst providing value for money.

These issues have been addressed and taken into account in the draft Commissioning, Quality & Delivery Framework Agreement ('Framework Agreement') for NEPTS.

2.4 Reviewing the Effectiveness of EASC

The Quality, Safety & Risk Committee of Cwm Taf University Health Board UHB (host body), advises and assures the Joint Committee on the effectiveness of its risk management arrangements, by reviewing its risk register and approach to risk management at each of its meetings. It is also important to note that the risk register is a routine feature of the business of the Joint Committee.

3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

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

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

3.1.1 External Audit

During 2017-2018, the EASC's external auditors were the Wales Audit Office (WAO). The Cwm Taf University Health Board UHB Audit Committee has worked constructively with the WAO and the areas examined included:

- Review of Emergency Ambulance Services Commissioning Arrangements[3]

The WAO undertook audit work on unscheduled care in 2009 and 2013, which highlighted challenges across Wales in managing emergency and urgent demand, manifesting themselves in significant pressures within services, delays for patients and difficulties in meeting key performance targets. Since then EASC was established in 2014 and the Auditor General set out his intention in his 2016 audit plans for NHS bodies to review the arrangements for commissioning emergency ambulance services. The aim was to understand whether they are improving services for patients, and the wider unscheduled care system. The WAO undertook a review of EASC in 2017 and the "Review of Emergency Ambulance Services Commissioning Arrangements" report was published in August 2017 and made a number of recommendations for Welsh Government and NHS bodies.

The WAO made 12 recommendations and the overall conclusion from the WAO review was that the new collaborative commissioning arrangements have helped to drive some important changes for emergency ambulance services in Wales; however, in their view these arrangements were not yet mature and will require greater commitment by some partners to demonstrate their full impact. The EASC accepted the findings of the report and devised an improvement plan to address the recommendations made and to strengthen and develop EASC's governance arrangements.

[3] WAO Report: Review of Emergency Ambulance Services Commissioning Arrangements http://www.audit.wales/publication/review-emergency-ambulance-services-commissioning-arrangements

As a hosted organisation under Cwm Taf University Health Board UHB, the work of external audit is monitored by the Cwm Taf University Health Board UHB Audit Committee through regular progress reports. Their work is both timely and professional. The recommendations made are relevant and helpful in our overall assurance and governance arrangements and our work on minimising risk. There are clear and open relationships with officers and the reports produced are comprehensive and well presented.

In addition to EASC matters, the Cwm Taf University Health Board UHB Audit Committee has been kept apprised by its external auditors of developments across NHS Wales and elsewhere in the public service. These discussions have been helpful in extending the Audit Committee's awareness of the wider context of our work.

3.1.2 Internal Audit

The Cwm Taf University Health Board Audit Committee regularly review and consider the work and findings of the internal audit team. The Director of Audit and Assurance and the relevant Heads of Internal Audit have attended each meeting to discuss their work and present their findings. The Audit Committee are satisfied with the liaison and coordination between the external and internal auditors.

During the reporting period 2018-2019 the EASC were audited on:

- Governance and performance - report due Quarter 4
- EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review (not rated)
- Internal Audit report: Follow up of Wales Audit Office EASC Commissioning Arrangements Report (Reasonable Assurance)
- Wales Audit Office Review of Emergency Ambulance Services Commissioning Arrangements Update and Closure Report

No reports received a "limited assurance" assessment rating.

3.4 Counter Fraud

Counter Fraud support is incorporated within the hosting agreement with Cwm Taf University Health Board. Local Counter Fraud Plans relating to the role of the Host body, including matters relating to EASC, are considered via the Cwm Taf University Health Board Audit Committee.

3.5 Integrated Governance

The Cwm Taf University Health Board UHB Audit Committee is responsible for the maintenance and effective system of integrated governance. It has maintained oversight of the whole process by seeking specific reports on assurance, which include:

- Tracking of Audit Recommendations
- EASC Risk Register

During 2018-2019, the Cwm Taf University Health Board UHB Quality, Safety and Risk Committee played a proactive role in communicating suggested amendments to governance procedures and the corporate risk register.

3.6 Quality

3.6.1 Ambulance Quality Indicators and New Clinical Response Model

Following a clinical review of how NHS Wales measures the timeliness and quality of delivery of emergency ambulance services in response to the recommendation from the McClelland review that the Welsh Government should consider moving from a primary focus on the 8-minute response time target to a more intelligent suite of targets and measures, across the whole unscheduled care system and new clinical response model was formally adopted in February 2017. The Cabinet Secretary for Health and Social Services announced the adoption of the model, using evidence provided from the Independent Evaluation Commissioned by EASC on behalf of the Cabinet Secretary.

To support the measurement of the new Clinical Model a comprehensive suite of Ambulance Quality Indicators (AQIs) were developed in collaboration with Welsh Ambulance Services Trust and Welsh Government. The new AQIs were first published as part of a pilot in January 2016, and thereafter quarterly reports were presented to each EASC meeting.

The AQI reports for the 2018-2019 reporting period can be viewed on the links below:

- April-June 2018
- July-September 2018
- October-December 2018

3.6.2 Quality and Patient Experience

During 2018-2019, the Joint Committee has continued its commitment to assuring the quality of services by including a section on "Quality, Safety and Patient Experience" as one of the core considerations on the committee report template which directs the report author to consider the implications when drafting reports for EASC meetings.

4. CAPACITY TO HANDLE RISK

As the Chief Ambulance Services Commissioner for NHS Wales, I have responsibility for maintaining a sound system of internal control that supports the achievement of EASC's policies, aims and objectives and need to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively, through the development implementation and review of Collaborative Commissioning Framework Agreements.

The Joint Committee's Sub Groups have assisted in providing these assurances and I am supported by the Head of Internal Audit's related work, report and opinion on the effectiveness of our system of internal control.

The EASC Risk Register is reviewed by the Joint Committee each of whom ensures that key risks identified are aligned to delivery and are considered and scrutinised by the Cwm Taf University Health Board UHB Quality, Safety & Risk Committee as a whole.

It must be noted that responsibility for the commissioning of Emergency Ambulance Services, Emergency Medical Retrieval & Transfer Services and Non-Emergency Patient Transport Services remains that of individual health boards, discharged collaboratively through the Emergency Ambulance Services Joint Committee (EASC).

The joint Memorandum of Understanding (MoU) between the EASC; Welsh Government and the Chief Ambulance Services Commissioner was endorsed by the Joint Committee in March 2016 and was reviewed at the meeting in November 2018 alongside the Standing Orders and the Hosting Agreement with the host body (Cwm Taf University Health Board University Health Board).

5. THE RISK AND CONTROL FRAMEWORK

Under the hosting agreement with Cwm Taf University Health Board, the EASC complies with their Risk Management Policy and Risk Assessment Procedure.

The aim of the Risk Management Policy is to:

- Ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the 'risk taker is the risk manager' and that risks are owned and managed appropriately;
- Utilise the agreed approach to risk when developing and reviewing the Resource and Operational Plan;
- Embed both the principles and mechanisms of risk management into the organisation;
- Involve staff at all levels in the process; and
- Revitalise its approach to risk management, including health and safety.

Risk management relating to the activities of EASC has matured throughout the year and arrangements for reporting risks agreed and developed.

The Committee Risk Register forms part of the process in terms of the identification and management of strategic risks in relation to the commissioning of Emergency Ambulance Services and during this year has been extended to take into consideration commissioning risks associated with Emergency Medical Retrieval & Transfer Service and Non-Emergency Patient Transport Service.

- The Risk Register continues to evolve and is a 'living' document and should be in a state of constant change to reflect increases, decreases and the elimination of risks;
- The Risk Register will be subject to continuous review by the Chief Ambulance Services Commissioner and the work of the Joint Committee Sub Groups;
- It is for the Joint Committee to determine whether there is sufficient assurance in the rigour of internal systems to be confident that there are adequate controls over the management of principal risks to the strategic objectives.

5.1 Joint Committee Risk Register

As at 31st March 2019, there were 3 risks categorised as Extreme / High these being:

Risk Reference	Description of risk identified	Initial Score	Current Score	Mitigating Actions
EASC 07	Failure to progress WAST staffing roster changes across Wales in alignment with demand patterns identified within the ORH report.	15	15	• Realign rosters (primarily UCS); • Progress implementation and evaluation of Roster Pilots; and • Adopt (if evaluation favourable) successful pilots across Health Board areas, as appropriate.
EASC 08	Failure to provide alternative services	12	15	• Directory of services not complete, now concentrating on 5 key areas • Pilots in place and being evaluated across 2 Health Board areas.
EASC 13 (added July 2018)	Failure to ensure the commissioning of emergency ambulance services is appropriately clinically categorised	15	15	• New Clinical desk • Lessons learned from previous work on red category • Ambulance release protocol • Amber Review

5.2 Policies and Procedures

The EASC follows the policies and procedures of Cwm Taf University Health Board UHB, as the host organisation.

5.3 Information Governance

The EASC has established arrangements for Information Governance to ensure that information is managed in line with the relevant ethical law and legislation, applicable regulations and takes guidance, where required from the Information Commissioner's Office (ICO). This includes legislation such as the Data Protection Act (1998) and the Caldicott Report (1997/2013)

that covers the data that we collect and the processing of this to ensure that we only use it for compatible purposes and it remains secure and confidential whilst in our custody.

The EASC receive information governance support from Cwm Taf University Health Board on areas such as the Freedom of Information Act, Information Asset Ownership, Information Governance Breaches, Records Management, new guidance documentation and training materials, areas of concern and latest new information and law including the implementation of the General Data Protection Regulations (GDPR).

The Board Secretary/Director of Corporate Services & Governance at Cwm Taf University Health Board UHB is the designated Senior Information Risk Owner (SIRO) in relation to Information Governance for the EASC and, due to our hosted status; the Caldicott Guardian for Cwm Taf University Health Board UHB is the Executive Medical Director.

5.3 Information Governance

For the reporting period 2018-2019 no EASC related information governance breaches were reported.

5.4 Integrated Medium Term Plan (IMTP)

The basis for the EASC's planning has been the original national collaborative commissioning quality and delivery framework which all seven Health Boards have signed up to. The framework provides the mechanism to support the recommendations of Professor Siobhan McClelland in the "A Strategic Review of Welsh Ambulance Services" published in 2013[4].

The framework puts in place a structure which is clear and directly aligned to the delivery of better care. The framework introduces clear accountability for the provision of emergency ambulance services and sees the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of health boards and holding WAST to account as the provider of emergency ambulance services. Each Health Board is required to demonstrate their ambition of the framework through making reference to the collaborative work of the EASC within individual Health Board IMTPs.

5.5 Health and Care Standards for NHS Wales

The Welsh Government's "Health and Care Standards for NHS Wales[5]" provide a framework for consistent standards of practice and delivery

[4] Professor Siobhan McClelland in the "A Strategic Review of Welsh Ambulance Services", 2013 http://www.wales.nhs.uk/sitesplus/documents/1134/McClelland%20Review%20Report.pdf
[5]Welsh Government's Health and Care Standards Framework, April 2015

across the NHS in Wales, and for continuous improvement. The work of EASC is included within the annual self-assessment that Cwm Taf University Health Board UHB are required to undertake to assess its compliance against the themes and associated sub-criteria within the guidance framework.

5.6 Governance & Accountability Assessment

The Governance & Accountability Assessment is more relevant to the host body, Cwm Taf University Health Board UHB, which will be undertaken in April 2018.

The Wales Audit Office (WAO) undertook a national review of the Emergency Ambulance Services Commissioning arrangements in 2017, which considered matters relating to governance. The WAO report on the "Review of Emergency Ambulance Services Commissioning Arrangements"[6] was published in July 2017 and outlined a number of recommendations for EASC to implement to strengthen and develop its governance and assurance framework.

5.7 Appointment of Independent Chair

In March 2018 Term of Office of Professor McClelland, Chair had ended and she had not sought an extension of term. The Cabinet Secretary approved the decision to advertise the vacancy and Dr Chris Turner has been successfully appointed in November 2018.

6. MANDATORY DISCLOSURES

The EASC is also required to report that arrangements are in place to manage and respond to the following governance issues:

6.1 Equality, Diversity and Human Rights

Control measures are in place to ensure that the EASC's obligation all obligations under equality, diversity and human rights legislation are complied with. The EASC follows the policies and procedures of the Cwm Taf University Health Board UHB as the host organisation.

As a non-statutory hosted organisation under Cwm Taf University Health Board UHB, EASC is required to adhere to the Cwm Taf University Health

http://www.wales.nhs.uk/governance-emanual/health-and-care-standards

[6] WAO Report "Review of Emergency Ambulance Services Commissioning Arrangements", July 2017
http://www.audit.wales/system/files/publications/review_emergency_ambulance_commissioning_arrangements_english.pdf

Board UHB Equality and Diversity policy which sets out the UHB's commitment to equality and diversity and the legal setting for doing so.

6.2 Welsh Language

The EASC is committed to ensuring that the Welsh and English languages are treated on the basis of equality in the services we provide to the public and other NHS partner organisations in Wales. This is in accordance with the Cwm Taf University Health Board UHB Welsh Language Scheme, Welsh Language Act 1993 the Welsh Language Measure (Wales) 2011 and the Welsh Language Standards (Health Sector) Regulations once approved by the National Assembly for Wales.

The work of the EASC in relation to Welsh language is included within the Cwm Taf University Health Board approved Welsh language scheme and their Annual Welsh Language Monitoring report to the Welsh Language Commissioner.

6.3 Handling Complaints and Concerns

The EASC is committed to ensuring a professional and customer focussed service through the work of the Joint Committee and as a hosted organisation under Cwm Taf University Health Board UHB adheres to its complaint and concerns policy.

During 2018-2019 no formal complaints were received concerning the work of the EASC.

6.4 Freedom of Information Requests

The Freedom of Information Act (FOIA) 2000 give the public right of access to a variety of records and information held by public bodies and provides commitment to greater openness and transparency in the public sector.

During 2018-2019, the EASC received one request for information under the provision of the Freedom of Information Act (FOIA).

6.5 Data Security

The EASC is committed to ensuring that there are effective measures in place to safeguard information and as a hosted organisation under Cwm Taf University Health Board UHB adheres to its Data Security policies.

All Information Governance incidents involving data security are reviewed by the Information Governance team within Cwm Taf University Health Board UHB.

During 2018-2019 no Information Governance breaches were reported for the EASC.

6.6 ISO14001 – Sustainability and Carbon Reduction Delivery Plan

As a hosted organisation under Cwm Taf University Health Board UHB the EASC is committed to managing its environmental impact, the organisation's carbon footprint and increasing its sustainability and falls within the scope of the Cwm Taf University Health Board UHB ISO14001 accreditation.

6.7 Business Continuity Planning/Emergency Preparedness

The EASC is cognisant of the need to review the capability of the different organisations within NHS Wales to continue to deliver products or services at acceptable predefined levels following a disruptive incident. We recognise our contribution in supporting NHS Wales to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care, in accordance with requirement for NHS bodies to be classed as a category 1 responder deemed as being at the core of the response to most emergencies under the Civil Contingencies Act (2004).

The Joint Committee reviews the arrangements in place for cross border and cross boundary resource flows and that there are effective strategies in place for:

- People – the loss of personnel due to sickness or pandemic
- Premises – denial of access to normal places of work
- Information Management and Technology (IM & IT) and communications/ICT equipment issues
- Suppliers internal and external to the organisation.

The EASC is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify assess and implement applicable legislation and regulation requirements related to the continuity of operations, services as well as the interests of interested parties.

6.8 UK Corporate Governance Code

The EASC operates within the scope of the governance arrangements for the Cwm Taf University Health Board UHB. The Cwm Taf University Health Board UHB has undertaken an assessment against the main principles of the UK Corporate Governance Code[7] as they relate to an NHS public sector organisation in Wales. This assessment has been informed by the UHB's assessment against the "Governance, Leadership and Accountability"

[7] Financial Reporting Council, UK Corporate Governance Code https://www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code

theme of the Health and Care Standards framework undertaken by the Board.
Cwm Taf University Health Board UHB is satisfied that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code and not identified any departures from the Code through the year.

6.9 Ministerial Directions 2017-2018

In November 2018, the Minister for Health and Social Services sent a letter to all Health Boards and NHS Trusts advising of a change to the provision for voting for WHSSC, EASC and NWSSP Committee.

There were no specific EASC related directions / Circulars issued during the period.

7. CHIEF AMBULANCE SERVICES COMMISSIONER'S OVERALL REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the Chief Executives represented on the Joint Committee who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit reports.

As Accountable Officer I have overall responsibility for risk management and when required, report to the Cwm Taf University Health Board Audit Committee/Quality Safety and Risk Committee regarding the effectiveness of risk management within the EASC. My advice to the Joint Committee is informed by reports on internal controls received from all of its Committee and sub-group meetings and the Cwm Taf University Health Board UHB Audit Committee.

The Joint Committee has considered a range of reports relating to its areas of business during the last year, which have included internal and external audit reports and opinion. Each sub-group develops an annual report of its business and the areas that it has covered during the last year and these are reported in public to the EASC.

The internal control framework and internal and external related audit support is maturing and will continue to be strengthened going forward.

I wish to highlight the following matters that are considered significant and have presented challenges in 2018-2019:

7.1.1 Amber Review

The Amber review, commissioned in April 2018 by Welsh Government and the NHS Wales Emergency Ambulance Services Committee, was led by clinicians within the National Collaborative Commissioning Unit and completed in October 2018. The review was commissioned to address two concerns: firstly, whether there was a systemic problem with the clinical response model that was leading to poorer service provision, and secondly: were patients categorised as Amber coming to harm whilst waiting for a response in the community.

The main conclusion was that some patients in the Amber category are waiting far too long for a response, but that the cause of this was related to the availability and resourcing of ambulances and not the categorisation of incidents. The implementation programme is currently in place and due to complete by the end of 2019

7.1.2 Non-Emergency Patient Transport

The modernisation of NEPTS business case support the transfer of commissioning arrangements and responsibilities from the nine commissioning organisations to a single body, this being the Emergency Ambulance Service Committee (EASC). EASC, who on behalf of NHS Wales, hold the Welsh Ambulance Services NHS Trust (WAST) accountable to deliver against the standards, requirements, and performance and quality indicators contained within a new commissioning framework.

Responsibility for commissioning NEPTS formally transferred to EASC in April 2016. The first organisation (Cardiff & Vale UHB transferred its commissioning arrangements in July 2018. This was followed by Velindre NHST in September 2018. The most recent timetable will see Hywel Dda transferred 1st April and the remaining organisations by October 2019.

7.1.3 Emergency Medical Retrieval and Response Service

The Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru was established in April 2015. It is operational 12 hours per day 0800-2000, 7 days per week. It has three operational bases at Caernarfon airport, Welshpool airport and Llanelli airbase. It utilises Wales Air Ambulance aircraft and a fleet of Rapid Response Vehicles.

The service is delivered by Consultants (from Emergency Medicine, Anaesthesia and Intensive Care Medicine) and EMRTS Critical Care Practitioners (CCPs).A single Air Support Desk located at Vantage Point House, Cwmbran, tasks all bases. The ASD is a unique selling point for the EMRTS in terms of tasking and acting as the single point of contact

for logistics, communications and coordination. A Service expansion review and expansion business case have been developed as part of the future development of the service.

7.1.4 Internal Audit of EASC

In May 2019 the Internal Audit team published a report on the Review of Emergency Ambulances Commissioning Arrangements"[8].

The main conclusion from the review report was:

"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 review made 3 recommendations and a 'draft' management response will be considered at a future Joint Committee meeting.

7.2 LOOKING AHEAD

As a result of its work during the year the Cwm Taf University Health Board UHB Audit Committee Cwm Taf University Health Board UHB/Quality, Safety and Risk Committee is satisfied that the EASC has appropriate and robust internal controls in place and that the systems of governance incorporated in the EASC Standing Orders are fully embedded within the Organisation.

Looking forward to 2018-2019 the Cwm Taf University Health Board UHB Audit Committee and where appropriate it's Quality, Safety and Risk Committee will continue to consider and review the financial, management, governance and quality and risk issues that are an essential component to the success of the EASC.

Specifically they will:

- Continue to examine the governance and internal controls of the EASC and specifically implement the recommendations of the May Internal Audit report
- Monitor closely risks faced by the EASC
- Develop the follow up action plan in relation to the outputs of the Amber Review

[8]WAO Review of Emergency Ambulances Commissioning Arrangements, August 2017 http://www.audit.wales/system/files/publications/review_emergency_ambulance_commissioning_arrangements_english.pdf

- Continue to refine and review the commissioning intentions for EMS, NEPT's and EMRT's
- Continue to develop links into the Unscheduled Care Programme through the products within the NCCU IMTP I particular:
    - What does good look like for urgent care?
    - Measurement
    - Big 4 Clinical Issues
    - Quality & Delivery Frameworks
    - Policy & Guidance
    - Supporting Welsh Government
- Further development of AQI's into NEPTS and EMRTS
- Provide advice and support to WAST and Health Boards
- Provide advice and support in the delivery of the EMRT's service expansion

8. CONCLUSION

As the Chief Ambulance Services Commissioner, I will ensure that through robust management and accountability frameworks, significant internal control problems do not occur in the future. However, if such situations do arise, swift and robust action will be taken, to manage the event and to ensure that learning is spread throughout the organisation.

Signed: Date:

Mr Stephen Harrhy
Chief Ambulance Services Commissioner, NHS Wales

DRAFT

Accountability Report

2018/19

Signed

Date :

TABLE OF CONTENTS

	ACCOUNTABILITY REPORT 2018-2019	Page number
1	INTRODUCTION	3
2	ACCOUNTABILITY REPORT	4
3	CORPORATE GOVERNANCE REPORT	5
	ANNUAL GOVERNANCE STATEMENT	6
	DIRECTORS REPORT 2018-2019	62
	STATEMENT OF ACCOUNTABILITY 2018-2019	78
4	REMUNERATION AND STAFF REPORT 2018-2019	81
5	NATIONAL ASSEMBLY FOR WALES ACCOUNTABILITY AND AUDIT REPORT 2018 -2019	95

ACCOUNTABILITY REPORT 2018-2019

1 INTRODUCTION

The Government Financial Reporting Manual (FReM) is the technical accounting guide to the preparation of the financial statements. HM Treasury published a revised version of the Government Financial Reporting Manual (FReM) 2018-2019, in December 2018 and states that NHS bodies are required to publish, as a single document, a three-part annual report and accounts document which includes:

1.1 The Performance Report

The purpose of the performance section of the annual report is to provide information on the entity, its main objectives and strategies and the principal risks that it faces. The report must include:

- An overview
- A Performance analysis.

1.2 The Accountability Report

The purpose of the accountability section of the annual report is to meet key accountability requirements to the National Assembly for Wales, which must include the following sections:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A National Assembly for Wales Accountability and Audit Report.

1.3 The Financial Statements

- The Audited Annual Accounts 2018-2019.

2 THE ACCOUNTABILITY REPORT

a. The Corporate Governance Report

This explains the composition and organisational governance structures and how they support the achievement of the entity's objectives. It includes a Director's Report, a Statement of Accounting Officers responsibilities and a Governance statement. The Director of Corporate Services & Governance / Board Secretary and the Corporate Services team has compiled the report, the main document being the Annual Governance Statement (AGS). The compilation of this section of the report has been informed by a review of the business undertaken by the Board and its Committees / Advisory Groups over the last year and has had input from the Chief Executive, as Accountable Officer, the Executive Team and Members of the Audit Committee.

b. Remuneration and Staff Report

This sets out the Health Board's remuneration policy for directors, reports on how that policy has been implemented and sets out the amounts awarded to directors and where relevant the link between performance and remuneration. This section contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc. and has been compiled by the Finance department and the Workforce & Organisational Development directorate.

c. National Assembly for Wales Accountability and Audit Report

This contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in Her Majesty's Treasury Guidance, material remote contingent liabilities, long-term expenditure trends, and the audit certificate and report.

The timescale for publication of the Annual Report 2018-2019 varies from that of the Accountability Report which was considered and approval by the Audit Committee and Board in May 2019. The Annual Report must be finalised for presentation at the Annual General Meeting (AGM) on 31 July 2019, having first been reviewed by the Wales Audit Office (WAO).

Corporate Governance Report

2018-2019

'DRAFT' ANNUAL GOVERNANCE STATEMENT (AGS)
2018-2019

1. 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 this 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.

Cwm Taf University Health Board (UHB), was established on the 1 October 2009 with responsibility for the provision of services to more than 301,846[1] residents within the local authority boundary areas of Merthyr Tydfil and Rhondda Cynon Taf. Almost 79% of the population live in Rhondda Cynon Taff local authority and the remaining 21% in Merthyr Tydfil. Cwm Taf UHB's catchment population increases when patient flow from the Upper Rhymney Valley, South Powys, North Cardiff and the Western Vale area are included. Cwm Taf has 8,138 members of staff working at two district general hospitals and five community hospitals with 27 health centres/clinics/support facilities. It has 77 community pharmacies, 35 dental surgeries, 41 GP surgeries and 29 optometry practices.

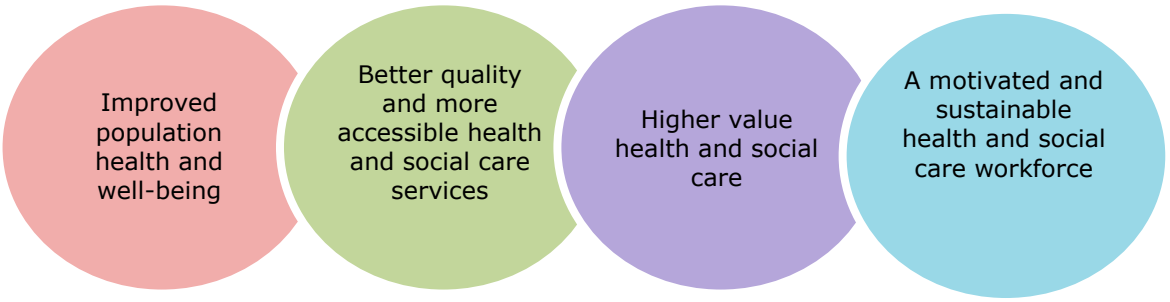
As of 1 April 2019 as a result of changes to the Bridgend County Borough Council boundary, the Health Board's name changed from Cwm Taf to Cwm Taf Morgannwg UHB as responsibility for the provision of services for the Bridgend population were transferred from Abertawe Bro Morgannwg (ABM) UHB. More information regarding the impact of the boundary change can be found on page 45 or via our website.

The Board's overarching role, is to ensure delivery of its three-year Integrated Medium Term Plan (IMTP) 2018 - 2021 in accordance with the relevant Welsh Government NHS Planning Framework, and the related organisational objectives aligned with the Institute of Healthcare Improvement's 'Triple Aim' are being progressed.

Organisational objectives:

- To **improve** quality, safety and patient experience
- To **protect** and **improve** population health
- To **ensure** that the services provided are accessible and sustainable into the future
- To **provide** strong governance and assurance
- To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.

The Quadruple Aim



The Health Board has integrated its well-being statement and delivery of its well-being objectives into its IMTP to ensure that the Wellbeing & Future Generations Act is at the core of decisions the Board makes about the delivery of its services. Most importantly, the main focus is to effect long-term change which improves the health, well-being and resilience of the communities we serve. This is the connecting link between all our well-being objectives which also encapsulates the five ways of working.

During 2018-19 the UHB provided a full range of hospital and community based services to the residents of Rhondda Cynon Taf and Merthyr Tydfil. These include the provision of local primary care services; GP Practices, Dental Practices, Optometry Practices and Community Pharmacy and the running of hospitals, health centres and community health teams. The UHB was also responsible for making arrangements for the residents of Rhondda Cynon Taf and Merthyr Tydfil to access health services where these are not provided within the Cwm Taf area. Detailed information about the services provided and the respective facilities can be found on our website in the section 'Local Services'. This can be accessed from the home page, or via the following link Our Services.

The Health Board is led by its Chair, Chief Executive and a Board of Executive Directors, Independent Members and Associate Members. The Chair, Vice-Chair, Independent Members and Associate Members are appointed for fixed-term periods by the Welsh Government. Each Independent Member has a specific area of responsibility and this, along with their level of Board and Committee meeting attendance is set out in the Director's report) at page 65.

Associate Members attend Board meetings on an ex-officio basis, but have no voting rights. Associate Members are outlined as follows:

Associate Member Role	Name	Attendance
Social Services A Director of Social Services, nominated by local authorities in the Cwm Taf UHB area.	Gio Isingrini, Group Director of Community & Children Services, Rhondda Cynon Taf County Borough Council	3/8 Public Board meetings

Associate Member Role	Name	Attendance
Stakeholder Reference	Claire Llewellyn Chair of the Stakeholder Reference Group	4/7 Public Board Meetings (stepped down in February 2019 prior to final Public Board meeting of the year)
Healthcare Professionals	Vacant Chair of the Healthcare Professionals Forum	Nil

The Executive Directors as set out below and are full-time NHS professionals appointed by the Board and they hold full permanent contracts of employment:

- Allison Williams, Chief Executive
- Ruth Treharne, Director of Planning & Performance / Deputy Chief Executive
- Kamal Asaad, Medical Director
- Joanne Davies, Director of Workforce & Organisational Development
- Kelechi Nnoaham, Public Health Director
- Alan Lawrie, Director of Primary, Community & Mental Health *(interim from April until December 2018 when substantively appointed)*
- Steve Webster, Director of Finance & Procurement
- John Palmer, Chief Operating Officer *(interim from April until December 2018 when substantively appointed)*
- Lynda Williams, Director of Nursing, Midwifery and Patient Services (until August 2018 / Angela Hopkins, Interim Director of Nursing, Midwifery & Patient Services (From September 2018 until 31 March 2019)

Greg Dix was appointed to the post of Director of Nursing, Midwifery & Patient Care from April 2019. Two additional Directors (Robert Williams and Stephen Harrhy[2]*) have been appointed but they have no voting rights at the Board.

The Board has overall responsibility for the strategic direction of the Health Board and provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. It also ensures that we have an open culture and high standards in the way in which its work is conducted. Board members share corporate responsibility for all decisions and play a key role in monitoring the performance of the organisation and for making sure that the Health Board is responsive to the needs of the communities it serves.

[2] ***Note -** From the 2 February 2015, Stephen M Harrhy, was appointed as the Chief Ambulance Services Commissioner (CASC) for Wales and Board Director Cwm Taf UHB and subsequently took on the additional role of Director of Unscheduled Care for NHS Wales in 2015/16.

The Chief Executive is accountable to the Health Board for ensuring that its health care services are effective and that the Health Board activities are managed in an efficient manner. The UHB has continued to strengthen its working arrangements with its local authority Partners, the third sector and local universities. During the year, this has included forging closer and stronger links with Bridgend Local Authority as a consequence of the agreed boundary change.

The Health Board was awarded University Health Board 'UHB' status by the Minister for Health and Social Services in November 2013. This was an important achievement in the organisation's development journey and a source of great pride. University status was re-accredited in 2017 and continues to help us in our ongoing drive to provide high quality, responsive care and services for the communities in strengthened collaboration with our academic partners.

The Board usually meets around seven times a year in public with additional (Special) meetings as necessary. The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair, nine other Independent Members, Associate Board Members, the Chief Executive, eight Executive Directors and two other Directors. The full membership of the Board is outlined on page 65.

All the meetings of the Board in 2018/19 were appropriately constituted and quorate.

Key business and risk matters considered by the Board during 2018/19 are outlined below:

- Considered updates regarding the significant concerns raised relating to Maternity Services and cooperated with the Royal College of Obstetricians & Gynaecologist & Royal College of Midwives Joint Review commissioned by the Minister for Health and Social Services, which reported in April 2019
- Overseen the ongoing development of arrangements to deliver the outcomes of the South Wales Programme and the delivery of a capital business case to expand neonatal and obstetric services at Prince Charles Hospital, which led to the commissioning of the new Maternity and Neonatal Units in Merthyr Tydfil and the successful establishment of a Free Standing Midwifery Led Unit at the Royal Glamorgan Hospital
- Overseen the implementation of the approved 2018-21 three-year IMTP and actively involved in the development and approval of the 2019-2022 plan and approved quarterly updates regarding progress on the 2018-21 IMTP
- Considered and discussed the organisational risk register and the monitoring and management of the assigned risks to key committees of the Board
- In alignment with the Board's maturing Board Assurance Framework (BAF), routinely received assurance reports from the Committees and Advisory Groups of the Board
- Considered and discussed financial performance and the related risks being managed by the Health Board
- Routinely received updates on matters relating to workforce, including performance metrics, recruitment, and legislative changes e.g. the Nurse Staffing Levels (Wales) Act 2016

- Received an update on the specific public health provisions covered by the Public Health (Wales) Act identifying potential implications for the UHB and received the Director of Public Health's Annual Report for 2017/18
- Received and approved the terms of reference for the Bridgend Joint Transition Board and considered updates regarding plans to deliver the changes relating to Bridgend Boundary Change in terms of services and facilities transferring from ABM UHB to Cwm Taf Morgannwg UHB
- Considered the 2018 Structured Assessment and the Auditor General for Wales' Annual Audit Report for 2018, and approved the Board's response
- Received regular reports on patient experience and discussed the Public Service Ombudsman Annual Letter for 2017/18
- Discussed and approved the Annual Carers Report for 2017/18
- Routinely considered the Board's performance in relation to key national and local targets and agreed mitigating actions in response to improved performance where appropriate, this included actions to address and improve cancer target performance; stroke services; referral to treatment (RTT) waiting times, mental health measure compliance and workforce indicators
- Discussed an evaluation of the robustness of the plans put into place for the winter of 2017/18 and approval of a Winter Planning & Preparedness plan for 2018/19
- Received an update on the uptake of screening and arrangements in place with Public Health Wales Screening Division to continue investigations for the early detection of disease
- Received capital and discretionary programme updates
- Received updates on a range of partnerships initiatives and updates on the work of the South Central and East Regional Planning and Delivery Forum and NHS Wales Collaborative
- Received a position statement regarding the findings of the Gosport War Memorial Hospital inquiry into deaths from inappropriate prescribing of opiates and received an update on the Infected Blood Inquiry and approved a Charter for bereaved families
- Received an overview of the work being undertaken in relation to Arts, Health & Wellbeing
- Discussed the outcome of the consultation into the review of Adult Thoracic Surgery services and approved the recommended way forward
- Discussed a report regarding the change to the UHB's escalation status to 'enhanced monitoring and the plans in place to address the issues raised in order to return to 'routine' monitoring status (further information regarding this is on page 22-24
- Received and approved the closure of Pantglas branch surgery in Aberfan
- Received a Performance Framework update regarding systems and processes in place to deliver Welsh Government requirements in respect of Continuing Heath Care during 2018/19
- Received a report and approved a Funded Nursing Care rate uplift in line with the previously approved Inflationary Uplift Mechanism
- Progress against the Social Services & Well-Being (Wales) Act 2014 (the SSWB Act) and the Well-Being of Future Generations (Wales) Act (2015)
- Routinely received updates from Board Champions, including those relating to Welsh Language, Equality, Patient & Public Engagement, Vulnerable Adults and Older People; and Staff.

The UHB hosts two all-Wales Joint Statutory Committees:

- **The Welsh Health Specialised Services Committee (WHSSC),** is a statutory joint committee of the seven Local Health Boards which was established in April 2010. WHSSC is responsible for the joint planning and commissioning of over £500m of specialised and tertiary health care services on an all Wales basis.

- **The Emergency Ambulance Services Committee (EASC),** is a statutory joint committee of the seven Local Health Boards, with three Welsh NHS Trusts as Associate Members, which was established in April 2014. The EASC is responsible for the joint planning and commissioning of circa £155m of Emergency Ambulance Services, including Emergency Medical Retrieval & Transfer Service (EMRTS) on an all-Wales basis and commissioning Non-Emergency Patient Transport Services.

In 2017, the Welsh Government approved the business case for the development of an NHS Wales National Imaging Academy. The £4.3m Academy hosted by the UHB was officially opened by the Minister for Health and Social Services, Vaughan Gething, in February 2019. It is training the next generation of radiologists, radiographers, sonographers and imaging professionals within a modern, innovative, specialist training environment.

1.1 Committees of the Board and Advisory Groups

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in the terms and conditions of appointment, Board members also fulfil a number of Champion roles where they act as ambassadors for these matters.

The Health Board has a range of committees which are chaired by Independent Members of the Board and have key roles in relation to the system of governance and assurance, decision making, scrutiny, development discussions, assessment of current risks and performance monitoring. The Committees provide regular assurance reports to the Board to contribute to its assessment of assurance and to provide scrutiny on the delivery of key objectives. There is also cross representation between Committees to support the connection of the business of committees and also to seek to integrate assurance reporting.

At a local level, NHS organisations in Wales must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegation to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the UHB.

These documents, together with the range of corporate policies set by the Board make up the Governance Framework and define - its 'ways of working'.

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

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

The Committees have met regularly during the year, with update reports outlining key risks and highlighting areas which need to be brought to the Board's attention to contribute to its assessment of assurance and provide scrutiny against the delivery of objectives. The Committees, as well as reporting to the Board, also work together on behalf of the Board to ensure, where required, that cross reporting and consideration takes place and assurance and advice is provided to the Board and the wider organisation.

The Wales Audit Office (WAO) Structured Assessment 2018 acknowledged that the Board continues to be generally well-run, providing a good level of scrutiny and challenge. The Board recognises, however, that further work is required to improve its quality and safety governance arrangements and is committed to addressing these issues in the forthcoming financial year. Our system of Governance and Accountability during the year is therefore demonstrated in the following diagram:

Cwm Taf University Health Board – Governance and Assurance Structure

Board Assurance Framework

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Welsh Government

Emergency Ambulance Services Committee (EASC)

Welsh Health Specialised Services Committee (WHSSC)

Advisory Groups

Stakeholder Reference Group

Working in Partnership Group

Health Professionals Forum

The Board

Joint Committees

Welsh Health Specialised Services Committee (WHSSC)

NHS Wales Shared Services Partnership (NHSWSSPC)

Emergency Ambulance Services Committee (EASC)

Audit Committee

Charitable Funds Committee

Quality, Standards and Patient and Staff Safety

Corporate and Clinical Risk Management

Academic Partnership Board

Finance Performance & Workforce Committee

Quality Safety & Risk Committee

Mental Health Act Monitoring Committee

Executive Board

Remuneration & Terms of Service Committee

Primary and Community Care Committee

Integrated Governance Committee

Executive Programme Board / Strategic Planning Group / Strategic Partnerships Group
Capital Programme Board / Executive Capital Management Group
Corporate and Clinical Directorate Clinical Business Meetings (Ward to Board)

Types of Internal and External Assurance

Community Health Councils, Older Persons Commissioner, Patient Groups

Statutory Inspections (Health and Safety Executive), Information Commissioner, Welsh Language Commissioner

Regulatory Bodies (Healthcare Inspectorate Wales, Care Quality Commission)

Clinical Audit & Effectiveness 1,000 Lives+

Internal and External Audit

The purpose of the **Integrated Governance Committee** is to provide assurance to the Board around the UHB's healthcare assurance and risk management frameworks, ensuring that there is an accurate reflection of existing risks, key controls, assurances, and action plans to deliver against gaps in assurance. In 2018/19 the Committee considered:

- Progress with implementation of its Integrated Governance & Accountability Action Plan
- WAO and Internal Audit progress updates
- Oversight and coordination of the Board's Governance & Accountability Module Annual Self-Assessment for 2018-2019
- Consideration of the schedule of referral of matters to committees of the Board
- Board Committee Chair reports.

The Board's Standing Orders require Committees to undertake an annual assessment of their own effectiveness and report the outcome of these to the Health Board. Over the last year the following improvement actions (agreed through self-assessment) were progressed:

- To be added from the pending 2018/19 self-assessment (May 2019)

Feedback from Board Committee self-assessments is used to inform positive changes. Last year's assessments identified a number of key actions, which were generic themes identified from the feedback, a summary of which is outlined in the following table:

Feedback	Suggested Action	Progress with action
Ensure the Terms of Reference are reviewed annually	The terms of reference are reviewed annually in tandem with the review of standing orders.	Completed
Committee Member training	Develop bespoke local induction training sessions for new Independent Members (IM's) and consider training requirements for long-serving IM's.	New IMs attended the national induction training organised by Academi Wales / NHS Confederation Wales and Cwm Taf UHB held its own local induction training and site visits for new IM's.
More timely circulation of Committee Minutes / Action Notes	Minutes should be circulated to members in 'draft' format once approved by the Committee Chair.	The team endeavour to issue the minutes as swiftly as possible once approved by the Chair. Further progress is needed in this area.

DRAFT

The **Charitable Funds Committee** oversees the Health Board's charitable funds, as the Board is the corporate trustee for the Charitable Funds held by the organisation. This is reflected in the overall governance structure of the organisation to provide assurance that Charitable Funds are being appropriately considered and overseen.

An important Committee of the Board in relation to the overall Board Assurance arrangements including development of the Annual Governance Statement is the **Audit Committee**, which on behalf of the Board keeps under review the design and adequacy of the Health Board's governance and assurance arrangements.

During 2018-2019, key issues considered by the Audit Committee relating to the overall governance of the organisation have been:

- Overseeing the UHB's system of internal control
- Reviewing reliable sources of assurance and being satisfied with the associated course of action
- A continued focus on improvements in the financial systems, controls procedures and the monitoring of payments and trending processes, including improved compliance this year, with the Public Sector Prompt Payment duty and related target
- Sponsored an increasing programme of compliance, including internal audit activity across corporate and clinical Directorates
- Overseen the local arrangements for counter fraud and received regular update reports on related activity, including investigations
- Keeping under review the Health Board's risk management strategy, risk appetite and related processes
- Provided oversight and scrutiny to hosted bodies, namely Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC)
- Overseen and recommended approval of the revised Standing Orders of the Board
- Internal and external audit reports, and tracking progress against internal and external audit recommendations, developing and strengthening related internal processes. Calling and holding Executive Directors to account, where appropriate, in relation to internal and external audit activity.

The Committee is therefore a key source of assurance to the Board that the Organisation has effective controls in place to manage the significant risks to achieving its Strategic Objectives.

The **Remuneration and Terms of Services Committee** of the Board, is chaired by the Chair of the UHB and includes all Independent Board Members and meets periodically throughout the year to consider matters relating to Director and Very Senior Managers (VSMs) Remuneration and Terms of Service and other related matters, which includes applications for Voluntary Early Release from employment and annual performance appraisals for the Chief Executive and Directors of the Board.

DRAFT

The **Quality, Safety & Risk Committee** is a key Committee of the Board, primarily aligned with assessment of the Health Board's overall quality, clinical governance and assurance and related risk management arrangements. During 2018/19, key issues considered by the Quality, Safety & Risk Committee were:

- The UHB's Quality Strategy (aligned with the Board's *'Cwm Taf Cares'* philosophy) developed for one year only to ensure the quality agenda focuses on the key priorities of the Board and developed a quality dashboard to consider progress with key quality and safety related targets during the work to transition in relation to the Bridgend Boundary Change
- The development of the Quality and Safety Framework and set up sub groups to underpin and support the work of the Committee
- Received and considered reports on Bridgend Boundary Change
- Considered planned and unannounced review and inspection activity by Healthcare Inspectorate Wales (HIW) and the Community Health Council (CHC), along with the UHB's internal inspection processes and updates on key quality issues such as maternity services
- Overseen the development of the Annual Quality Statement 2018/19
- Development and review of the UHB's Corporate Risk Register
- Monitoring the quality implications in relation to the Board's work on follow up appointments not booked
- Monitoring and scrutiny of the UHB's arrangements with regards to compliance with legislative and regulatory requirements for workplace Health & Safety, including Moving & Handling, Violence & Aggression, Staff Surveillance including skin action plan and Fire Safety
- Monitored and scrutinised delivery of the Action Plan in response to the findings of the Human Tissue Authority (HTA) Inspection
- In addition to overseeing the risk registers of the Health Board and hosted bodies, also reviewed the Committee's assigned risks and provided risk management oversight and scrutiny to hosted bodies, namely the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC)
- Approved various annual reports and organisational policies
- Received updates on progress relating to compliance in relation to quality, safety & risk, including patient experience, concerns, safeguarding, infection prevention & control, information governance, equality & diversity and Welsh language;
- Received the annual review of mortality report and other important audit work including National Emergency Laparotomy Audit (NELA)
- Considered relevant reports referred by Audit Committee;
- Routinely considered and discussed Directorate Exception Reports, and
- Held Quality Summits in March 2018 and April 2019, with engagement with Clinical Directorates to inform the UHB's priorities for the year and to review progress against them.

As highlighted by WAO in the 2018 Structured Assessment, there are weaknesses in the UHB's quality and safety governance arrangements, this factor being recognised by the Board, with action already being taken to address the situation.

DRAFT

Work has already taken place to revisit and refine the Quality, Safety & Risk supporting groups and progress has been made in developing a Clinical Governance Framework and a Delivery Framework. However, in response to the issues identified that have led to recent escalation of the Board's monitoring status strengthening the overall organisational quality governance arrangements is the key priority for the Board going forward.

Additional detail on performance in relation to quality, safety and risk can be viewed in CTUHB's Annual Quality Statement which will be published in July 2019 and can be accessed via this link.

The **Primary & Community Care Committee** was constituted by the UHB in 2014, initially to support the development of a Strategy for Primary Care, which informed the UHB's IMTP submitted in 2015 and subsequent refreshed versions of the plan. The Committee's focus is on scrutinising the delivery of key elements of the IMTP that relate to Primary Care. The Committee is chaired by the Vice Chair of the UHB.

Over the past year, the Committee considered the following key areas of activity:

- The delivery and implementation of the primary care delivery plan (informed by the Primary Care Strategy) as it relates to the Board's IMTP
- Reviewed and monitored delivery of the oral and eye health delivery plans
- Reviewed and monitored delivery of agreed primary care investments
- Monitored progress on the delivery of the Oral Health and Eye Care Plans
- Overseen arrangements for Primary Care Contractor service developments and related cluster hub work particularly in relation to GP Sustainability and the GP Out of Hours service e(including Patient Experience)
- Reviewed and monitored actions being taken to sustain Primary Care Services across Cwm Taf UHB
- Reviewed matters referred by Audit Committee e.g. Post Payment Verification; Discharge Planning (WAO)
- Considered and discussed assigned risks from the Organisational Risk Register
- Considered the primary & community care Transformation Plan, and district nursing and medicines management issues
- Considered and discussed the Pacesetter Initiative – Advanced Training Practice
- Routinely reviewed Integrated Performance Dashboard as it related to Primary Care
- Reviewed, considered and discussed the Board's Inverse Care Law programme of work and related progress
- Reviewed, considered and discussed the Board's Population Segmentation programme of work and related progress.

The **Finance, Performance & Workforce Committee** scrutinises the Health Board's performance, aligned to its IMTP commitments. The Committee's key areas of activity during the year were:

- Active involvement in the development and scrutiny of the refreshed 2019-2022 IMTP

DRAFT

- Routinely reviewed and scrutinised the UHB's integrated performance dashboard, cancer service performance and primary care child & adolescent mental health service performance
- Routinely, reviewed and scrutinised the UHB's financial performance, such as the development of savings plans and directorate budget setting and delivery of agreed savings plans including medical agency expenditure
- Reviewed and scrutinised key areas of workforce activity, including the increasing impact of workforce shortages, particularly within medical and registered nursing & midwifery staff groups, staff sickness and the mitigating actions being taken both locally and nationally
- Received annual updates regarding facilities, estates & energy performance
- Received various deep-dives analysis reports across various clinical services
- Reviewed and scrutinised the development of the Board's commissioning & contracting plan
- Reviewed and scrutinised ambulance performance and considered an update regarding winter pressures in terms of future plans and how the UHB worked with the Welsh Ambulance Services NHS Trust to improve systems
- Reviewed and scrutinised the demand and capacity plans for Ophthalmology and received an analysis on Follow-Up Not Booked outpatients
- Reviewed WAO and Internal Audit reports
- Received clinical efficiency reports in agreed key service areas
- Received deep-dive financial reports for agreed directorates, and
- Reviewed assigned organisational risks.

The **Mental Health Act Monitoring Committee** is chaired by the Vice Chair of the Health Board and monitors the Health Board's compliance with the requirements of the Mental Health Act and met three times during 2018/19.

The work of the Committee, including its terms of reference were reviewed and refreshed during the year and related processes and focus areas have been strengthened. The Committee's key areas of activity during the year included:

- Quarterly review of statistical performance in relation to compliance with the Mental Health Act
- Review and scrutiny of reported breaches as they relate to the Mental Health Act
- A business case between health boards and South Wales Police around use of Section 136 of the Mental Health Act
- Working with key partners such as South Wales Police, the Local Authorities and the Welsh Ambulance Services NHS Trust
- Oversee the work of the mental health act operational group, and
- Bridgend Boundary Change.

DRAFT

In addition to the Committees of the Board, the Board has three advisory groups.

Stakeholder Reference Group (SRG)
The Group is formed from a range of partner organisations from across the Health Board's area and engages with and has involvement in the Health Board's strategic direction, advises on service improvement proposals and provides feedback to the Board on the impact of its operations on the communities it serves. The SRG met on six occasions during 2018/19 and has been actively engaged in the development of the Board's Integrated Medium Term Plan (IMTP) 2019-2022, including supporting the development of a public facing easy-read summary of the plan.

Working in Partnership Forum (WIPF) The UHB and staff-side representatives have a strong working relationship and the Board recognises the importance of engaging with staff organisations on key issues facing the Health Board. The WIPF met regularly during the year, providing the formal mechanism through which the UHB works together with trade unions and professional bodies to improve health services for the population it serves.

In addition, the Health Board engages with its Medical Workforce through its Hospital Medical Staff Committees (HMSCs). WIPF is the forum where key stakeholders engage with each other to inform debate and seek to agree local priorities on workforce and health service issues. During 2018/19, the Forum has worked closely with senior management in progressing the service redesign and change agenda, ensuring appropriate arrangements are in place to support staff.

During the year, significant strategic issues were discussed which include:

- progress on implementation of the 2018-2020 IMTP and the development of the 2019-2022 IMTP
- the outcome and actions arising from the NHS Staff Survey
- progress with Bridgend boundary change
- updates regarding quality governance issues in relation to maternity services
- A range of policies which impact on staff
- proposals around the NHS Transformation Fund, and
- progress regarding new organisational structures.

Healthcare Professionals' Forum (HPF) The Forum comprises representatives from a range of clinical and healthcare professions within the Health Board and across primary care practitioners and provides advice to the Board on all professional and clinical issues it considers appropriate.

The HPF met once during 2018/19, and considered a variety of issues including the initiative 'Stay well at Home', the consultation proposals on Thoracic Surgery, Bridgend Boundary Change and the General Data Protection Regulations. The HPF, under the guidance of a new Chair is currently reviewing and developing its work programme to inform its work over the coming year.

DRAFT

The Health Board also operates an **Academic Partnership Board (APB)** chaired by the Director of Public Health which includes representation from Cardiff University, Cardiff Metropolitan University and the University of South Wales. The APB oversees the work of the Health Board and partners in relation to the Health Board's University status and ensures that the related strategy of the Board in this area of its work is taken forward in partnership with academic providers. The Board is supported by the Academic Partnership Steering Group. The APB held a workshop in July 2018 looking at issues such as patient focussed research and innovation, the importance of clinical engagement and considered the joint work programme for the next three to five years. A further workshop was also held in November 2018 and plans are in place to clarify the direction for the next year.

2. GOVERNING THE HEALTH BOARD

The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound clinical and corporate governance arrangements in place. The Board promotes a culture of openness, honesty and transparency in decision making and has high standards in the quality of clinical care, financial stewardship, as well as responding to the health needs of the population it serves.

The Board takes its accountability for clinical governance, corporate governance, clinical risk management, risk management, serious incident reporting and matters of internal control seriously. It regularly reviews its structures and clinical and corporate procedures to support the achievement of the organisation's policies, aims and objectives, whilst safeguarding its patients, staff and the public, as well as the organisation's assets.

The Board:

- Determines its strategic direction and related objectives
- Identifies the principal clinical and corporate risks that threaten the achievement of its objectives
- Agrees its "risk appetite" recognising the interdependencies of objectives and the impact of mitigating clinical and corporate risks
- Agrees the key strategic and operational plans that will deliver those objectives and which encompass the controls and actions in place to manage the identified risks
- Monitors delivery through robust performance, scrutiny and assurance arrangements
- Ensures that plans are in place to take corrective action where there is minimal assurance that agreed objectives will be fully delivered, and
- Sustains and upholds dynamic clinical and corporate risk management arrangements across the Health Board.

Together, Board Members share corporate responsibility for all decisions and play a key role in monitoring the performance of the Health Board.

DRAFT

The Health Board's performance across a range of associated areas including the management of risk, governance, financial and non-financial control is monitored by the Welsh Government.

The delivery of governance and assurance arrangements is built on an organisational culture that is based on listening and learning. Recent events identified particularly within maternity services will result in the Board re-evaluating its approach and vision. This will direct the Board's role in determining policy and setting strategic direction and also ensure that there are more effective systems of internal control mechanisms for the UHB to support the delivery of high standards of clinical and corporate governance. This is set against a backdrop of the UHB ensuring that it remains responsive to the needs of communities, which will also be reviewed in light of the failings identified within our maternity services.

The review of the effectiveness of the system of internal control is informed by the work of Executive Directors within the organisation. These Directors have responsibility for the development and maintenance of the Risk Assurance and Internal Control Framework, supported by the Internal Auditors and comments made by the External Auditors in the Annual Audit Report and other reports received throughout the year. In addition, the work of Health Inspectorate Wales, both investigations and reviews, informs my opinion.

The various Committees have overseen the delivery of key areas of the Board's strategic intent and statutory responsibilities, whilst the Audit Committee has overseen the related controls assurance arrangements. A plan will be developed to address weaknesses and ensure continuous improvement of the system in place and this will be built upon as part of the UHB's board assurance framework (BAF), which now requires updating and refreshing.

The scrutiny of these arrangements is in part informed through the internal mechanisms but also through the independent and impartial views expressed by a range of bodies external to the Health Board.

These include:

- Welsh Government
- Wales Audit Office (WAO)
- Internal Audit & Assurance (NHS Wales Shared Services Partnership – NWSSP)
- Healthcare Inspectorate Wales (HIW)
- Welsh Risk Pool (WRP)
- Community Health Council (CHC)
- Health & Safety Executive (HSE)
- Human Tissue Authority (HTA)
- South Wales Fire & Rescue Service (SWF&RS)
- Postgraduate Medical & Training Board, Postgraduate & Undergraduate Deanery's, Royal Colleges and other academic bodies
- Other accredited bodies.

DRAFT

Welsh Government operates Joint Escalation and Intervention Arrangements, which are informed by twice yearly meetings with WAO and HIW to discuss the overall position of each Welsh health board and trust and a wide range of information and intelligence is considered to help identify any issues of particular concern in relation to quality or performance. As a result one of the following levels of escalation is allocated to each organisation:

- Routine monitoring
- Enhanced monitoring
- Targeted intervention
- Special measures.

Since March 2014, CTUHB has maintained a status of "routine arrangements" - the lowest level reflecting "normal" business. However, this changed in January 2019 to "enhanced monitoring" status as a result of a number of concerns relating to quality governance arrangements which are summarised as follows:

- Concerns regarding maternity services resulting in a joint Royal College of Obstetricians and Gynaecologists and Royal College of Midwives review;
- IR(ME)R (Ionising Radiation (Medical Exposure) Regulations) compliance issues following a HIW inspection;
- Pathology services following a Human Tissue Authority inspection;
- Quality governance arrangements as set out in the WAO 2018 Structured Assessment work;
- The quality of serious incident reporting, highlighted through meetings and other incidents, needing an external review of process to be commissioned;
- The health board's response to actions contained within HIW inspection reports;
- Compliance with the Nurse Staffing Levels (Wales) Act.

The change in escalation status is to enable focused attention on actions to remedy specific concerns and to improve assurance processes to enable a return to "routine monitoring" status as soon as is possible and appropriate. The Board fully accepted the need for strengthened assurance in a number of important areas and has reaffirmed its top priority continues to be high quality patient care & safe services.

Immediate action was taken to address the issues raised and a de-escalation plan agreed by the Board which describes the necessary key actions. Progress against this plan is being monitored on a weekly basis and via the Board, its Committees and the Executive Board.

Amongst the key actions already complete are:

- The development, approval and implementation of the Quality and Safety Framework – this was approved in February 2019, a related delivery framework is under development
- Approved a resource uplift to ensure compliance with the requirements of the Nurse Staffing (Wales) Act - additional resources necessary for implementation have been agreed

DRAFT

- The development and implementation of an action plan in response to issues with Ionising Radiation regulations compliance
- Regular updates on progress with actions necessary to meet Human Tissue Authority requirements have been provided with the majority of these actions scheduled for completion during the spring of April 2019.

On 30 April 2019, aligned with the publication of a report on Maternity Services, commissioned by the Minister for Health & Social Services by the Royal College of Obstetricians & Gynaecologists and the Royal College of Midwives, the Minister increased the level of the organisation's status to 'Targeted Intervention' and put Maternity Services (of the former Cwm Taf UHB) into 'Special Measures', although any learning from the improvement actions should apply to the Bridgend locality maternity services, which from 1 April 2019, form part of the Cwm Taf Morgannwg UHB.

A summary of the concerns raised within the report and also considered by the Tripartite Group comprising of Welsh Government officials, Wales Audit Office and Healthcare Inspectorate Wales, included:

- Quality governance
- Data accuracy
- Serious incident reporting and
- Critically leadership and organisational governance, with the group raising a high level of concern in relation to the Board's governance arrangements for quality. This includes matters highlighted through serious incident reporting and regulatory visits.

The Health Board, with external support aligned with its enhanced escalation status, will need to secure immediate and sustained improvement in the quality and safety of maternity services, as well as in the overall effectiveness of Board leadership and governance – particularly in respect of quality.

The Minister has also announced in relation to Maternity, the establishment of an independent maternity oversight panel to:

- Seek robust assurance from the Health Board that the report recommendations are being implemented against agreed milestones
- Agree a process and establish an independent multidisciplinary clinical review of the identified 43 cases and a look back exercise to 2010, as recommended by the review
- Advise the Health Board on actions needed for effective public and user engagement in improving maternity services and rebuilding trust and confidence, and
- Advise the Minister on progress, including the need for and timing of any follow up review.

DRAFT

As the Board works to strengthen quality governance within the organisation, alignment with the activities of the oversight panel and the application of learning across the whole organisation will be critical to success and sustainable improvement.

2.1 The Purpose of the System of Internal Control

The Board is accountable for governance and the system of internal control. As Accountable Officer the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding public funds and organisation's assets for which they are personally responsible in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales. The Chief Executive's performance in the discharge of these personal responsibilities is assessed by the Director General Health & Social Services/Chief Executive NHS Wales, Welsh Government.

The UHB's systems of internal control is informed by the work of internal auditors, clinical audit and directors within the organisation, who have responsibility for the development and maintenance of risk assurance and internal control frameworks. As external auditors, Wales Audit Office (WAO) provide comments on the UHB's systems in their Annual Audit Report and other reports, including the Structured Assessment. The work of HIW also has an important and significant impact in the UHB, from both their announced and unannounced inspections and reports making a significant contribution to improving service quality. The Community Health Council (CHC) also undertakes a comprehensive visiting programme and such feedback and engagement is a key assurance tool used by the UHB.

As well as responding to the actions arising from such reports, the UHB strives to ensure that general lessons are learned. For example, the issues identified within maternity services has resulted in a change to the Board's approach with more consideration and discussion regarding how scrutiny and assurance is best achieved. Discussions at the December 2018 meeting of the Integrated Governance Committee centred on how the Board could more proactively assess itself and use the evidence provided from external reports and reviews to assure itself in relation to the quality and safety of services, as well as ensuring the best governance route for assurance. This will now be helped by the external support offered as a consequence of our increased escalation status

The aim of the UHB's BAF is to map the business of the Board and its Committees against its five key organisational objectives. It is aligned to its three-year plan and continues to mature, providing a useful tool for the organisation being used by the Board Members for scrutiny and assurance on clinical and corporate matters. However the Board recognises that this requires further update and refresh particularly in light of recent events.

DRAFT

The Board has agreed to hold a development session early in 2019 to discuss its approach to the BAF and Risk Management including its risk appetite. The BAF supports the Board to deliver its strategy as outlined within the IMTP informing the Board regarding the principal clinical and corporate risks to the delivery of its objectives. The BAF aligns principal risks, key controls, its risk appetite and assurances on controls alongside each objective. Gaps are identified where key controls and assurances are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gaps.

Each principal clinical and corporate risk is assigned to the Board or a Board Committee, which has responsibility on behalf of the Board to seek assurance and provide scrutiny, so that those risks are being managed in accordance with the agreed risk appetite, approved plans and the organisations values. Each risk has a lead director allocated in order that the mitigation actions are owned and acted upon and regularly reviewed and updated. (Further details around risk management is set out on pages 27 - 29).



To ensure appropriate scrutiny and assurance arrangements are in place, the Board is supported by a number of committees, namely, Integrated Governance; Audit; Quality, Safety and Risk; Remuneration and Terms of Service; Mental Health Act Monitoring; Finance, Performance and Workforce; Charitable Funds and the Primary and Community Care Committee.

These Board Committees undertake scrutiny and assurance in relation to the delivery of the Board's strategic priorities, compliance with legislation, providing safe and effective services, learning lessons, sharing good practice and delivering other key targets identified within this IMTP.

During 2018/19 an additional Committee was established to scrutinise and oversee the changes required to deliver the Bridgend Boundary Change – the Joint Transition Board (joint in terms of working with ABM UHB).

The organisation recognises the important role that patients, public and staff have in proactively participating in their care and therefore work is underway to introduce a more co-ordinated approach to ensure that the patient's voice is underpinning all that the organisation does in providing high quality safe and effective services. A one-year Interim Quality Strategy has been developed to last until July 2019, to take account of the Bridgend Boundary change.

DRAFT

A Quality and Safety Framework has been approved and a delivery framework to support its implementation is under development. Both will be further refined in line with best practice arising from the 2019 WAO Thematic Review of Quality Governance, the forthcoming HIW Review and further work in response to local reports and audits. Public and service users will be engaged on the development of the follow on Quality Strategy in line with the WAO Structured Assessment recommendation aimed at improving quality governance arrangements. Further changes to the quality governance such as the Quality and Safety Framework, as well as the arrangements to underpin the work of the Quality Safety and Risk Committee is scheduled for within the first three months of 2019/20 to ensure that there is pace to the changes planned.

This work will be further informed by the important lessons that the Board learns from reviews undertaken by external bodies and regulators on services and systems within the Health Board and from external reports and specifically the most recent report on Maternity Services.

The Health Board's governance and assurance arrangements have a strong focus on performance and delivery. Whilst challenges remain going forward, good progress is being made in this area of our work. Robust scrutiny through the Board's Finance, Performance and Workforce Committee will remain the focus going forward. The Health Board through its established clinical/corporate business meeting model, has strengthened its arrangements for reviewing delivery and holding Directorates to account, reflecting the move to integrated planning and delivery.

Independent Members and Directors recognise the important role they have to play in making sure that there is a connection between the Board and all levels of the organisation, particularly given the increased level of escalation status. There is a programme of Independent Member and Executive Director visits, as well as drop-in sessions for staff to meet the Board.

The Health Board will ultimately approve and oversee implementation and delivery of the three-year Plan. Central to implementation and delivery of the Plan is robust local scrutiny and assurance arrangements endorsed by the Board that provide assurance in relation to contractor services, directly provided services and commissioned services.

Our systems of internal control are designed to manage risk to a reasonable level rather than to eliminate all risks within the organisation. It therefore provides reasonable and not absolute assurance of effectiveness.

It is based wherever possible on best practice and is an ongoing process designed to identify and prioritise risks to the achievement of the organisations policies, aims and objectives and to evaluate the likelihood of those risks being realised.

DRAFT

The impact of these risks is then assessed in order that they can be managed efficiently, effectively and economically. The system in place across the Health Board is in accordance with Welsh Government guidance.

The system of internal control has been in place for the whole of the financial year ending 31 March 2019 and up to the date of approval of the annual report and accounts for 2018-2019.

The Governance & Assurance Framework arrangements established by the Board are outlined in the table below. Members will note that in June last year, following a review of the Executive Programme Board, reporting through to Executive Board, I established in its place the Efficiency, Productivity and Value Board, which primarily overseas the Board's delivery of its Financial Savings Plan and related Cross-Cutting Theme work.

Capacity to Handle Risk

The Board has overall responsibility and authority for the Risk Management Programme through the receipt and evaluation of reports indicating the status and progress of Health Board-wide risk management activities. The lead Director for risk is the Director of Corporate Services and Governance / Board Secretary, who is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Depending on the nature of the risk, other directors will take the lead, for example, patient safety risks fall within the responsibility of the Medical Director and the Director of Nursing, Midwifery & Patient Services.

The Audit, Integrated Governance, Quality, Safety & Risk, and Finance, Performance & Workforce Committees comprise a variety of Independent Members and Executive Directors and they oversee the Health Board's risk management arrangements making recommendations for change as appropriate. Representatives from the CHC attend Health Board meetings and have speaking rights at Board meetings. They also attend other Committees and sub-groups as appropriate.

Work continued to strengthen and mature the UHB's BAF which includes the organisation's risk appetite and process for ensuring that the Board's plans are built on a foundation of risk assessment that informs mitigating actions. To support this, the UHB has an Organisational Risk Register (further details of which are in page 36), which is approved by the Board, published quarterly and considered by the Executive Board and the Quality, Safety & Risk Committee, with specific risks assigned to key Board Committees, as appropriate. Case studies and patient stories are routinely used at the UHB Quality, Safety & Risk Committee and some of its reporting scrutiny panel(s) in order that lessons can be disseminated and shared. By linking together issues arising from complaints, claims and concerns, it has also been possible to identify important points of learning and areas of best practice.

DRAFT

Arrangements at a Directorate level are in place to ensure that health and safety issues are properly considered and managed in line with the Board's Risk Management Strategy and related policy. In addition to reporting risks via the meeting arrangements within the organisation, operational managers and directors are able to notify a significant risk to the appropriate Executive Director for consideration and where necessary, notification to the Board. Regular audits are undertaken on prioritised areas and this information is then used to ensure necessary improvements are introduced and implemented. A training programme is in place and related resource issues are being addressed to ensure improved compliance and uptake of statutory and mandatory training. Staff awareness of the need to manage risks continues to be reinforced as part of routine communication and briefing and specific senior management discussions around risk reporting and the 'DATIX' risk module continues to be rolled-out to better capture assessed risks and the actions being taken in mitigation. The organisational risk register is under constant review and is being updated on a bi-monthly basis.

In reviewing the robustness of a developing Organisational Risk Register, Board Members consider whether the top recorded risks are those that Members of the Board can relate to and indeed evidence that they are informing the work of the Board and its Committees in delivering its related strategy.

Going forward, it is recognised that the Bridgend boundary change means that 2019/20 is an atypical year for the organisation. Whilst the legacy and handover statements pertaining to the Bridgend component of the organisation should ensure high visibility of all risks and opportunities, there will need to be a more detailed piece of work over the next 12 months to ensure all issues are identified and mitigations in place.

2.2 The Risk and Assurance Framework

The organisation's commitment to the principle that risk must be managed means that the UHB will continue to work to ensure that:

- There is compliance with legislative requirements where non-compliance would pose a serious risk
- Evidence based guidance and best practice is utilised in order to support the highest standard of clinical practice
- All sources and consequences of risk are identified and risks are assessed and either eliminated or minimised
- Information concerning risk is shared with staff across the Health Board and, where appropriate, partner organisations
- Damage and injuries are minimised, and people's health and wellbeing is optimised
- Resources diverted away from patient care to fund risk reduction are minimised
- Lessons are learned from compliments, incidents, and claims in order to share best practice and reduce the likelihood of a recurrence.

DRAFT

Patients and the public have an important part to play by proactively participating in their care and the organisation addresses this requirement within its Risk Management and other strategies. Case studies and patient stories are presented to the Quality, Safety & Risk Committee and Concerns/Claims scrutiny panels, in order that lessons can be disseminated and shared.



Health care professionals, including GPs, pharmacists, dental practitioners, optometrists and nursing care homes, voluntary organisations and those where we have partnership relationships for service delivery, e.g. local authorities and other health boards, are responsible for identifying and managing their own risks through contractual processes.

Clinical governance processes are intended to provide assurance to the Board that services are safe and meet organisational, external and professional standards. Work continues, to embed the Health & Care Standards Framework into the everyday working of the organisation and to ensure appropriate links are made to other key strategies, including the Board's Quality Delivery Plan. Work to strengthen the arrangements including the development of a Quality & Safety Framework for Governance has been approved and work commenced on its implementation.

The Health Board's quality improvement plans are aligned both nationally and locally.

In respect of the other areas of primary care, including dental and optometry, annual visits and monitoring, similar to that for general practice also take place. Concerns across primary care are also monitored for trends and issues are addressed and where appropriate reported into the Board, with improvement actions agreed.

The UHB is committed to listening to our patients, service users, carers to ensure that feedback on patient, user and carers experiences are obtained, published, and acted upon to harness the learning in order to inform developing quality improvements. The UHB has also pledged to create a culture that welcomes and facilitates the involvement of patients, service users and carers in the development, improvement and monitoring of the patient care and frontline services.

The UHB has a scrutiny process in place, overseen by Independent Board Members, whereby every opportunity is taken to review and learn lessons when things go wrong.

DRAFT

2.3 Mortality Review

We continue to develop and strengthen our robust processes for undertaking mortality reviews that span all hospital inpatient deaths. This process also includes General Practitioners, in addition to multi-disciplinary hospital teams.

Our work has been recognised nationally, following the publication of Professor Stephen Palmer's review of the use of risk adjusted mortality index (RAMI) data within NHS Wales, on behalf of the Health Minister in 2014 and this work continues to evolve and is routinely reported to Quality, Safety & Risk Committee and the Board.

2.4 Integrated Performance Dashboard

The UHB has a comprehensive Integrated Performance Dashboard that is presented to the Executive Board monthly. The dashboard is also presented to the UHB's public Board meeting as part of our commitment to openness and transparency, and it is presented to a number of Board Committees for scrutiny and assurance.

Since its inception in October 2012, the Integrated Performance Dashboard has continued to evolve and develop. The Dashboard report is categorised into segments to highlight any specific areas which may be under formal escalation measures by the Welsh Government and is accompanied by a narrative to provide detailed explanation on key areas, as well as to highlight areas of best practice within the UHB. During this year an agreed set of workforce performance metrics, were developed and are also being routinely reported to Board.

The Board recognises the importance of high quality data to inform its decision making at Board and committee level and has invested significant resource to strengthen and develop reporting mechanisms and business intelligence.

2.5 Organisational Vision

For the year 2018/19 this has been:

> "To be recognised as a population well-being organisation that continually makes a positive contribution to improving the lives of all Cwm Taf residents".

- We will work with communities to prevent ill-health, protect good health and promote better health and well-being.
- We will provide high quality care as locally as possible wherever it is safe and sustainable.
- Our service delivery will be innovative, reflect the principles of prudent health care and promote better value for users.

DRAFT

- We will work collaboratively with our public service partners and a broader range of partners to join up health and other services where this potentially represents better value for our residents and care users.
- Through our commitment to corporate social responsibility and to improving health and social equity, we will work with our staff, partners and communities to build upon strong local relationships and solid foundations of the past.

The University Health Board Quality Strategy (approved in December 2018) builds on a long standing commitment by the University Health Board to create and maintain the best possible environment for the people of Cwm Taf to realise their potential in terms of health and wellbeing, along with countless conversations, spanning all population groups and services, between the people of Cwm Taf, the Health Board, and key stakeholders over the last year. Simply, we want to achieve the Institute for Healthcare Improvement's Quadruple Aims.

The following key priorities feature in the business of the Board:

- Ensure the Board learns from and implements the improvement actions identified as part of the internal and external reviews of Maternity Services
- Continue to improve patient experience throughout the UHB
- Embrace the prevention agenda, for example by encouraging our patients and staff to adopt 'one more healthy behaviour' and support the well-being of our communities with our partners
- Demonstrate greater integration across health & social care, particularly in the way in which services are provided to our more vulnerable client groups with increased joint commissioning arrangements, pooled budgets and making better use of our estate in partnership
- Implement our refreshed primary and community care plans including improving the sustainability of primary care; further development of our Clusters and Cluster Plans, improved demand management and evidencing the shift of service from secondary to primary and community care
- Implementation of our next step mental health service improvements, including the next phase of older adult mental health service redesign and new approaches to dementia care
- Further develop our clinical service strategy, including the implementation of the outcomes of the South Wales Programme (specifically paediatrics, obstetrics and neonates 2018-2019) following the Bridgend boundary change
- Continue to improve scheduled and unscheduled patient care, patient flow and urgent care processes including: maintaining and improving upon the target of no patients waiting for treatment over 36 weeks; maintaining and improving upon the target of no patients waiting over 8 weeks for diagnostics, continuing to work to the 95% 4 hour target (maintaining wherever possible at least 90% performance) and having no patients waiting over 12 hours
- Continue to meet the 31 day target and work to meeting the 62-day cancer target, maintaining at least a 90% position

DRAFT

- Development of regional service planning and delivery where appropriate in areas such as regional treatment centres such as diagnostics, ophthalmology and orthopaedics, as well as vascular and Ear, Nose & Throat (ENT) service redesign
- Address recruitment and retention challenges with a priority on workforce planning and redesign and development/implementation of new roles such as Physician Associates;
- Further developing leadership and delivery capacity across the organisation;
- Continue our strong involvement and approach to the commissioning of specialist services working with partners such as the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC) and Velindre NHS Trust
- Engage with an increasing number of members of the public and staff in Cwm Taf through a variety of accessible platforms to involve people in the design and development of new clinically led and patient focused services, both in and out of hospital
- Improve data quality, including reporting and transparency
- Ensure compliance with legislation, and
- Achieve financial balance.

3. REVIEW OF GOVERNANCE ARRANGEMENTS

The UHB has an Integrated Governance & Accountability Action Plan, which takes account of lessons learned from the Betsi Cadwaladr UHB (BCUHB) joint review undertaken by the WAO and HIW "An Overview of Governance Arrangements - Betsi Cadwaladr UHB"[3](HIW) review and the 'Andrews' Report on the external independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital within ABM UHB. The lessons learned from these reports assisted Cwm Taf UHB in the development of its own governance arrangements.

The Integrated Governance Committee has routinely reviewed and monitored progress against the action plan and the majority of the outstanding management actions were completed during 2018-2019 and the action plan closed by the Committee.

A significant amount of work has been undertaken in recent years to strengthen and develop the governance and accountability arrangements supporting the delivery of the quality, performance and financial targets within CTUHB and this progress had also been recognised by the WAO within previous annual structured assessment reports. However, in the 2018 Structured Assessment, WAO raised concerns about some aspects of quality governance, risk management and oversight of ICT arrangements that require improvement, which are also cited in the Minister's decision to escalate the monitoring status of the UHB.

[3] WAO & HIW Joint Report – "Overview of Governance Arrangements at BCU" http://www.audit.wales/publication/overview-governance-arrangements-betsi-cadwaladr-university-health-board-0

DRAFT

The Health Board's governance and assurance arrangements have a strong focus on sustained performance and delivery, and whilst some challenges remain, good progress is being made in this area of our work. The Board's Finance, Performance & Workforce Committee will continue to apply robust scrutiny for all work areas going forward.

4. THREE-YEAR INTEGRATED MEDIUM TERM PLAN (IMTP)

The NHS Finance (Wales) Act 2014 was introduced on 27 January 2014 and changed the financial duties of Local Health Boards (LHBs) under the NHS (Wales) Act 2006 from an annual statutory requirement for expenditure not to exceed resource limit, to a regime which considers the financial duty to manage its resources within approved limits over a three-year period.



The Welsh Government issued a Welsh Health Circular 2015/014 in December 2016[4] providing further clarity on the financial duties specifically from 2016-2017 onwards LHB's have:

- 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) and the directions issued by the Welsh Ministers under section 175(2), to prepare a plan to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The WHC retains these duties and exercises the powers of direction in the NHS (Wales) Act 2006 section 175 (6) to set the statutory financial duty in section 175 (1) for both revenue and capital funding allocations.

[4] WHC/2015/014, December 2016
http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf

The Health Board's IMTP has been refreshed following extensive engagement within the organisation and builds upon the UHB's approved plans over the last three years. The structure of the Plan has been revised to reflect both changes within the UHB and revised Welsh Government guidance. The Board has undertaken a significant amount of work to plan, design, develop and secure the delivery of safe and high quality preventative, primary, community, hospital care services and specialised and tertiary services for the population of Cwm Taf, and continues to ensure that CTUHB maintains progress to develop its 3 year Integrated Medium Term Plan (IMTP). In accordance with the legislative duty the IMTPs for 2015-2018, 2016-2019, 2017-2020 and 2018-2021 were approved by the Board and submitted to Welsh Government within the required timescale and approved by Welsh Ministers.

A copy of the Board approved IMTP 2018-2021, was submitted to Welsh Ministers on the 31 March 2018 and the submission was supported by correspondence outlining the associated risks and basis on which the Board had approved its submission. The document can be viewed on our website: Cwm Taf UHB Approved 2018 - 2021 Integrated Medium Term Plan.

A public facing summary of the IMTP has also been developed with input from the SRG and the CHC representing our staff and local communities.

The Health Board has adopted a truly integrated planning approach with a 'golden thread' running through our Plan which links quality to population need, service planning, demand and capacity, workforce, digital, capital and financial planning. To support this approach, the Health Board has an integrated Business Partner Model. This model is embedded and maturing. Support is in situ from our corporate departments, namely: Patient Care and Safety; Planning; Workforce and Operational Development; Finance; Procurement; IT and Performance and Information.

The Plan has been developed as part of a 'bottom-up' planning process, building upon our Directorate, Locality, Corporate Department and Cross-Cutting Theme plans, which includes Bridgend Service Groups. It integrates our service, workforce and financial plans and makes explicit links with the performance and quality improvements intended over the coming three year period.

The Board recognises the significance of developing its culture, both in response to the increased level of escalation and the inevitable change as a consequence of the Bridgend boundary change. This is a top priority for the Health Board in 2019/2020 in order that it can realise the benefits associated with delivering this IMTP taking into account the wider population that we will serve. The Director of Workforce and Organisational Development is leading on the development of bespoke organisational development approaches across the Health Board to address issues of culture and behaviour, an example of this has commenced within maternity services. This approach will be replicated across the Health Board within key services.

DRAFT

The Board approved plan was ratified at its public Board meeting with a copy made available to the public via the website. The Board has received confirmation from Welsh Government that it has approved its IMTP for 2019-2022 plan (approved by the Board on 28 March 2019).

Robust local scrutiny is central to the implementation and delivery of the Cwm Taf plan, which provides assurance that the Board are actively involved in decision making processes in relation to performance, contractor services, and services that are provided directly or which are commissioned. Overall, the Health Board continues to make solid and steady progress in delivering against its IMTP. The Plan builds upon and updates the Health Board's previously approved Plan and in doing so, it recognises the growing responsibilities following the Bridgend boundary change. The Plan describes the entirety of the Health Board's business, explaining how its budget and workforce will be deployed over the coming three-year period. From April 2019, a number of existing Cwm Taf and Bridgend health functions and services will be fully integrated, whilst others will integrate over the life of this Plan. Hence, in developing the Plan, our business is described threefold, i.e. from either an integrated perspective, Cwm Taf perspective or Bridgend perspective, underpinned with a commitment that the 2020-23 document will be for a truly integrated Cwm Taf Morgannwg UHB.

Whilst the positive developments reflect the hard work and commitment of the Health Board's workforce and contractor professions, there is no room for complacency, and with ongoing challenges in relation to performance and recruitment, our Board maintains a strong focus on quality, performance and delivery and can demonstrate that the Health Board is an organisation that has matured in its governance and assurance arrangements.

The Health Board achieved a break-even position for its 2018/19 financial plan in revenue expenditure terms, with a small surplus, in line with the financial plan element of the IMTP, which was a success given the challenging nature of our plan. Capital expenditure was managed closely to plan and the Capital Resource Limit target was met, with a small under spend against planned expenditure.

Further detail on the Health Board's achievements and actions being taken to address continued operational challenges anticipated in 2019-2020, can be found in our new Integrated Medium Term Plan for 2019-2022, particularly in Chapter 2, which outlines progress in delivering the Plan.

DRAFT

5. AREAS OF RISK

The Health Board has an approved Risk Management Policy, a Board Assurance Framework (BAF) and an Organisational Risk Register. The risk profile of the UHB changes over time and the risk register is reviewed by the Board and regularly considered at Committee meetings, capturing the key risks that could impact upon the Health Board's achievement of its objectives if not adequately assessed, mitigated and monitored.

The organisational risk register currently includes Extreme / High risks which are categorised into the following groupings:

Categories / Risk Rating	Extreme (rated 15 -25)	High (rated 8-12)
Setting the direction and performance and operational efficiency	5	4
To improve quality, safety and patient experience	11	1
Statutory Compliance	8	2
Finance (including claims)	1	1
Workforce / Organisational Development / Innovation	0	1
Business continuity	2	1
Total Risks	27	10

High / Extreme Risks (Rating 20 and above)

In considering the robustness of a developing organisational risk register, Board Members regularly review whether the top recorded risks are those that Members of the Board can relate to and indeed evidence that they are informing the work of the Board and its Committees in delivering its related Strategy.

As at March 2019, the top risks outlined within the Health Board's risk register were:

- Under Reporting of Clinical Incidents/Serious Adverse Incidents in Maternity Services.

- Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators leading to increased levels of escalation
- Failure to recruit sufficient numbers of medical & dental staff and its related impact on staffing rotas and finance going forward (also aligned with South Wales Programme outcome)
- Failure to recruit sufficient numbers of registered nursing and midwifery staff
- Reduction in medical staff training posts
- Increasing dependency on agency staff to cover registered nursing, midwifery and medical staff gaps
- Fire Safety compliance and ongoing issues with Prince Charles Hospital site (Ground & First Floor)
- Lack of control and capacity to accommodate all hospital follow up outpatient appointments
- Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.
- Achieving financial break even on a recurring basis.
- Failure to continue to provide GP out of hours services as currently configured.

The Health Board has received a number of updates on matters relating to Maternity services, following the identification of under reporting of incidents and Serious Untoward Incidents (SUIs). The associated issues raised by the recent (30 April 2019) publication of the Royal College of Obstetricians & Gynaecologists and Royal College of Midwives report, commissioned by the Minister for Health & Social Services will necessitate a review of the Organisation's risk register.

The Chair of the Health Board has been working with the Board Members to plan the board development programme for 2019/20. A discussion on risk management, the risk appetite and its link with the Board Assurance Framework, to demonstrate how this underpins the governance of the organisation. The Board Secretary is working with external providers to assist the Board in developing its risk approach in line with the recommendations within the Structured Assessment and to assure the Board and its external regulators that the Health Board has a clear and open approach to managing risk effectively.

Plans are being developed by the Head of Health, Safety & Fire to review risk management arrangements at the Directorate level to ensure that risks are recorded and regularly updated, mitigation clarified and management action taken. The Health and Safety Coordinators group ensure that health and safety issues are properly considered and managed. Regular audits are being planned on prioritised areas with the results being used to inform necessary improvements.

It is important to note that there are mitigating actions and scrutiny arrangements in place for all the risks contained within the organisational risk register that are also subject to regular review. During the year, eight risks were added and two risks removed. The following risks were added:

DRAFT

- **Risk 039**: Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.
- **Risk 040**: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.
- **Risk 041:** Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.
- **Risk 042:** Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.
- **Risk 043:** Under Reporting of Clinical Incidents/Serious Adverse Incidents in Maternity Services.
- **Risk 044:** Risk of information technology failures following national outages during 2018 and cyber security risk, which could lead to loss of information or information governance issues.
- **Risk 045:** Risk of interruption to service sustainability, provision and de-stabilising the Board's financial position as a result of Brexit.
- **Risk 046**: Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators.

During the year, the Board supported the removal of the following risks:

- **Risk 038:** Inconsistent approach and arrangements in place for the management and monitoring of patients requiring anticoagulation management within Cwm Taf UHB. Committee Members agreed with the Director of Primary Community and Mental Health that the risk was being managed and anticoagulation was added to the forward look to ensure that the service continued on its improvement trajectory.
- **Risk 029:** Failure to invest in and develop Primary Care Services, across RCT and Merthyr Tydfil but particularly in the Rhondda Valleys. Following discussion at the October and January meeting of the Primary and Community Care Committee Members agreed that the risk identified would be more appropriately managed and identified within Risk 036 which relates to the recruitment and retention of all staff groups.

5.1 Maternity Services Review

Following changes in the senior management team and a review of clinical governance arrangements in the Cwm Taf maternity services early in 2018, concern was expressed internally that there was potential variation in the reporting arrangements and investigation of incidents. This meant that the Board could not be wholly assured that all serious incidents had been appropriately investigated and any learning fully addressed. The position was initially escalated to the responsible Executive Directors early in the summer 2018 and subsequently discussed with Welsh Government and reported to the Quality, Safety & Risk Committee (QSR) and to the Board at each of its meetings during the remainder of 2018/19.

DRAFT

A Maternity Improvement Board (MIB) was established on 6 November 2018, with an independent external Chair to monitor the actions and oversee the improvements within the service.

As part of the support arrangements for concerned patients a telephone helpline was set up in October 2018 along with a dedicated email address and all contacts have been provided with a named individual providing ongoing support. The reference period for the initial review was identified as 1 January 2016 to end September 2018, a period which covers circa 10,500 births which highlighted a total of 43 cases. A multidisciplinary clinical review process, involving midwives, obstetricians and anaesthetists, was initiated to review these cases, 18 were reported as serious untoward incidents (SUIs) at the time of the incident with a further 25 potential cases being identified and submitted retrospectively, pending further review and confirmation of status.

Regular updates have been provided to the Board since September 2018. An outline report in respect of the outcomes, trends, themes and actions taken, has been presented to the full Board and more detailed discussion will take place in the Quality, Safety & Risk Committee to inform further improvement actions as appropriate. Where reviews have identified omissions in care, the women affected, have been informed.

A Review by Royal College of Obstetricians & Gynaecologists (RCOG) was commissioned by Welsh Government and this visit was undertaken in January 2019; a number of actions were put into place soon after which were set out in a report to the Board in March 2019. The final report from the RCOG was published on 30 April 2019 and as a consequence of the significant findings and recommendations, also aligned with an escalation of our monitoring status, the Health Board will work with the proposed Welsh Government arrangements to update its Maternity Improvement plan to reflect new issues raised from the report and the Health Board response will be shared in full with stakeholders and made available to the public through the Board papers and the Cwm Taf Morgannwg UHB website.

5.2 Fire Safety

The University Health Board continues to work in partnership with South Wales Fire and Rescue Service (SWFRS) in managing the fire risks across its estate. In addition to the measures undertaken to the Ground and First Floors in the Merthyr Block at Prince Charles Hospital, Merthyr Tydfil, which remains the subject of a Fire Enforcement Notice.

The UHB has also had to consider fire safety measures across all of its other buildings and key work has continued to be undertaken to support fire safety compliance across the UHB with regular dialogue with senior officials in SWFRS.

DRAFT

Following meetings between Senior Officers and members of the SWFRS, the Director General/Chief Executive NHS Wales and officials from Welsh Government have discussed the capital works progressed to date, and what further work is planned to manage and mitigate the fire safety related risks associated with the Prince Charles Hospital building.

Detailed plans for a phased approach to progressing with the remainder of the Capital Scheme at the hospital site continue to be developed with Welsh Government in accordance with an agreed phased process for submission and approval of business cases. The first phase of the remaining works has commenced which will, over time, allow the Health Board to comply fully with the requirements of the Fire Safety Enforcement Notice. It is important that the sequencing and inter-dependency of each of the scheme's business cases, run concurrently in order to ensure there is no delay to achieving full compliance with the enforcement actions identified.

It is also important for the Board and other Stakeholders to understand the implications of the phasing of the Schemes, including noting that Internal Audit & Assurance Capital & Estates Audit have undertaken an initial high-level review of the Health Board's management of major capital, with a focus on the project at Prince Charles Hospital to redevelop the ground and first floor. However, noting the size and challenges related to the project, audit work in relation to this project is still ongoing, with agreement that further related fieldwork, will be undertaken during 2018/19.

5.3 GP Out of Hours (OOH) Services

An alternative model for GP out of hours (OOH) services implemented in 2015-2016 has been evaluated and the Board received a report in May 2017 to endorse the adoption of the current model as the way forward. The public were kept updated on progress through the established public fora meetings and ongoing engagement with the Community Health Council (CHC). Sustainability of GP OOH Services remains a key risk and an area of focus for the Health Board and we continue to work to develop innovative solutions for the future.

5.4 Primary Care Services

As I have reported in previous years, there remains an increasing risk of the Board's ability to sustain effective Primary Care Services as currently configured across all areas of the UHB. A small number of practices have merged or become directly managed by the Health Board over recent years. Primary Care Cluster leads are working on outline plans for sustainability, which could result in new models of closer collaborative working, and potentially further agreed mergers. This work will continue to be taken forward by the Board in 2019-2020.

DRAFT

5.5 New Legislation

Following the introduction of the **Social Services and Well-being (Wales) Act 2014** ("the Act"), and **the Well-Being of Future Generations (Wales) Act 2015**, the UHB has worked closely with the Cwm Taf Public Services Board (PSB), which was the first in Wales to agree a co-terminus approach to collaborative working across health and local authority boundaries. The Well-Being of Future Generations Act stipulates that public bodies must publish a Well-being Statement including an explanation as to how the objectives will help achieve the well-being goals and how the sustainable development principle has been applied.

Under the leadership of the Director of Public Health, the Cwm Taf PSB developed its Well-being Plan which was published in May 2018. In line with the 2018/19 Cwm Taf Internal Audit Plan a review of arrangements for ensuring the requirements of the Well-being of Future Generations Act (WFGA) (Wales) 2015 are being met, was carried out in 2018 which found that the Board could take reasonable assurance as regards secure governance, risk management and internal control.

Whilst the Health Board is proud of the early work completed to embrace the principles of the Act and to embed the Well-Being Objectives within the IMTP, we recognise that there is much work left to do to strengthen and mature our approach even further. This will therefore continue to be a key area of activity within delivery of the IMTP and progress against delivery of the Well-Being Objectives is also being monitored via the quarterly IMTP progress reports, which are prepared for the Executive Board, UHB Board and Welsh Government, and will also be reported on formally via the Health Board's Annual Report.

From April 2018, Health Boards are required to calculate the nurse staffing level for every adult acute medical and surgical inpatient area as defined under section 25B of the **Nurse Staffing Levels (Wales) Act 2016 Act.** An adult acuity tool was developed to enable continuous monitoring against a baseline assessment and action plan to ensure full compliance with the requirements of the Act. A report as to progress was received by the Board at its March 2019 meeting which confirmed investment for this issue has been included within the IMTP and that compliance actions are being developed linked to workforce plans.

5.6 Human Tissue Authority

Following an inspection by the Human Tissue Authority at the end of March 2018 updates on progress with actions have been provided to the Quality, Safety & Risk (QSR) Committee with 25 of the 32 recommended actions completed, with the remaining outstanding 7 recommendations being monitored on a weekly basis. These last 7 will be under consideration during the HTA corrective and preventative action (CAPA) closure inspection visit, taking place on 8 and 9 May 2019.

DRAFT

Confirmation has been sent to the HTA confirming that Swansea Bay University Health Board will continue to take responsibility for mortuary services in Princess of Wales hospital from April 2019 with a transition plan over 2019/20 focusing on ensuring that the lessons learned being applied within Cwm Taf Morgannwg UHB prior to its full adoption in 2020.

5.7 Healthcare Inspectorate Wales (HIW)

Following a HIW inspection regarding Ionising Radiation (Medical Exposure) Regulations in Prince Charles Hospital's radiology department in December 2018 an action plan was approved and reported to the Board in January 2019. Following revisions an amended action plan was submitted to HIW at the end of February 2019 and in March 2019 HIW confirmed that this provided sufficient assurance and therefore the improvement plan was accepted. This is because the improvements identified by HIW have either been addressed, and/or progress is being made to ensure that patient safety is protected. Progress on the on-going actions is being monitored on a weekly basis and will be reported back to the Board and the Quality, Safety and Risk Committee.

In addition, work is being progressed to review responses made to HIW reviews by other organisations, in order that any lessons can be learned and regular engagement meetings are being put into place between HIW and the UHB.

5.8 Director Posts/Portfolios

From December 2018, John Palmer formally took-up the post of Chief Operating Officer after a period acting into the role. This portfolio includes business support and information technology.

The new Director of Nursing, Midwifery and Patient Services Greg Dix took-up post as of 1 April 2019 taking over from Angela Hopkins who was the interim Director of Nursing, Midwifery and Patient Services until 31 March 2019.

The post of Director of Primary, Community and Mental Health was taken up by Alan Lawrie from December 2018 following a period of acting into the role.

5.9 Workforce

The workforce is the Health Board's biggest asset, not least because of the direct impact on the patient experience and pay represents such a significant proportion of expenditure.

We continue to work hard in addressing local, national and international recruitment to address significant workforce shortages and to reduce the current spend on locums by use of 'retire & return' for nurses and the introduction of e-rostering and e-job planning with progress being reported to and scrutinised by the appropriate committees of the Board.

DRAFT

HIW and the CHC have shared their related concerns about levels of registered nurse staffing cover in some areas of the Health Board, when feeding back on announced and unannounced visits to clinical areas and action plans are in place to mitigate the concerns raised, whilst the Health Board continues to address, what is, a national recruitment shortage.

Managed agency contracts are in place for medical and nursing staff and all-Wales framework for nurse agency contracts is in place.

5.10 Paediatrics Neonatal & Obstetric Services

In progressing the service outcomes associated with the South Wales Programme and specifically the development at Prince Charles Hospital, a new model of maternity services was put into place as of early March 2019 (with a Consultant led service at Prince Charles Hospital with an 'Alongside Midwifery-Led Unit', ante-natal and post-natal facilities, a day assessment unit, an early pregnancy assessment unit and two integrated theatres dedicated to obstetrics within the footprint of the new maternity unit with obstetric services at Prince Charles Hospital co-located with a new Neonatal Unit). Clinical teams, estates and facilities teams, communication team, managers and support staff all worked together to ensure a seamless service transfer. In addition, staff at Royal Glamorgan Hospital successfully implemented provision for women with lower risk pregnancies, where care can be provided in the Freestanding Midwifery unit that will manage 200-250 cases per annum. The service at RGH is complemented by Consultant-led ante-natal clinics, a Midwifery Day Assessment unit with community midwifery services across Cwm Taf supporting care in the home, including the option for women to choose a home birth.

The Board is considering the most appropriate timing for the transfer of the inpatient Paediatric service to Prince Charles Hospital, which was scheduled to transfer in June 2019.

5.11 Pensions

We continue to consider and monitor potential impact that the changes to the pension taxation regime at UK level is having on senior members of the workforce, both within our directly employed services and in relation to our Primary Care and Out-of-Hours contractor services. The changes are impacting on the ability of NHS Organisations to retain high earning employees and contractor staff. Furthermore, senior medical staff are indicating that they will no longer undertake additional contracted work such as Waiting List Initiatives or paid 'back-fill' sessions as the tax and pension implications are prohibitive. This presents a potentially significant risk to NHS organisations in respect of maximising productivity and delivery of some performance targets.

DRAFT

5.12 IR35

The IR35 legislation which is also known as the 'intermediary's legislation' is a set of rules that aid in the determination of the tax and national insurance contributions a candidate working through an intermediary should pay, based on the substance of that working arrangement. The key change is that the Health Board is required to apply these rules and the UHB has been working with other NHS bodies and the NHS Wales Shared Services Partnership to ensure a consistent approach. Contracts have been changed to include clauses giving the right for engagers to seek assurances and information and evidence to show that income is being treated correctly for the purpose of tax and national insurance contributions and especially with regard to IR35.

5.13 Information Communication & Technology

The Health Board also experienced a number of network outages during the year, which impacted on access to clinical systems. These were NHS Wales Informatics Services (NWIS) related. Reviews of all such incidents are undertaken and the related findings used to address any identified improvement actions either locally or nationally.

In light of comments raised within the WAO 2018 Structured Assessment, the Board has agreed to establish an ICT Committee of the Board, to raise the profile, monitoring and scrutiny of delivery of the related Strategy.

5.14 Health & Safety Executive (HSE)

The HSE has engaged with the Health Board regarding a Personal Protective Equipment (PPE) matter within our operating theatres and the potential impact this had on staff with regards Ionising Radiation Medical Exposure Regulations (IRMeR). The Health Board submitted a revised and amended second action plan to HSE and a response received during March 2019 confirmed that this provided sufficient assurance and therefore the improvement plan has been accepted.

The HSE has also recently completed an investigation into circumstances surrounding a possible case of dermatitis in the Royal Glamorgan Hospital.

Following HSE's investigation conclusion, they identified that the Health Board had contraventions in compliance with current health and safety legislation. As a result they issued the Health Board with a notification letter outlining these contraventions along with a set of actions for the UHB to address.

An updated action plan has recently been submitted to the HSE and progress with regards its delivery, will continue to be monitored via the Quality, Safety & Risk Committee.

DRAFT

The HSE has informed us of staff safety matters relating to Bridgend staff, following the issuing of an Improvement Notice with regards Electrical Safety Dynamic Air Mattresses. An action plan has been submitted prior to the transfer taking place in April 2019 and further work is being progressed to monitor and ensure corrective actions are being implemented.

5.15 Unscheduled Care

The Health Board, like all NHS organisations across the United Kingdom, experiences sustained excess pressures, between January and March, in its unscheduled care activity. However, this year performance against the 4, 8 and 12 hour tier 1 Accident & Emergency targets along with delays for inpatient admission improved when compared with the previous year.

Whilst the Health Board with partners put plans in place to respond to the expected increase in activity, the Health Board will review its plans with partners in order to learn from and strengthen planning for next winter. This will be particularly challenging in respect of Princess of Wales Hospital given differences in culture, practice and partnership infrastructure.

There remains an increasing and heavy reliance on locum medical staff, particularly at Royal Glamorgan Hospital, but across A&E generally, in order to continue to maintain and sustain safe Accident & Emergency services across all 3 hospital sites.

5.16 Clinical Service Sustainability

The current arrangements to support the NHS System delivery of sustainable clinical services needs to be strengthened to address the very real requirement to redesign clinical services across organisational boundaries. Whilst the NHS Wales Collaborative and the South Central & East Regional Planning & Delivery Forum are in place, there remains a need for a system that addresses and simplifies some of the current complex governance and accountability arrangements.

5.17 Bridgend Boundary Change

The Minister for Health and Social Services announced on 14 June 2018 that from 1 April 2019, the responsibility for commissioning healthcare services for the people in the Bridgend County Borough Council (Bridgend CBC) area would move from Abertawe Bro Morgannwg University Health Board (ABM UHB) to Cwm Taf University Health Board (UHB).

This local government boundary change means that Bridgend CBC would be established within the south east Wales regional footprint for healthcare provision and social services complementing existing economic and education partnerships. As a result, the Bridgend CBC's partnership arrangements would become broadly comparable with all other local authority partnership arrangements in Wales.

DRAFT

The secondary impact of the boundary change was a name change for both organisations. From 1 April 2019, Abertawe Bro Morgannwg University Health Board became known as Swansea Bay University Health Board and Cwm Taf University Health Board became known as Cwm Taf Morgannwg University Health Board.

As agreed by both the Health Boards, a Joint Transition Board (JTB) was established as a sub-committee of each health board to oversee the implementation of the boundary change. The JTB met monthly during 2018-19 and received regular updates via the Transition Director on the programme of work from the Joint Transition Programme Group (JTPG). The programme of work has been taken forward by a number of work streams that report into the JTPG, each jointly chaired by representatives of ABM UHB and Cwm Taf UHB. The JTPG met monthly during 2018/19.

In order to enact the decision by the Welsh Government to implement the boundary change there was a legal requirement to lay an Area Change Order before the National Assembly for Wales. The Area Change Order was laid on 25 February 2019 and a copy of the Order is available online:
The Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019. A Transfer Order has also been completed that covers the transfer of property, staff, assets and liabilities has also been completed.

Colleagues across both organisations worked closely together, to identify all clinical services that fall within the scope of the transfer, working through every identified service, and both Health Boards have agreed the future service provider arrangements, the final clinical service listing was reported to the Health Boards in March 2019. For some services, a Service Level Agreement (SLA) has been put in place and ABM UHB will continue to provide services to the population of Bridgend on behalf of CT UHB and vice versa.

In practice, this was an administrative change and not a service change and thus patients should not notice any changes to their healthcare services. Services are not being lost or reduced, and how patients access services and receive their care remains the same from 1 April 2019. Patients will continue to travel to the same place as they do now to receive their care, there are no changes to patient flows or referral arrangements. Whilst health boards cannot guarantee that services will never change, if they do need to change an undertaken has been given to consult with Community Health Councils and local populations.

A workforce transfer process was agreed through both Health Board Partnership Committees and has informed and guided the decision making regarding all staff posts impacted by the change. The process of transferring identified services and the staff affected was led by the requirements under the TUPE as amended by the Collection Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 and those laid out in the All Wales Organisational Change Policy (OCP).

DRAFT

A legacy statement has been to provide a comprehensive summary of work which identifies known quality and patient safety issues and good practice. The information within the statement has been used by Cwm Taf UHB to ensure a smooth transition and mitigate risks to quality and patient safety.

A comprehensive handover statement has been developed following existing best practice guidance. It includes an overarching summary of key information in relation to:

- How the Joint Transition Programme was established and managed
- Key decisions made in relation to staffing, finance and corporate governance issues
- Functions that have transferred and the governance framework in place for partnership working
- The resources, assets, functions and liabilities that will transfer to CT UHB; and
- Residual issues and opportunities that require further work beyond April 2019.

The JTB met for the last time on 23 April 2019 to draw the Joint Transition Programme to a close. A Memorandum of Understanding (MoU) has been completed, incorporating the principles that the JTB has used to work together to manage the transition and boundary change thus far. The aim of the MoU is to set out the agreement reached by the two organisations in relation to the future co-operation, sharing of sites, staff and other resources and the exchange of information.

It is intended to complement and not override any long-term agreements and service level agreements entered into by the two organisations. It reflects that both organisations agree to adhere to its principles and to show proper regard for each other's activities and responsibilities.

The key principles underpinning the service and financial basis for the transfer were agreed at the outset of the Transformation Programme and it is expected that the final detail of the changes to the financial allocation will be confirmed in May 2019.

6. MANDATORY DISCLOSURES

In addition to the need to report against delivery of the Health and Care Standards and the Standards for Health Services in Wales, the UHB is also required to report that arrangements are in place to manage and respond to the following governance issues:

6.1 Health and Care Standards for Health Services

On 1 April 2015, the Health and Care Standards came into force, published by the Welsh Government to bring together and update the expectations previously set out in 'Doing Well Doing Better Standards for Health Services in Wales' and the Fundamentals of Care in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

DRAFT

The organisation uses the Health and Care Standards as part of its framework for gaining assurance on its ability to fulfil its aims and objectives for the delivery of safe, high quality health services. This involves self-assessment of performance against the standards across its activities and application of the standards at all levels throughout the organisation. The Standards form an important part of the assessment required during the development of all Board and Board Committee papers (contained within the house style template).

The Board had planned to complete a self-assessment against the Governance and Accountability Module at its April 2019 Integrated Governance Committee meeting. However, due to the serious and important report into maternity services this has been deferred pending discussion with HIW regarding the proposed quality governance review.

6.2 Equality, Diversity and Human Rights

The Health Board is committed to the principles of equality and diversity and the importance of meeting the needs of the nine protected groups under the Equality Act 2010. The UHB's policy on equal opportunities and in relation to disabled employees is made equally accessible to staff and the public.

Control measures are in place to ensure that all Cwm Taf Health Board's obligations under equality, diversity and human rights legislation are complied with. The UHB has been successful in being accredited as a level 3 Disability Confident Employer under the UK Government's Disability Confident Scheme being the first Welsh health board to do so.

Equality issues are monitored by the Health Board's Equality and Welsh Language Forum which reports through the Quality, Safety & Risk Committee to the Board. The 2018/19 Equality Annual Report is currently being finalised for submission to a meeting of the Health Board.

6.3 Emergency Preparedness / Civil Contingencies / Disaster Recovery

The organisation continues to maintain its duties as a Category 1 responder and has strengthened its level of compliance with the addition of a Critical Threat Level Response Protocol. The Civil Contingencies Act requires organisations to maintain emergency plans to ensure that should such a situation arise, the organisation is fully prepared so that it can respond in conjunction with its partner agencies whether this is in the form of action to prevent or reduce the risk of an emergency or its effects.

The Chief Executive has responsibility for discharging the Health Board's obligations under the Act, however on a day-to-day basis, lead managers ensure existing plans are updated in line with legislative changes and national guidance.

DRAFT

The Health Board has a Major Incident Plan that takes full account of the requirements of Welsh Government guidance to NHS Wales and all associated guidance and Major Incident Exercises have been attended by Executives, senior managers, senior nurses and support managers. The UHB continues to maintain its duties as a Category 1 responder and has strengthened its level of compliance with the development of a Silver Commander Training package delivered to senior managers and executives attending Wales Gold training.

The UHB has an all-Wales NHS Mass Casualty Response plan designed to coordinate NHS resources and communication across Wales to manage a major incident involving a large number of casualties. This work has involved Welsh Government, Health Boards, Welsh Ambulance and specialist resources and is incorporated in our Major Incident plan.

Medical Emergency Response Incident Team have continued to receive training and development for attendance mass casualty incidents, with a high level of re-certification achieved through attendance and assessment at 'Exercise Leopold'. There have also been business continuity exercises addressing issues such a staff shortages, supply chain failure and social care sector.

The Health Board has fully participated in NHS planning preparations around Brexit and is compliant with the reporting requirements of Welsh Government and the South Wales Local Resilience Forum. A Joint Emergency Services Interoperability Protocol awareness package has been delivered for staff and training and exercising session have been provided to train staff in the use of the decontamination tents and use in the decontamination of casualties. Training has included and emphasised the separate personal protective equipment requirements for treating highly contagious infectious diseases and training in the use of powered respiratory protective suits and masks.

6.4 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 Scheme is managed on our behalf by the NHS Wales Shared Services Partnership (NWSSP).

DRAFT

Carbon Reduction Delivery Plans

The organisation has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the climate change Act and the Adaptation Reporting requirements are complied with.



6.5 Ministerial Directions and Welsh Health Circulars (WHC)

Ministerial Directions issued by the Welsh Government during 2018/19 have been considered and where appropriate implemented. The WHCs published by Welsh Government during 2018-2019 are centrally logged within the UHB with a lead Executive Director being assigned to oversee implementation of any required actions. Where appropriate, the Board or one of its Committees is also sighted on the contents of WHCs.

The Safety Alert Broadcast System Procedure has been developed and implemented to ensure that each WHC is followed up until all actions are completed. The UHB can confirm that all WHCs have been fully considered and implemented as appropriate.

6.6 Data Security and Information Governance

The Board has strict responsibilities to ensure personal data and information is held securely. All information governance related incidents are investigated and reviewed by the Information Governance Group. During the period April 2018 and March 2019 there were two personal data security incidents which needed to be reported to the Information Commissioners Office (ICO). The first related to a letter with a partial address which did not arrive with the intended recipient. The other related to community pharmacy vehicle which was stolen affecting five Health Boards due to theft of delivery information. The ICO was satisfied by the actions taken as a result.

A planned approach was undertaken to ensure organisational preparedness for the General Data Protection Regulation (GDPR) implemented in May 2018 which marked the biggest change to data protection legislation in the last 20 years. GDPR builds upon the previous Data Protection Act, strengthening individual's rights and the requirements for the appropriate and secure processing of personal data.

DRAFT

Key areas progressed include raising awareness across the organisation and communicating with all staff, developing and implementing a comprehensive Information Asset Register and ensuring good information governance practices by increasing the awareness and requirements for completion of mandatory training via an e-learning package. Staff training numbers have steadily increased over the year with the current compliance at the end of March 2019 reaching 70.46%, an increase of 10% over the past 12 months.

The UHB has been focussing on keys areas that have the most impact in terms of compliance. The following key areas were progressed in this respect:

- Establishment of the GDPR Preparations Task & Finish Group, reporting through the Information Governance Group and Quality, Safety & Risk Committee
- GDPR Communications Campaign for managers and staff including intranet site, briefings, newsletters and posters
- Development and on-going population of an organisational-wide Information Asset Register
- Personal Data Breaches Procedure (to meet the requirement to report data breaches within 72 hours)
- Data Protection Impact Assessment (DPIA) Procedure (to meet the requirement to ensure a "privacy by design" approach and accountability requirements)
- Development of privacy notices
- Contractual reviews by local procurement.

In addition, advice and support is available to contractor professions, who as independent contractors, retain legal responsibility for the personal identifiable data that they hold.

6.7 The Corporate Governance Code for Central Government Departments

The organisation has undertaken an assessment against the main principles of The Corporate Governance Code for Central Government Departments as they relate to an NHS public sector organisation in Wales. This assessment has been informed by the Health Board's assessment against the Governance and Accountability Module undertaken by the Board in April 2019 and also evidenced by feedback received from internal and external audits. The Health Board considers that there have been no departures from the code as it applies to the NHS bodies in Wales.

The Health Board is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. Declaration of interests received from Board Members are set out at page 71.

DRAFT

6.8 Welsh Language

The Health Board is committed to ensuring that the Welsh and English languages are treated on the basis of equality in the services we provide to the public and other NHS partner organisations in Wales. This is in accordance with the Health Board's Welsh Language Scheme, Welsh Language Act 1993, the Welsh Language Measure (Wales) 2011 and the Welsh Language Standards (No7) Regulations which were approved by the National Assembly for Wales on the 20 March 2018.



The quality of care, patient safety, dignity and respect can be compromised by the failure to communicate with patients and service users in their first language and it is recognised that many people can only communicate and participate in their care as equal partners effectively through the medium of Welsh.

The Health Board is therefore committed to meeting the Welsh language needs and preferences of service users and has made good progress implementing its statutory Welsh Language Scheme and the Welsh Government's strategic framework for Welsh language services in health, social services and social care: 'More Than Just Words'. The aim of this work has been to improve the availability, accessibility, quality and equality of our Welsh medium services.

Following the confirmation of the requirements of Welsh Language Standards at the end of November 2018 the Health Board has put into place an action plan to deliver the necessary requirements during 2019/20 into 2020/21. This is based upon joint working with other UHBs to ensure a consistent approach making best use of resources. A further Welsh Language Translation post has been established in anticipation of an increase in translation demand. Progress against Welsh Language Standards is reported to our internal Welsh Language and Equality Forum, the Board, the Welsh Language Commissioner and Welsh Government with Annual Monitoring and statistical reports being submitted to the Welsh Language Commissioner and Welsh Government.

7. REVIEW OF EFFECTIVENESS

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

DRAFT

I have overall responsibility for risk management and report to the Board regarding the overall effectiveness of risk management across the Health Board. My advice to the Board is informed by reports on internal controls received from all its Committees and in particular the Audit Committee, Quality, Safety & Risk Committee and the Finance Performance & Workforce Committee, with the Integrated Governance Committee ensuring alignment and connections with the Board's business. The Quality, Safety & Risk Committee also provides assurance relating to issues of clinical governance, patient safety, patient experience and the application of the Health and Care Standards. In addition, reports submitted to the Board by the Executive Team identify risk issues for consideration.

Each of the Health Board's Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal audit reports and external audit reports and reports on professional standards and from other regulatory bodies. The Committees have also considered and advised on areas for local and national strategic developments and new policy areas.

Each Committee develops an annual report of its business and the areas that it has covered during the last year and these are reported in public to the Board. Overall I consider the arrangements supporting the system of internal control in place within Cwm Taf UHB, to be appropriate. However, recognising the issues raised within the 2018 WAO Structured Assessment and significant matters of concern raised within the Maternity Services external review reports, it is clear we have areas where internal control and quality governance need to be strengthened.

In response to the change in escalation status, the additional governance advice provided to the Board will positively support the organisation to improve culture, systems and processes. We will use this opportunity, together with the learning from the 2019 WAO national thematic audit on quality governance and the proposed HIW local governance review, to further strengthen systems of internal control going forward.

7.1 Internal Audit

Internal audit deliver an agreed Internal Audit & Assurance Plan for the year and provide an overall opinion on the system of internal control to me and the Board through the Audit Committee. 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 (NWSSP). 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 received from the Head of Internal Audit on governance, risk management and control is a function of the 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.

DRAFT

The Head of Internal Audit opinion for 2018/19 is that the Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

The Head of Internal Audit has concluded:

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

In reaching the opinion the Head of Internal Audit has applied both professional judgement and the Audit & Assurance 'Supporting criteria for the overall opinion' guidance produced by the Director of Audit & Assurance and shared with key stakeholders, the details of which are contained within his Annual Report to the Audit Committee.

The Head of Internal Audit has concluded reasonable assurance can be reported for seven of the assurance domains. However, The Capital and Estates management domain was allocated Limited Assurance as, two out of the four reviews that we undertook in the domain during the year were given a limited assurance rating. These reviews related to water safety (draft report), and to the capital project for the redevelopment of Prince Charles Hospital.

The audit work undertaken during 2018/19 and reported to the Audit Committee has been aggregated and explained further in the Annual Report:

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews, which impact on the Head of Internal Audit opinion including audit work performed at other organisations.

DRAFT

These detailed results have been aggregated to build a picture of assurance across the eight assurance domains around which the risk-based Internal Audit plan is framed. In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. During the year, one audit assignment was deferred to 2019/20, this was for consultant job planning. In addition, the audit resource for the review of GP Out of Hours was used as part of our wider review of the Health Board's Primary Care directorate.

Further, we undertook an additional review within the Emergency Ambulance Services Committee (EASC) relating to non-emergency patient transport services. Where changes were made to the audit plan, the reasons were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review; the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

The Head of Internal Audit Annual Report provides a summary of the findings in each of the domains, and an assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.

The results of any audit work related to the Health and Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability Module.

Other assurance reviews which impact on the Head of Internal Audit opinion, including audit work performed in relation to systems operated by the NHS Wales Shared Services Partnership.

These detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed. In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, a number of assignments planned this year did not proceed to full audits following preliminary planning work as either management acknowledged that the present situation would only offer limited assurance or limited audit work has identified issues of concern – the significance of risk exposure for those has also been taken into account in forming the opinion across the Domains.

A summary of the related findings is outlined within the full Head of Internal Audit Annual Report.

DRAFT

Draft Audit Summary by Assurance Domain							
Assurance domain	**Audit count**	**Overall rating**	**Not rated**	**No assurance**	**Limited assurance**	**Reasonable assurance**	**Substantial assurance**
Corporate Governance, Risk and Regulatory Compliance	6		-	-	• Raising concerns	• Risk management • Wellbeing of Future Generations Act • Primary care directorate - management arrangements • Facilities directorate - management arrangements	• Primary Care Committee – Governance arrangements
Strategic Planning, Performance Management and Reporting	5		-	-	-	• Facilities directorate - management arrangements • Continuing Health Care • Performance management – follow up • Service Change plan	• Primary Care Directorate – Management arrangements
Financial Governance and Management	5		-	-	-	• Commissioning • Facilities directorate - Compliance • Primary Care directorate - Compliance	• Main financial systems • Welsh risk pool claims
Clinical Governance, Quality and Safety	4		-	-	• Medical equipment and devices	• JAG accreditation – follow up • AQS • Patient experience	-

DRAFT

Information Governance and Security	3		-	-	• *Cyber Security (Draft)*	• GDPR • IT systems - continuity	-
Operational Service and Functional management	3		-	-	-	• Facilities directorate - Compliance • Primary Care directorate – Compliance • Mobile phone arrangements	-
Workforce Management	5		-	-	• Retention of staff • Facilities directorate management arrangements -	• Mandatory training • Primary care directorate - management arrangements • Management of absence targets	-
Capital and Estates Management	4		-	-	• Water safety • Management of major capital - PCH	-	• Environmental sustainability • Carbon reduction commitment

DRAFT

WHSSC

Assurance domain	Audit count	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
WHSSC	4	-	-	-	● High cost drugs ● Review of network groups and advisory boards ● Risk management ● Governance arrangements	-

EASC

Assurance	Audit count	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
EASC	2	Non-Emergency Patient Transport Service – follow up of baseline review	-	-	● Governance and performance arrangements	-

Key to symbols:

● Audit undertaken within the annual Internal Audit plan

Italics Reports not yet finalised but have been issued in draft

DRAFT

7.2 Structured Assessment 2018 and Annual Audit Report 2018

Further information regarding reports published by the Wales Audit Office (WAO) is available via this link.

WAO undertakes its Structured Assessment to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources. The 2018 review concluded that:

> "…the Board continues to operate well, however, aspects of quality governance, risk management and oversight of ICT arrangements do require improvement. The Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones. Overall, financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. There is a need for continued action to address several significant workforce challenges, including factors driving the relatively high use of locum and agency staff. The Health Board focuses on delivery of its key access targets and has examples of innovative ways of working to improve efficiency and productivity."

The Annual Audit report recognised discharge planning and primary care services had some aspects of good practice but that there were also opportunities to strengthen arrangements for securing efficient and economical use of resources. It said the Health Board was participating in the National Fraud Initiative although limited use had been made of data matches released in 2017. It noted the administration of the Board meetings to be good with positive levels of scrutiny and challenge evidenced at both Board and committee meetings. The Quality, Safety and Risk Committee was noted to have a large agenda and it suggested reports be made more succinct with a review required of the work of the committee to prioritising workload and refine the information it receives to help support effective scrutiny. As a result, a Quality and Safety Governance Framework was developed and approved in February 2019. An implementation plan is now being developed to deliver this.

Whilst the report noted the development of a BAF (which is currently under review) and that a risk management strategy in place, it referenced the need to improve the operational identification, review and mitigation of risk. It highlighted the need for the organisation to demonstrate organisational learning and assurance that issues such as those in maternity services are not more widespread.

7.3 Counter Fraud

Until 31 March 2019, Counter Fraud Services are provided by the Cardiff and Vale University Health Board's Counter Fraud Service. (From 1 April 2019 onwards this service will be delivered via Swansea Bay University Health Board). The 2018/19 work plan was completed and covered all of the requirements in accordance with the Welsh Government Directions. The Counter Fraud Service provides regular reports and updates to members of the Executive Board and directly to the Audit Committee.

DRAFT

The Audit Committee received the Counter Fraud and Corruption Annual Report for 2018-2019 and updated on related work which was self-assessed and/or reviewed against the relevant "NHS Counter Fraud Standards for Providers – Fraud, Bribery and Corruption / NHS Standard" Contract.

8. CONCLUSION

This Governance Statement indicates that whilst progress continues to be made in some areas, the Health Board has faced a number of challenges with regards its quality governance and communication arrangements, which has contributed to, Welsh Government enhancing our organisational escalation status from 'Routine' to 'Enhanced' monitoring, in October 2018. During the year, the Royal College of Obstetricians & Gynaecologists and the Royal College of Midwives, jointly undertook a review of Maternity Services, commissioned by the Minister for Health & Social Services. The College report, which was damning and identified a number of failures in our service, was published on 30 April 2019. As a consequence the Minister for Health and Social Services increased our escalation level to 'Targeted' for the Organisation as a whole and put Maternity Services into 'Special' Measures, the highest level of escalation.

In addition to the above, there have been 7 areas of the business of our organisation reviewed during the last year, that have received 'limited' assurance ratings from Internal Audit and as a consequence, management action has been taken. A summary of the 7 reports outlined above, which have been considered by the Audit Committee, along with the relevant management actions taken and planned, will continue to be monitored by the Audit Committee and a follow up review of progress is also scheduled into the 2019/20 Internal Audit & Assurance Plan.

As the Accountable Officer, I will ensure that we learn from recent experiences, seek help from others and take the opportunity to adopt best practice so that with robust management and accountability frameworks, significant internal control problems do not occur in the future. However, if such situations do arise, swift and robust action will be taken, to be open about any failings, manage the event and to ensure that learning is spread throughout the organisation.

The revised planning guidance and our approved three-year Integrated Medium Term Plan for 2018-2021 sets out the strategy for the University Health Board and outlines high level objectives and key priority areas for progressing over the next three-years.

The boundary change from 1 April 2019, incorporating the responsibility for the commissioning and delivery of healthcare services for the Bridgend community into Cwm Taf Morgannwg UHB, brings a new set of challenges and opportunities for the organisation. The increased scale and complexity of the organisation will demand new ways of working and further strengthening of systems of governance.

My review confirms that there have been internal control issues, which have been identified during the year and in most of the related areas, addressed with the remedial action taken.

DRAFT

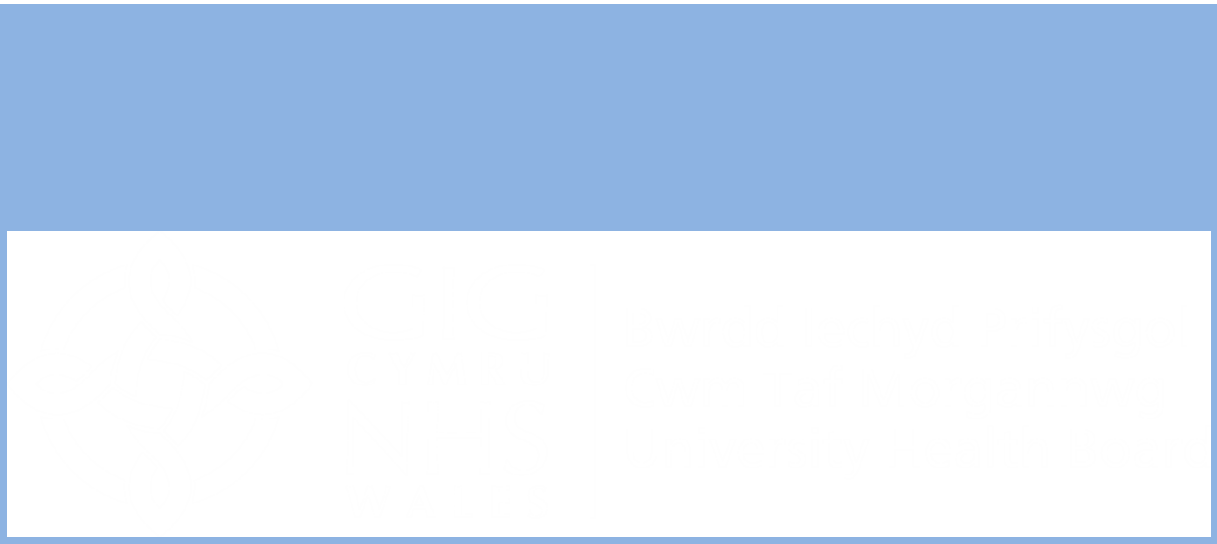
However, the Maternity Services external reports have identified significant issues associated with Quality Governance and the Board will need to address the identified learning and its application across the whole organisation.

The support provided by Welsh Government in light of our enhanced escalation status enables us to draw on the expertise of others to help improve and develop our governance arrangements and strengthen assurance internally and externally going forward.

MRS ALLISON WILLIAMS
CHIEF EXECUTIVE

Date: May 2019

DRAFT



Directors Report

2018-2019

The Directors' Report

The following tables contain:

Table 1 Board Level Committees and Advisory Groups

Table 2 Detailed information in relation to the composition of the Board and including Executive Directors, Independent Members, Associate Board Members and who have authority or responsibility for directing or controlling the major activities of Cwm Taf University Health Board during the financial year 2018-2019.

Table 3 Details of company directorships and other significant interests held by members of the Board which may conflict with the responsibilities as Board members.

Table 4 Details relating to membership of the Board level assurance committees and the Audit Committee.

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

DRAFT

Table 1

BOARD LEVEL COMMITTEES AND ADVISORY GROUP MEETINGS

The Board and its Committees are fully established and operating in line with the Board's Standing Orders. The following table outlines dates of Board (including Board Development Sessions) and Committee meetings held during 2018-2019.

Board/Committee / Group	April 18	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 19	Feb	Mar
Board (*Board Development Sessions)	26.4.18*	31.5.18	28.06.18 28.6.18*	26.7.18	30.8.18 30.8.18*	27.9.19	31.10.18*	29.11.18	20.12.18*	30.1.19	28.2.19*	28.3.18
Academic Partnership Board			7.6.18			13.9.18			11.12.18			
Audit Committee	16.4.19	18.5.18 31.5.18		9.7.18			8.10.18			14.1.19	11.2.18	
Charitable Funds							31.10.18					
Finance, Performance & Workforce Committee	19.4.18	24.5.18	21.6.18	19.7.18		20.9.18	25.10.18	22.11.18		24.1.19	21.2.19	
Integrated Governance Committee	26.4.18				30.8.18				20.12.18			
Mental Health Act Monitoring Committee		10.5.18			9.8.18			8.11.18				
Primary & Community Care Committee	4.4.18		27.6.18				10.10.18			9.1.19		
Remuneration and Terms of Service			28.6.18				31.10.18	29.11.18			28.2.19	
Stakeholder Reference Group	19.4.18		15.6.18		16.8.19	6.9.18	18.10.18		13.12.19		20.2.19	
Working in Partnership Forum							23.10.18		11.12.18			
Healthcare Professionals Forum				12.7.18								
Quality, Safety & Risk Committee		9.5.18				6.9.18			6.9.18			7.3.19

All meetings of the Board were quorate. There was only one Board Committee meeting which was inquorate and that was the Mental Health Act Monitoring Committee which met on 8 November 2018.

Table 2

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Marcus Longley	Chair	Board Remuneration and Terms of Service Committee (Chair); Charitable Funds Committee; Integrated Governance Committee;	Welsh Language	**8/8** **4/4** **1/1** **3/3**
Maria Thomas	Vice-Chair	Board Remuneration & Terms of Service Committee; Charitable Funds Committee; Integrated Governance Committee; Audit Committee; Quality, Safety & Risk Committee (Chair); Mental Health Act Monitoring Committee (Chair); Primary & Community Care Committee (Chair)	Safeguarding Volunteers Mental Health	**7/8** **3/4** **1/1** **2/3** **7/7** **4/4** **3/3** **4/4**
Paul Griffiths	Independent Member (Finance)	Board; Remuneration & Terms of Service Committee; Charitable Funds Committee; Audit Committee; Finance, Performance & Workforce Committee.	Capital (Design) Capital (Environ) Energy Management	**8/8** **4/4** **1/1** **7/7** **10/10**
James Hehir	Independent Member (Legal)	Board; Remuneration & Terms of Service Committee; Charitable Funds Committee; Quality, Safety & Risk Committee	Equality and Diversity Violence & Aggression	**7/8** **4/4** **1/1** **3/4**

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Mel Jehu	Independent Member	Board Remuneration and Terms of Service Committee; Charitable Funds Committee; Integrated Governance Committee; Finance, Performance & Workforce Committee (Chair) Mental Health Act Monitoring Committee.	Veterans Health Armed Forces	**6/8** **4/4** **1/1** **3/3** **10/10** **2/3**
Keiron Montague	Independent Member (Community)	Board; Remuneration & Terms of Service Committee; Charitable Funds Committee; Finance, Performance & Workforce Committee; Quality, Safety & Risk Committee; Primary & Community Care Committee	Cleanliness, Hygiene & Infection Control Corporate health standards	**7/8** **3/4** **0/1** **8/10 (1IP)** **3/4** **3/4**
Robert Smith	Independent Member (Local Authority)	Board; Remuneration & Terms of Service Committee; Charitable Funds Committee; Finance, Performance & Workforce Committee; Primary & Community Care Committee	Organ Donation	**5/8** **4/4** **1/1** **7/10 (1IP)** **4/4**
Chris Turner	Independent Member (Information Technology and Governance) (Until Jan 2019)	Board; Remuneration and Terms of Service Committee; Integrated Governance Committee; Charitable Funds Committee Audit Committee (Chair); Academic Partnership Board	Information Governance ICT Freedom of Information Raising Concerns	**5/6** **3/3** **3/3** **1/1** **5/5** **0/0**

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Gaynor Jones	Independent Member (Trade Union) (Until July 2018)	Remunerations & Terms of Service Committee; Quality, Safety & Risk Committee;		**0/1** **1/1**
Nicola Milligan	Independent Member (Trade Union) (From August 2018)	Board; Remunerations & Terms of Service Committee; Charitable Funds Committee; Quality, Safety & Risk Committee; Primary & Community Care Committee		**5/5** **3/4** **1/1** **2/2** **1/1**
Dilys Jouvenat	Independent Member (Third Sector) (From August 2018)	Board; Remunerations & Terms of Service Committee; Charitable Funds Committee; Audit Committee; Finance, Performance & Workforce Committee; Quality, Safety & Risk Committee	Raising Concerns Carers Vulnerable Adults Older People	**5/5** **3/3** **1/1** **3/3** **6/10** **1/2**
Gio Isingrini	Associate Board Member (Social Services)	Board		**3/8**
Phil White	Associate Member (Bridgend)	Board		**1/2**
Clare Llewellyn	Associate Member (Stakeholder Reference)	Board		**4/7**

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Allison Williams	Chief Executive	Board; Remuneration and Terms of Service Committee (**IA**); Charitable Funds Committee; Integrated Governance Committee; Emergency Ambulance Services Committee; Welsh Health Specialised Services Committee.		**8/8** **4/4** **1/1** **3/3** **6/6 (3 IA only)**
Steve Webster	Director of Finance & Procurement	Board; Charitable Funds Committee; Integrated Governance Committee; Audit Committee (**IA**); Finance, Performance & Workforce Committee (**IA**);		**8/8** **0/1** **3/3** **6/7** **9/10**
Stephen Harrhy	Board Director	Board; Charitable Funds Committee		**6/8** **1/1**
Kelechi Nnoaham	Director of Public Health	Board; Charitable Funds Committee; Integrated Governance Committee; Quality, Safety & Risk Committee (**IA**); Primary & Community Care Committee (**IA**)		**5/8 (1 IP)** **1/1** **1/3 (1IP)** **1/4** **3/4**
Alan Lawrie (Acting until substantive appointment in December 2018)	Director of Primary, Community & Mental Health	Board; Charitable Funds Committee; Integrated Governance Committee; Finance, Performance & Workforce Committee (**IA**); Quality, Safety & Risk Committee (**IA**); Mental Health Act Monitoring Committee (**IA**); Primary & Community Care Committee (**IA**).		**8/8** **1/1** **2/3** **6/10** **4/4** **2/3** **4/4**

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Ruth Treharne	Deputy Chief Executive /Director of Planning and Performance	Board; Charitable Funds Committee; Integrated Governance Committee; Finance, Performance & Workforce Committee; Primary & Community Care Committee (**IA**)		**7/8** **1/1** **3/3** **8/10 (2IP)** **3/4**
Joanna Davies	Director of Workforce & OD	Board; Remuneration & Terms of Service Committee (**IA**); Charitable Funds Committee; Integrated Governance Committee; Finance, Performance & Workforce Committee (**IA**); Quality, Safety & Risk Committee (**IA**); Primary & Community Care Committee (**IA**)		**6/8 (1 IP)** **4/4** **1/1** **2/3** **8/10 (2 IP)** **2/4** **0/4**
Kamal Asaad	Medical Director	Board; Charitable Funds Committee; Integrated Governance Committee; Quality, Safety & Risk Committee (**IA**); Primary & Community Care Committee (**IA**);		**6/8** **1/1** **2/3** **2/4** **0/4**
John Palmer (Acting until substantive appointment in December 2018)	Chief Operating Officer	Board; Charitable Funds Committee; Finance, Performance & Workforce Committee (**IA**); Quality, Safety & Risk Committee (**IA**).		**6/8** **0/1** **10/10 (4 IP)** **4/4**
Lynda Williams (until August 2018)	Director of Nursing, Midwifery and Patient Services	Board; Integrated Governance Committee; Quality, Safety & Risk Committee (**IA**); Primary & Community Care Committee (**IA**)		**3/3** **1/1** **1/1 IP** **1/2**

BOARD MEMBER	POSITION (AREA OF EXPERTISE)	BOARD COMMITTEE MEMBERSHIP	CHAMPION ROLE	BOARD & COMMITTEE ATTENDANCE 2018/19
Angela Hopkins (from September 2018)	Interim Director of Nursing, Midwifery & Patient Care	Board; Charitable Funds Committee; Integrated Governance Committee; Quality, Safety & Risk Committee (**IA**); Primary & Community Care Committee (**IA**)		**3/4** **1/1** **0/1** **3/3** **0/2**
Robert Williams (long term sick from September 2018 to March 2019)	Board Secretary / Director of Corporate Services & Governance	Board; Remuneration & Terms of Service Committee (**IA)**; Charitable Funds Committee (**IA**); Integrated Governance Committee; Audit Committee (**IA**); Quality, Safety & Risk Committee (**IA**); Also periodically attends a range of other Board Committee meetings on a regular basis.		**2/8** **1/3** **0/1** **1/3** **4/7** **1/4**
Gwenan Roberts	Interim Board Secretary (From September 2018 onwards into 2019)	Board; Remuneration & Terms of Service Committee (**IA**); Charitable Funds Committee (**IA**); Integrated Governance Committee; Audit Committee; Quality, Safety & Risk Committee (**IA**);		**5/6** **2/3** **1/1** **2/3 (1IP)** **2/3** **1/3**

Note – There are occasions when Directors are not able to attend Board Committee meetings that an Assistant Director attends on their behalf.
IA – in attendance
IP – present for part of meeting
N/A – Not applicable

Table 3 - DIRECTORS INTERESTS

Directors of the Board have declared the following interests which may be relevant to the business of the University Health Board.

Name	Designation	Nature of Interest
Marcus Longley	Independent Member Chair	Board Member, Professional Standards Authority for Health & Social Care.
Maria Thomas	Independent Member	Justice of the Peace. Executive Member, Macmillan Cancer Support Merthyr. Trustee Safe Merthyr Tydfil. Chair, Governors, Gwaunfarren School. Consultant Governor, South Wales Consortium. Executive Member, St John's Eye Hospital Jerusalem. Member of St Johns. Director of Winchfawr Investments.
Keiron Montague	Independent Member (Community)	Staff member of Cynon Taff Community Housing ending on 31/1/19. Trustee of Merthyr and the Valleys MIND Trustee of Full Circle Education CIC Independent Member of the Supporting People National Advisory Board. Staff member of Trivallis starting 4/2/19.
Mel Jehu	Independent Member (Community)	Independent Member of the Police Crime Panel for the South Wales Police Force. Trustee, Cancer Aid Merthyr Tydfil. Chair, RCT Council Standards Committee. Trustee Safer Merthyr Tydfil.

Name	Designation	Nature of Interest
James Hehir	Independent Member (Legal)	Director Llandarcy Park Ltd. Solicitor of the Supreme Court. HMCTS Clerk to the Dyfed Powys & North Wales Justices. Member, Law Society England & Wales. Member, Neath Port Talbot Law Society. Member, Swansea Law Society. Member, Neath Port Talbot Contact Centre. Council Member Justices' Clerks Society. Member Justices' Clerks Society. Associate Member Magistrates' Association. Honorary Vice President, West Glamorgan Magistrates' Association. Clerk to Neath Port Talbot Justices. Clerk to the Neath Port Talbot & Swansea Justices. Patron Neath YMCA. Member of the Liberal Democrats.
Paul Griffiths	Independent Member (Finance)	Nil Return.
Jayne Sadgrove	Independent Member (University)	Member of staff at Cardiff University. Daughter-in-law is a member of staff at the Royal Glamorgan Hospital.
Dilys Jouvenat	Independent Member (Third Sector)	Chair of RCT Citizens Advice they may be involved in delivering projects via SLA with the Health Board
Robert Smith	Independent Member (Local Authority)	Nil return.

Name	Designation	Nature of Interest
Nicola Milligan	Independent Member (Staff Side Representative)	RCN Welsh Board.
Allison Williams	Chief Executive	Trustee & Non-Executive Director – Workforce Development Trust (Formerly known as Skills for Health Limited) (Charitable Company- unpaid). Husband employed by Welsh Ambulance Services Trust.
Ruth Treharne	Deputy Chief Executive / Director of Planning & Performance	Nil return.
Stephen Harrhy	Board Director	Chief Ambulance Services Commissioner for Wales.
Robert Williams	Director of Governance & Corporate Services / Board Secretary	Wife is an employee of Cwm Taf UHB.
Gwenan Roberts	Interim Board Secretary	Partner works in the Blood Bank Pathology Dept., Royal Glamorgan Hospital.
Kelechi Nnoaham	Director of Public Health	Wife works for the Health Board.
John Palmer	Chief Operating Officer	Nil return.
Joanna Davies	Director of Workforce & Organisational Development	Nil return.

Name	Designation	Nature of Interest
Steve Webster	Director of Finance	Nil return.
Alan Lawrie	Director of Primary, Community and Mental Health	Nil return.
Kamal Asaad	Medical Director	Nil return.
Angela Hopkins	Interim Director of Nursing, Midwifery & Patient Services	Nil return.
Phillip White	Associate Board Member (Bridgend)	Director, The Clever Green Portal Company Ltd. Director, Whitedge Renewables. Trustee Board Member Care and Repair, Bridgend.
Gio Isingrini	Associate Board Member (Social Services)	Nil return.
Clare Llewellyn	Associate Member	Work as an Associate Trainer and external Quality Assurer for Agored Cymru. Freelance Internal Verifier for Valleys Kids. Husband works for ABMUHB at present and will transfer to Cwm Taf Morgannwg UHB in April 2019.
Lynda Williams (left 12/8/18)	Director of Nursing, Midwifery and Patient Services	Nil return.

Name	Designation	Nature of Interest
Gaynor Jones (left July 2018)	Independent Member	Chair RCN Welsh Board. Member RCN Trade Union Committee.
Christopher Turner (left 31/12/18)	Independent Member	Senior Professional Fellow (Honorary), Cardiff University. Independent Governor –Cardiff Metropolitan University. Interim Chair of EASC.
Collette Kiernan (left April 2018)	Chair, Health Professions Forum	Nil return.

Table 4 - Membership of the Board's Audit Committee

Paul Griffiths	Independent Member (Finance)	(Chair of Audit Committee) Member from October 2017
Maria Thomas	Vice Chair / Independent Member (Third Sector)	Member from 2014
Jayne Sadgrove	Independent Member (University)	Member from April 2016
Dilys Jouvenat	Independent Member	Member from August 2018

Environmental, Social and Community Issues

The Health Board as a large local employer and public service provider is cognisant of the impact it has on the environment and takes steps to minimise this, where possible. We take pride in running our healthcare services responsibly. We work hard to reduce our impact on the environment, to encourage staff to make healthy lifestyle choices and to strengthen our relationships with local people. Our strategic approach to sustainability ensures that we not only look at ways to reduce fixed costs such as energy, water and waste, but we also embed efficiency principles within our processes for procuring goods and services

In particular we shall:

- Ensure that all employees, including contractors, are responsible for working in a manner that protects the environment
- Integrate environmental management into operating procedures to ensure that long term and short term environmental issues are considered
- Ensure we remain committed to continual improvement and the prevention of pollution in all areas of potential environmental impact; and
- Ensure compliance with all relevant environmental legislation, Health and Care Standards for Wales and Welsh Government Directives.

Building on the good progress made over recent years, the organisation continues to bring together both the behavioural and technical elements of change and are improving communicaiton through a variety of media platforms to strengthen our environmental, social and community responsibilities.

In reducing our environmental impact, we will:

- Reduce the consumption of finite resources, removing waste where possible

- Adopt a carbon based management approach specifically aimed at reducing CO2 emissions generated by energy, waste and transport by meeting the Welsh Government target objective of a 3% year on year reduction in our carbon footprint, and to work to extend this target and reduce energy costs;
- We will also look to purchase or produce a portion of energy from renewable sources
- Promote the minimization of waste generated through Health Board activities and reduce the environmental impact of waste disposal wherever possible by diverting waste from landfill and maximizing recycling opportunities
- Adopt site specific travel plans, which encourage shift away from single occupancy car journeys to more sustainable modes of transport such as public transport, car sharing and active travel, and
- Integrate the principles of sustainable development into every day purchasing decisions.

The Board's Sustainability Report will provide more specific detail on progress against this work over the year and this will feature prominently within the Health Board's Annual Report.

Statement of Accountability

2018-2019

Statement of the Chief Executive's responsibilities as Accountable Officer of Cwm Taf University Health Board

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer to the LHB. 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.

As Accountable Officer I can confirm that as far as I am aware there is no relevant audit information of which Cwm Taf University Health Board's auditors are unaware, and as Accountable Officer, I have taken all the steps that ought to have been taken to ensure that I am aware of any relevant audit information and can confirm that when required I have ensured WAO are aware of this information.

I can confirm that the annual report and accounts as a whole is fair, balanced and understandable and I take personal responsibility for these and the judgement required for doing so.

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

Date:

Allison Williams
Chief Executive

Statement of Directors Responsibilities

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

In preparing those accounts, the Directors are required to:

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

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

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

By Order of the Board

Signed:

On behalf of the Chair: Marcus Longley Dated:

Chief Executive: Allison Williams Dated:

Director of Finance: Steve Webster Dated:

Remuneration and Staff Report

2018-2019

Remuneration Relationship

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

The banded remuneration of the highest-paid director in the LHB in the financial year 2018-19 was £180,000 - £185,000 (2017-18, £175,000 - £180,000). This was 6.4 times (2017-18, 6.4) the median remuneration of the workforce, which was £28,442 (2017-18, £27,889).

In 2018-19, 5 (2017-18, 9) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £183,001 to £210,000 (2017-18 £177,001 to £253,000).

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.

Whole Workforce Profile

Extract as at 31 March 2019	Female		Male		Totals	
Staff Group	**FTE**	**Headcount**	**FTE**	**Headcount**	**FTE**	**Headcount**
Add Prof Scientific and Technical	175.03	214	85.15	94	260.19	308
Additional Clinical Services	1087.99	1256	229.08	241	1317.07	1497
Administrative and Clerical	1246.58	1457	264.59	270	1511.17	1727
Allied Health Professionals	350.72	387	84.56	85	435.28	472
Estates and Ancillary	467.59	704	273.03	292	740.61	996
Healthcare Scientists	96.52	106	58.00	59	154.52	165
Medical and Dental	273.42	299	362.06	383	635.48	682
Nursing and Midwifery Registered	2062.98	2284	210.35	218	2273.34	2502
Students	3.61	3	1.00	1	4.61	4
Grand Total	5764.46	6710	1567.82	1643	7332.27	8353

Gender analysis of Directors

Board Member	Female	Male
Independent Member	4	8 (1 part year)
Associate Member	0	2
Directors (Executive and Directors)	4 (1 part year)	8 (1 part year)

Sickness Absence Data

The following table details the sickness absence data and provides a comparison of information with 2017-2018 and 2016-2017.

	2018-2019	2017-2018	2016-2017
Days lost (long term – 28 days and over)	**119,240.85**	**107,215.37**	**108,289.95**
Days lost (short term)	**35,456.34**	**37,899.05**	**38,439.20**
Total days lost	**154,697.19**	**145,114.42**	**146,729.15**
Total staff years	**7310.85**	**7229.18**	**7114.21**
Average working days lost	**13.24**	**12.11**	**12.90**
Total staff employed in period headcount)	**8353**	**8277**	**8142**
Total staff employed in period with no absence (headcount)	**2775**	**3212**	**3211**
Percentage of staff with no sick leave	**38%**	**39%**	**39%**

Anxiety / Stress and musculoskeletal (31%) and also Other Musculoskeletal Problems (11.5%) problems remain the top reasons and account for 42.5% of all sickness absence. A comprehensive programme of work is in place, working with staff side partners to address sickness absence rates applying the all Wales Sickness Absence Policy.

Expenditure on consultancy

Consultancy services are the provision to management of advice and assistance relating to strategy, structure, management or operations of an organisation in pursuant of its objectives.

During the year, the Health Board spent £349,000 on external consultancy services.

Tax Assurance for Off-Payroll Appointees

Off Payroll information will be collated alongside WF & OD by the end of the month to ensure that there is information at the end of the 'link' when the final is submitted.

Reporting of other compensation schemes - exit packages					
Exit packages cost band (including any special payment element)	**2018-19**	**2018-19**	**2018-19**	**2018-19**	2017-18
	Number of compulsory redundancies	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	2
£25,000 to £50,000	0	0	0	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	3
	2018-19	**2018-19**	**2018-19**	**2018-19**	2017-18
Exit packages cost band (including any special payment element)	**Cost of compulsory redundancies**	**Cost of other departures**	**Total cost of exit packages**	**Cost of special element included in exit packages**	Total cost of exit packages
	£'s	**£'s**	**£'s**	**£'s**	£'s
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	37,289
£25,000 to £50,000	0	0	0	0	48,515
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	85,804

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. No applications for VERS were made and/or agreed during 2018/19.

Statement on Remuneration Policy

The remuneration of Senior Managers who are paid on the Very Senior Managers Pay Scale is determined by the Welsh Government and the UHB 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 UHB is able to award incremental uplift within the pay scale and should an increase be considered outside the range, a job description is submitted to WG for job evaluation. There are clear guidelines in place with regards to the awarding of additional increments and during the year there have not been any additional payments agreed. No changes to pay have been considered by the Committee outside these arrangements. The UHB does not have a system for performance related pay for its Very Senior Managers.

In addition to Very Senior Managers the UHB has a number of employment policies which ensure that pay levels are fairly and objectively reviewed for all other staff.

There is an All Wales Pay Progression Policy which from 1 April 2016 links staff performance through their pay scale and also a local UHB Policy for the re-evaluation of a post which requires individuals and their managers to submit a revised job description for job matching by matching panels comprised of management and staff representatives. The Agenda for Change job matching process is utilised and all results are recorded on the Job Evaluation system. For medical and dental staff the UHB complies with medical & dental terms and conditions which apply to medical remuneration.

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

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

Cwm Taf University Local Health Board Salary and Pension benefits of Senior Managers						
Single Total Figure of Remuneration 2018-19	**Salary**	**Benefits in kind (taxable)**	**Pension benefits**	**Pension benefits**	**Pension benefits**	**Total**
			1995 scheme	**2008 scheme**	**2015 scheme**	
	(bands of £5,000)	**to nearest £100**	**to nearest £1000**	**to nearest £1000**	**to nearest £1000**	**(bands of £5,000)**
Executive Directors	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Mrs A J Williams	180-185	0	6	n/a	43	225-230
Chief Executive						
Mr S J Webster	160-165	0	n/a	n/a	n/a	160-165
Director of Finance from 11th April 2018 (Note 1)						
Mr M Thomas	0-5	0	25	n/a	n/a	25-30
Interim Director of Finance to 10th April 2018 (Note 2)						
Mr J Palmer	125-30	0	n/a	1	30	155-160
Chief Operating Officer						
Mr A Lawrie	110-115	956	**	n/a	0	**
Director of Primary, Community & Mental Health Services		**Information received from NHS Pensions is incomplete.				
Mr K Asaad	155-160	0	8	n/a	n/a	165-170
Medical Director						
Mrs L Williams	40-45	0	0	0	0	40-45
Director of Nursing, Midwifery and Patient Services to 10th August 2018						
Professor A Hopkins	70-75	0	0	0	0	70-75
Director of Nursing, Midwifery and Patient Services from 3rd September 2018						
Ms R Treharne	130-135	0	0	n/a	30	160-165
Director of Planning and Performance / Deputy Chief Executive						
Mrs J M Davies	125-130	0	0	n/a	n/a	125-130
Director of Workforce and Organisational Development						
Dr K Nnoaham	125-130	0	n/a	6	31	165-170
Director of Public Health						
Mr R Williams	95-100	0	0	n/a	24	120-125
Director of Corporate Services & Governance/Board Secretary(Note 3)						
Miss G Roberts	45-50	0	64	n/a	20	130-135
Interim Board Secretary from 1st September 2018						

DRAFT

Independent Members	Salary	Benefits in kind (taxable)	Pension benefits	Pension benefits	Pension benefits	Total
			1995 scheme	2008 scheme	2015 scheme	
	(bands of £5,000)	to nearest £100	to nearest £1000	to nearest £1000	to nearest £1000	(bands of £5,000)
Prof M Longley	55-60	0				55-60
Chair						
Mrs M Thomas	45-50	0				45-50
Vice Chair						
Mr P Griffiths	10-15	0				10-15
Independent Member (Finance)						
Mr J Hehir	10-15	0				10-15
Independent Member (Legal)						
Dr. C B Turner	10-15	0				10-15
Independent Member (ICT Information Governance) to 31 Dec 2018						
Mr K Montague	10-15	0				10-15
Independent Member (Community)						
Cllr R Smith	10-15	0				10-15
Independent Member (Elected Representative)						
Mr M Jehu	10-15	0				10-15
Independent Member						
Mrs J Sadgrove (nee Dowden)	0	0				0
Independent Member (University) (Note 4)						
Mrs G Jones	0	0				0
Independent Member (Staff) to 11th April 2018 (Note 5)						
Mrs N D Milligan	0	0				*0*
Independent Member (Staff) from 30th August 2018 (Note 6)						
Mrs. D Jouvenat	5-10	0				5-10
Independent Member (Third Sector) from 30th August 2018						

Mr G Isingrini, Mrs C Llewellyn (01/04/2018-21/02/2019), Mrs C Kiernan (01/04/2018-07/05/2018) and Cllr P White (01/12/2018-31/03/2019) received no remuneration for their role as Associate Members Independent Members do not receive pensionable remuneration for their Board membership. Salary figures relate to remuneration for the period as Senior Manager only. Pension benefits relate to benefits accrued during the year, not just the period relating to their senior management service. Benefits in kind relates to lease car (figures given in hundreds).
Notes
1 - Mr S Webster chose not to be covered by the NHS pension arrangements during the reporting year.
2 - Mr M Thomas received additional remuneration which relates to payments received for other duties.
3 - Mr R Williams was absent from 1st April 2018 to 31st March 2019
4 - Mrs J Sadgrove (nee Dowden) receives no remuneration from Cwm Taf UHB for her role as Independent Member.
5 - Ms G Jones was a paid, full time employee of the organisation and received no additional remuneration as an Independent Member.
6 - Mrs ND Milligan is a paid, full time employee of the organisation and receives no additional remuneration as an Independent Member.

Salary and Pension benefits of Senior Managers Single Total Figure of Remuneration 2017-18	Salary	Benefits in kind(taxable)	Pension benefits	Pension benefits	Pension benefits	Total
			1995 scheme	2008 scheme	2015 scheme	
	(bands of £5,000)	to nearest £100	to nearest £1000	to nearest £1000	to nearest £1000	(bands of £5,000)
	£000	£00	£000	£000	£000	£000
Executive Directors						
Mrs A J Williams	175-180	0	11	n/a	41	225-230
Chief Executive						
Mr S J Webster	35-40	0	0	n/a	n/a	35-40
Director of Finance / Deputy Chief Executive to 26th June 2017						
Mr M Thomas	95-100	0	30	n/a	n/a	125-130
Interim Director of Finance from 17th June 2017 (Note 1)						
Mr J Palmer	120-125	2	n/a	0	28	150-155
Director of Primary, Community & Mental Health Services to 31st January 2018 and Interim Chief Operating Officer from 1st February 2018						
Mr A Lawrie	20-25	16	0	n/a	61	80-85
Director of Primary, Community & Mental Health Services from 21st January 2018						
Mr K Asaad	155-160	5	8	n/a	n/a	160-165
Medical Director						
Mrs L Williams	115-120	0	17	n/a	n/a	130-135
Director of Nursing, Midwifery and Patient Services						
Ms R Treharne	125-130	0	43	n/a	5	175-180
Director of Planning and Performance Deputy Chief Executive from 1st July 2017						
Mrs J M Davies	125-130	0	88	n/a	n/a	210-215
Director of Workforce and Organisational Development						
Mr C White	80-85	0	55	n/a	n/a	135-140
Director of Therapies and Health Science/Chief Operating Officer to 30th Nov 2017						
Mrs K McGrath	15-20	0	83	n/a	n/a	100-105
Interim Chief Operating Officer from 1st December 2017 to 29th January 2018 (Note 2)						
Dr K Nnoaham	125-130	0	n/a	0	57	185-190
Director of Public Health						
Mr R Williams	100-105	0	**	n/a	5	**
Director of Corporate Services & Governance/ Board Secretary	**Information received from NHS Pensions is incomplete.					

Independent Members	Salary	Benefits in kind(taxable)	Pension benefits	Pension benefits	Pension benefits	Total
			1995 scheme	2008 scheme	2015 scheme	
	(bands of £5,000)	to nearest £100	to nearest £1000	to nearest £1000	to nearest £1000	(bands of £5,000)
	£000	£00	£000	£000	£000	£000
Dr CDV Jones	25-30	0				25-30
Chairman to 30th September 2017						
Prof M Longley	25-30	0				25-30
Chair from 1st October 2017						
Prof D M Mead	35-40	0				35-40
Vice Chair to 31st December 2017						
Mrs M Thomas	20-25	0				20-25
Independent Member to 31st Dec 2017/Vice Chair from 1st Jan 2018						
Mr J L Hill-Tout	5-10	0				5-10
Independent Member to 30th September 2017						
Mr P Griffiths	5-10	0				5-10
Independent Member from 1st October 2017						
Mr A R Seculer	5-10	0				5-10
Independent Member to 30th September 2017						
Mr J Hehir	5-10	0				5-10
Independent Member from 1st October 2017						
Cllr Clive Jones	5-10	0				5-10
Independent Member to 30th September 2017						
Dr. C B Turner	10-15	0				10-15
Independent Member						
Mr K Montague	5-10	0				5-10
Independent Member (Local Authority) to 30th April 2017						
Independent Member (Community) from 1st October 2017 (Note 3)						
Cllr R Smith	5-10	0				5-10
Independent Member from 1st October 2017						
Mr M Jehu	10-15	0				10-15
Independent Member						
Mrs J Sadgrove (nee Dowden)	0	0				0
Independent Member (Note 4)						
Mrs G Jones	0	0				0
Independent Member (Note 5)						

Mr G Isingrini,Mrs C Llewellyn and Mrs C Kiernan received no remuneration for their role as Associate Members Independent Members do not receive pensionable remuneration for their Board membership. Salary figures relate to remuneration for the period as Senior Manager only. Pension benefits relate to benefits accrued during the year, not just the period relating to their senior management service. Benefits in kind relates to lease car and salary sacrifice benefits and mileage allowances received in excess of the Inland Revenue tax free rate (figures given in hundreds).
Notes
1 - Mr M Thomas received additional remuneration which relates to payments received for other duties.
2 - Mrs K McGrath received additional remuneration which relates to payments received for other duties.
3 - Mr K Montague was also an Associate Member from 1st May 2017 to 30th September 2017 but received no remuneration for this role.
4 - Mrs J Dowden receives no remuneration from Cwm Taf UHB for her role as Independent Member.
5 - Ms G Jones is a paid, full time employee of the organisation and receives no additional remuneration as an Independent Member.

Pension Benefits 2018-19	Real increase in pension at pensionable age	Real increase in pension lump sum at pensionable age	Total accrued pension at pensionable age at 31 March 2019	Lump sum at pensionable age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
Name and title	**(bands of £2,500)**	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**				
Executive Directors	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mrs A J Williams 1995 Pension Scheme	0-2.5	0-2.5	50-55	160-165	1143	992	121	0
Mrs A J Williams 2015 Pension Scheme	2.5-5	0	10-15	0	142	83	30	0
Chief Executive (Note 1)								
Mr S J Webster	n/a	n/a	n/a	n/a	n/a	1938	n/a	n/a
Director of Finance from 11th April 2018 (Note 2)								
Mr M Thomas	0-2.5	0-2.5	20-25	60-65	476	385	2	0
Interim Director of Finance to 10th April 2018								
Mr J Palmer 2008 Pension Scheme	0-2.5	0	0-5	0	17	14	3	0
Mr J Palmer 2015 Pension Scheme	0-2.5	0	5-10	0	99	59	20	0
Chief Operating Officer (Note 3)								
Mr A Lawrie 1995 Pension Scheme	**	**	**	**	**	**	**	0
Mr A Lawrie 2015 Pension Scheme	0-2.5	0	5-10	0	106	82	7	0
Director of Primary, Community & Mental Health Services	**Information received from NHS Pensions is incomplete.							
Mr K Asaad	0-2.5	2.5-5	65-70	200-205	n/a	n/a	n/a	0
Medical Director (Note 4)								
Mrs L Williams	0	0	40-45	160-165	n/a	1254	n/a	0
Director of Nursing, Midwifery and Patient Care to 10th August 2018 (Note 5)								
Professor A Hopkins	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Director of Nursing, Midwifery and Patient Care from 3rd September 2018 (Note 6)								
Ms R Treharne 1995 Scheme	0	0	50-55	150-155	1,095	961	105	0
Ms R Treharne 2015 Scheme	0-2.5	0	0-5	0	49	14	16	0
Director of Planning and Performance								
Deputy Chief Executive (Note 7)								

Mrs J M Davies	0-2.5	0-2.5	45-50	135-140	1,058	923	89	0
Director of Workforce and Organisational Development								
Dr K Nnoaham 2008 Pension Scheme	0-2.5	0	10-15	0	144	116	24	0
Dr K Nnoaham 2015 Pension Scheme	0-2.5	0	5-10	0	104	62	22	0
Director of Public Health								
Mr R Williams 1995 Pension Scheme	0	0	40-45	125-130	945	855	64	0
Mr R Williams 2015 Pension Scheme	0-2.5	0	0-5	0	38	11	13	0
Director of Corporate Services & Governance/ Board Secretary (Note 8) (Note 9)								
Miss G Roberts 1995 Pension Scheme	0-2.5	2.5-5	30-35	90-95	664	527	71	0
Miss G Roberts 2015 Pension Scheme	0-2.5	0	5-10	0	70	43	9	0
Acting Director of Corporate Services & Governance/ Board Secretary from 1st September 2018								
Notes:								
1.- Mrs A J Williams transferred from the 1995 pension scheme to the 2015 pension scheme on 1 February 2016								
2.- Mr S Webster chose not to be covered by the NHS pension arrangements during 2018-19								
3.- Mr J Palmer transferred from the 2008 pension scheme to the 2015 pension scheme on 1 April 2015								
4.- Mr K Asaad is over the normal retirement age for 1995 Section members, therefore a CETV is not applicable								
5.- Ms L Williams retired on 12th August 2018, therefore a CETV is not applicable								
6.- Professor A Hopkins is a member of the NEST (National Employment Savings Trust). The UHB is contributing to the NEST scheme in respect of this member. The UHB was unable to obtain pension benefit information from NEST in time for publication, however as the UHB has only paid £403 Employers Pension Contributions to this scheme in regard to Mrs A Hopkins it does not expect the pension benefit to be material.								
7.- Ms R Treharne transferred from the 1995 pension scheme to the 2015 pension scheme on 1 October 2017								
8.- Mr R Williams transferred from the 1995 pension scheme to the 2015 pension scheme on 1 October 2017								
9.- Mr R Williams was absent from 1st April 2018 to 31st March 2019								

The NHS Pension scheme which is open to all NHS employees requires all members to contribute on a tiered scale from 5% up to 14.5% of their pensionable pay depending on total earnings, with the employers contributing 14.3%.

Pensionable pay is determined by the number of years pensionable service and is related to the level of earnings/final salary at the time of retirement. Pension contributions of Executive Directors are entirely consistent with the standard NHS Pension Scheme. Pension benefits are calculated on the same basis for all members.

As Independent members do not receive pensionable remuneration for Board duties, there will be no entries in respect of pensions for Independent members

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
Real Increase in CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. In October 2018 the factors used to calculate the CETV increased which will have affected the values disclosed.

National Assembly for Wales Accountability and Audit Report

2018-2019

Where the Health Board undertakes an activity which is not funded directly by the WG the Health board receives and income to cover its costs. Further detail of income received is published in the health board's annual accounts.

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

Remote Contingent Liabilities

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

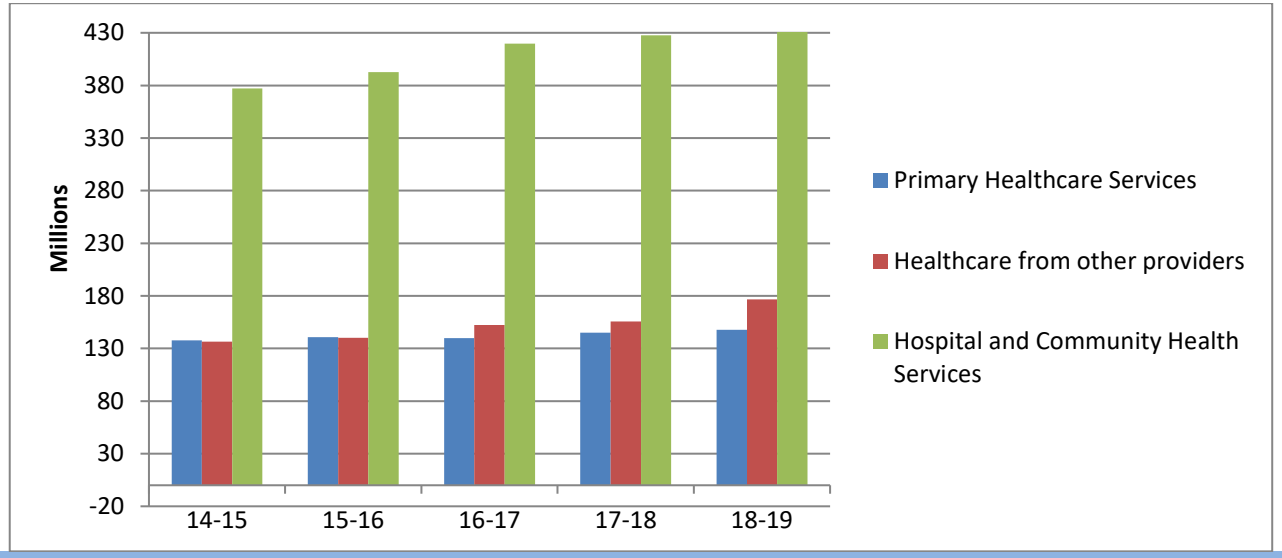
	2018-2019	2017-2018
	£000	£000
Guarantees	-	-
Indemnities	1,025	1,050
Letter of Comfort	-	-
Total	**1,025**	**1,050**

Miscellaneous income

	2014-15	2015-16	2016-17	2017-18	2018-19
	£000	£000	£000	£000	£000
Miscellaneous Income	72,996	79,386	80,188	82,852	102,517

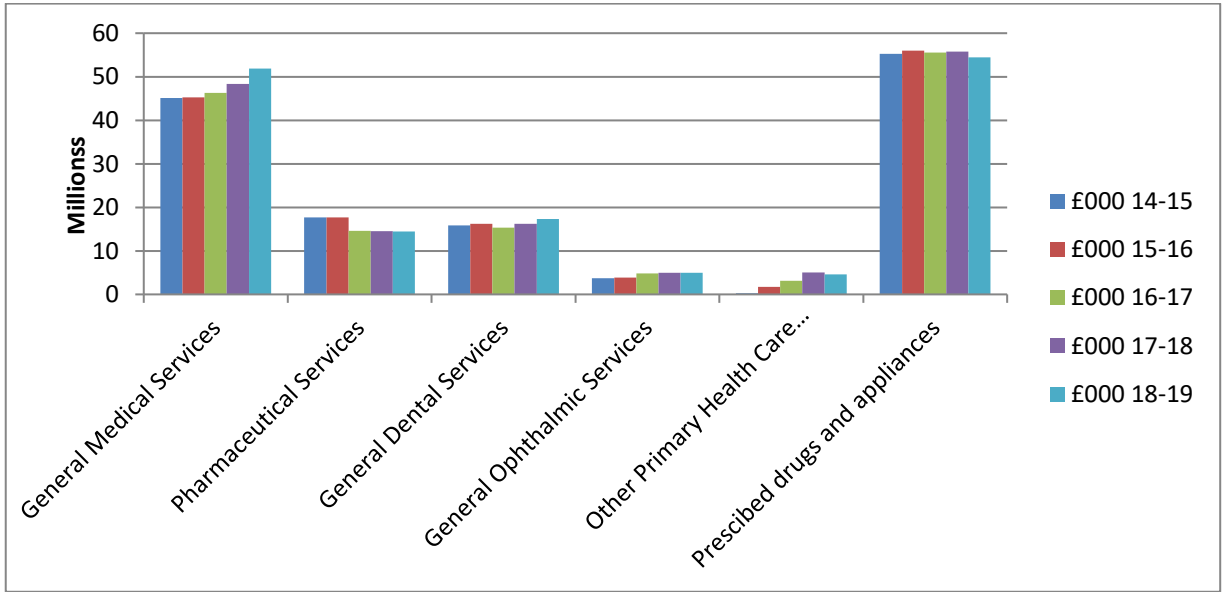
Cwm Taf University Health Board - Trend Statistics
Analysis of Expenditure of Cwm Taf Health Board activities (excluding WHSSC/EASC)

Operating Expenses	**£000**	**£000**	**£000**	**£000**	**£000**	**%**	**%**	**%**	**%**	**%**
	14-15	15-16	16-17	17-18	18-19	14-15	15-16	16-17	17-18	18-19
Primary Healthcare Services	137,847	140,777	139,733	144,853	147,605	21.16	20.90	19.63	19.89	18.69
Healthcare from other providers	136,533	140,060	152,234	155,798	176,628	20.96	20.80	21.39	21.40	22.36
Hospital and Community Health Services	377,116	392,669	419,847	427,501	465,602	57.88	58.30	58.98	58.71	58.95
Total	651,496	673,506	711,814	728,152	789,835	100.00	100.00	100.00	100.00	100.00



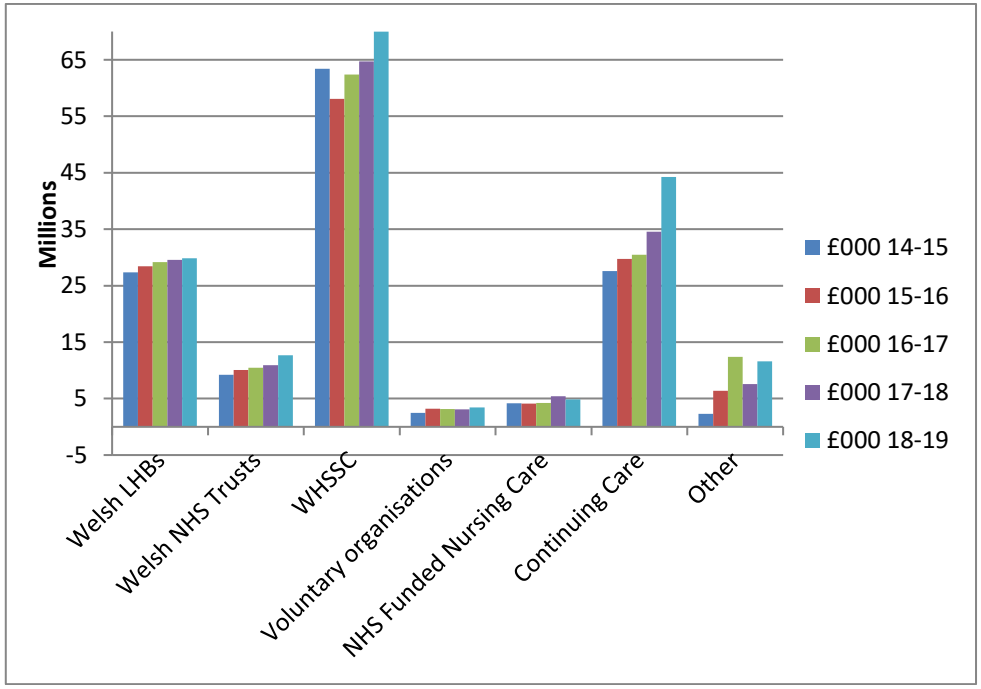
Expenditure on Primary Healthcare Services	**£000 14-15**	**£000 15-16**	**£000 16-17**	**£000 17-18**	**£000 18-19**	**% 14-15**	**% 15-16**	**% 16-17**	**% 17-18**	**% 18-19**

General Medical Services	45,143	45,283	46,280	48,327	51,875	32.75	32.17	33.12	33.36	35.14
Pharmaceutical Services	17,669	17,720	14,612	14,512	14,479	12.82	12.59	10.46	10.02	9.81
General Dental Services	15,849	16,238	15,358	16,214	17,285	11.50	11.53	10.99	11.19	11.71
General Ophthalmic Services	3,694	3,839	4,793	4,941	4,949	2.68	2.73	3.43	3.41	3.35
Other Primary Health Care expenditure	265	1,727	3,150	5,050	4,588	0.19	1.23	2.25	3.49	3.11
Prescribed drugs and appliances	55,227	55,970	55,540	55,809	54,429	40.06	39.76	39.75	38.53	36.87
Total	137,847	140,777	139,733	144,853	147,605	100	100	100	100	100

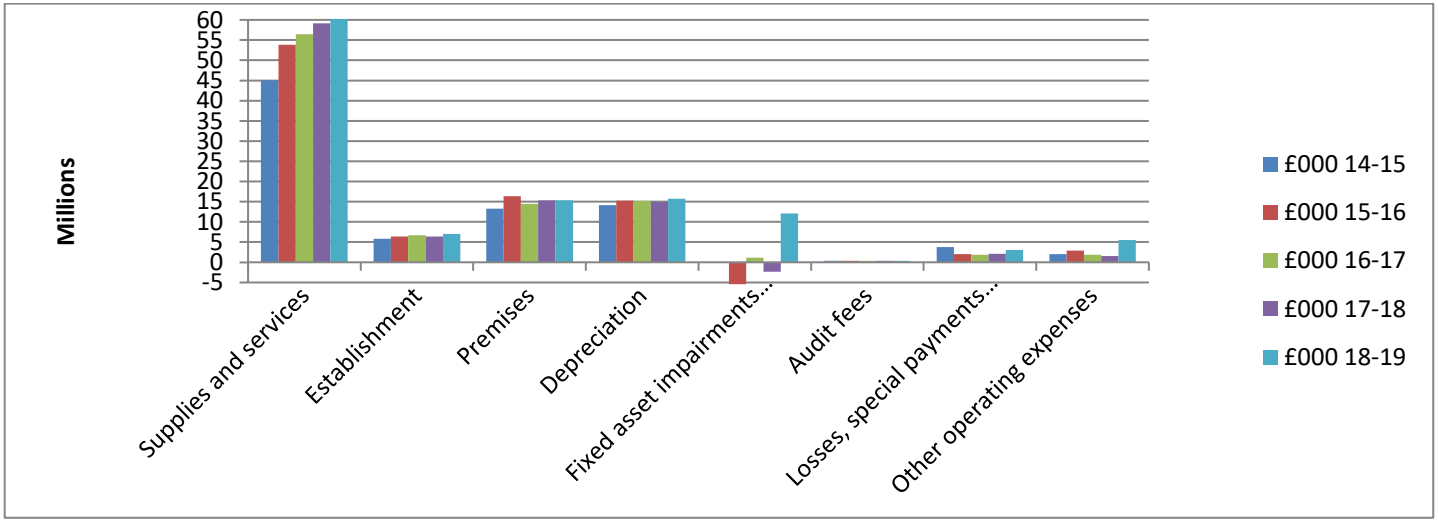


	£000	£000	£000	£000	£000	%	%	%	%	%

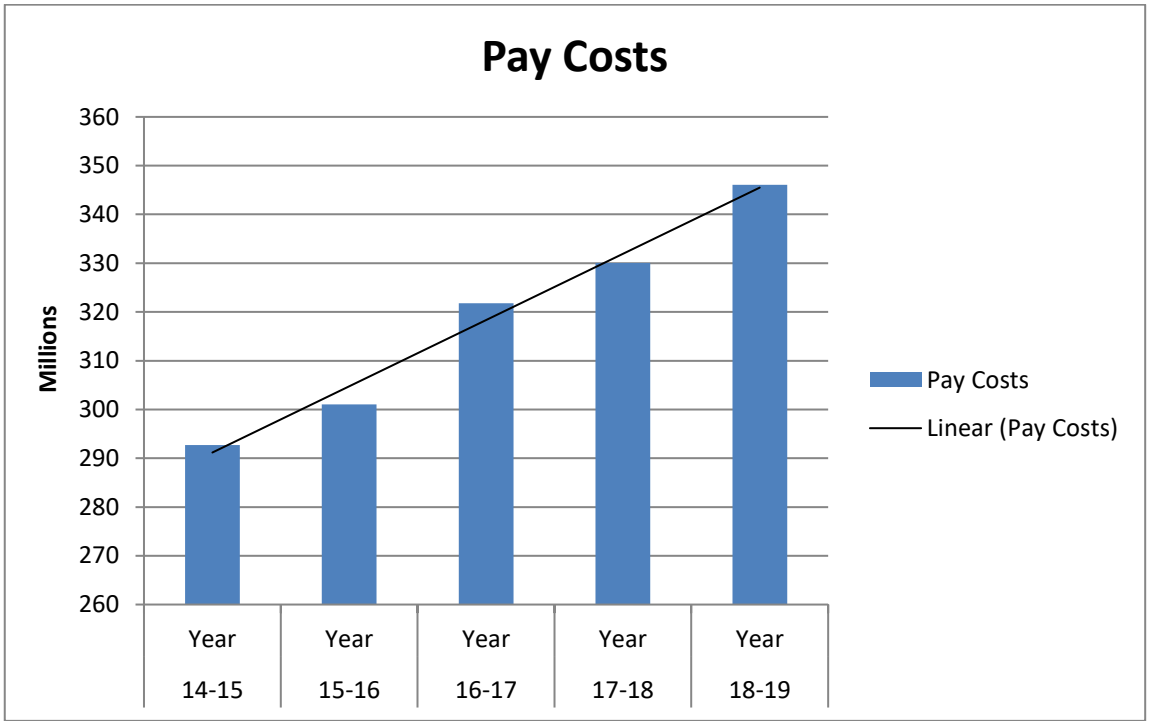
Expenditure on Healthcare from other providers	14-15	15-16	16-17	17-18	18-19	13-14	14-15	15-16	17-18	18-19
Welsh LHBs	27,382	28,438	29,195	29,549	29,842	20.06	20.30	19.18	18.97	16.90
Welsh NHS Trusts	9,199	10,062	10,482	10,932	12,689	6.74	7.18	6.89	7.02	7.18
WHSSC	63,410	58,097	62,361	64,727	69,963	46.44	41.48	40.96	41.55	39.61
Voluntary organisations	2,458	3,227	3,133	3,102	3,451	1.80	2.30	2.06	1.99	1.95
NHS Funded Nursing Care	4,165	4,116	4,209	5,400	4,867	3.05	2.94	2.76	3.47	2.76
Continuing Care	27,606	29,756	30,488	34,526	44,242	20.22	21.25	20.03	22.16	25.05
Other	2,313	6,364	12,366	7,562	11,574	1.69	4.54	8.12	4.85	6.55
Total	136,533	140,060	152,234	155,798	176,628	100	100	100	100.00	100.00



Expenditure on Hospital and Community Health Services	£000 14-15	£000 15-16	£000 16-17	£000 17-18	£000 18-19	% 14-15	% 15-16	% 16-17	% 17-18	% 18-19
Supplies and services	45,068	53,804	56,477	59,146	60,447	53.39	58.70	57.61	60.69	50.58
Establishment	5,788	6,350	6,722	6,418	7,000	6.86	6.93	6.86	6.59	5.86
Premises	13,290	16,342	14,422	15,305	15,353	15.74	17.83	14.71	15.70	12.85
Depreciation	14,114	15,254	15,157	14,934	15,765	16.72	16.64	15.46	15.32	13.19
Fixed asset impairments and reversals	0	-5,422	1,145	-2,325	12,046	0.00	-5.92	1.17	-2.39	10.08
Audit fees	366	366	361	355	352	0.43	0.40	0.37	0.36	0.29
Losses, special payments and irrecoverable debts	3,762	2,031	1,877	2,070	3,062	4.46	2.22	1.91	2.12	2.56
Other operating expenses	2,021	2,927	1,872	1,555	5,480	2.39	3.19	1.91	1.60	4.59
Total	84,409	91,652	98,033	97,458	119,505	100	100	100	100	100



Expenditure on Hospital and Community Health Services - Staff Costs	14-15 Year	15-16 Year	16-17 Year	17-18 Year	18-19 Year
Pay Costs	292,707	301,017	321,814	330,043	346,097



Performance against Resource Limits: **Revenue Resource Performance**	**2014-15 £'000**	**2015-16 £'000**	**2016-17 £'000**	**2017-18 £'000**	**2018-19 £'000**
Net operating costs for the year	578,655	594,251	631,729	645,338	687,347
Less general ophthalmic services expenditure and other non-cash limited expenditure	(3,643)	(4,269)	(1,181)	(784)	(725)
Less revenue consequences of bringing PFI schemes onto SoFP	(105)	(111)	(111)	(119)	(120)
Total operating expenses	574,907	589,871	630,437	644,435	686,502
Revenue Resource Allocation	574,937	589,893	630,455	644,458	686,518
Under /(over) spend against Allocation	30	22	18	23	16

Capital Resource Performance	**2014-15 £'000**	**2015-16 £'000**	**2016-17 £'000**	**2017-18 £'000**	**2018-19 £'000**
Gross capital expenditure	20,475	9,542	17,748	34,962	27,283
Add: Losses on disposal of donated assets	0	0	0	0	0
Less NBV of property, plant and equipment and intangible assets disposed	(1,252)	(102)	(66)	(4)	0
Less capital grants received	0	(60)	0	0	0
Less donations received	(19)	(3)	(95)	(64)	(3,115)
Charge against Capital Resource Allocation	19,204	9,377	17,587	34,894	24,168
Capital Resource Allocation	19,207	9,385	17,592	34,902	24,178
(Over) / Underspend against Capital Resource Allocation	3	8	5	8	10

Management Responses to Outstanding Audit Actions (May 2019) Appendix 1a

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Fire Management	Opportunities will be explored to better capture information, including developing the NWSSP: SES database and improve reporting from Divisions and Directorates. (D)	High	Director of Corporate Services & Governance/Board Secretary	Head of Operational Health, Safety & Fire Director of Corporate Services & Governance	Agreed. The key issue is the absence of meaningful management information and the limitations of a national software system, which results in workarounds being developed. Significant effort is made to ensure that the fire risk assessments are completed adequately; however, the 'Fire Auditing and Reporting System' cannot provide accurate/ up-to-date information for discussion with directorate managers. Noting the limitations of the national system, there are a number of local systems in place as a workaround, however this results in duplication. In the first instance, the issue will be raised with NWSSP: SES to request improvement of the national system, and advise on what action can be taken nationally to address this concern. Update May 2019 : A meeting took place with Shared Services Facilities and Estates Services in March 2019 where future options were discussed. An outline case will be developed for the provision of a new system to replace the existing one in 2019. However, this particular matter is not within the gift of the Health Board to resolve. Work is being taken forward with Operational lead Directors to strengthen reporting on Fire Management matters via the Clinical Business Meetings (CBMs) and/or Directorate Integrated Governance Meetings, which are also currently being reviewed and refreshed.	Ongoing The limitations of the national system have been raised but the matter is not in the control of the UHB. Revised completion date July 2019
	Updated DSEAR reviews will be conducted in accordance with HSE requirements. (O)	Medium	Director of Corporate Services & Governance/Board Secretary	Head of Health, Safety & Fire	Update December 2018 - Capital monies have now been allocated for this work and tenders are being prepared. Update May 2019 : Commencement and completion date for DSEAR Assessments is awaited from the Capital Team.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Fire folders be reviewed on a regular basis and out of date information removed and updated.(O)	Low	Director of Corporate Services & Governance/Board Secretary	Fire Safety Manager	Update December 2018 - The Audit of the 400+ Fire folders across the UHB was commenced in 12/18 and is due for completion 03/19. Update May 2019: To date, around 20% of the files have been reviewed and updated where appropriate. However, as a consequence of the added resource pressures, due to the Bridgend Boundary change, completion of this audit has been delayed until July/August 2019.	In progress. Audits will commence in Autumn 2018 – Revised completion date Summer 2019
JAG Accreditation Endoscopy - Follow Up	Approval of the Terms of Reference for the JAG working group should be documented to ensure it has been approved by an appropriate group or committee.	Low	Chief Operating Officer	Senior Nurse Medical Specialities	Update December 2018 - Terms of Reference now being reviewed and will be submitted to the Endoscopy Steering Group for approval. May 2019 Update – The Terms of Reference for the Endoscopy Steering Group have been subjected to an annual review and will be presented to the Group on 14 May 2019 for approval.	Will be complete May 2019
	Management should ensure that a project plan is in place that incorporates all the actions that are required to meet the JAG accreditation status by a required date. Each action identified should include reference to the domains and standards that it refers to, an identified lead, and the timescale for completion.	High	Chief Operating Officer	Demand and Capacity, waiting times management – Ruth Morrissey, continual. JAG accreditation plan - Neil Hawkes & Carolyn John, in place and being used.	There has been significant progress made on the timeliness of delivery of the service over the last year, not just in preparation for an improved position for JAG accreditation but to improve the quality of service for our patients. In addition, there has also been the development of a delivery plan for each site for JAG accreditation which is a live document for each site that is maintained via each JAG accreditation meeting. Within the plan each domain and progress is clearly shown. These plans will be used as the foundation for each JAG accreditation meeting. It will be used to focus the agenda and report progress. December 2018 update - Work in this area continues and is ongoing May 2019 Update – The Project Plan is very much a 'live' document that is subject to continual review. Work in the area continues and is ongoing.	Complete & Ongoing

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Review by the relevant consultants of the supporting appendices to the Operational Policy should be completed as soon as practically possible to allow for final approval of the Operational Policy.	Low	Chief Operating Officer	Consultant Gastroenterologist	December 2018 update - Diabetes guidelines received, for final approval & sign off in January 2019 ESG meeting. May 2019 Update – The review of documents that informs the supporting appendices, remains an ongoing piece of work.	In progress January 2019 In progress
Performance management monitoring and reporting follow up	**Updated Recommendation**. Management should continue to review the levels of support provided to directorates to ensure demand and capacity planning is embedded within their working environment. We note the need to analyse and manage the resource implications of the merger with Bridgend on the current demand and capacity work, to ensure the progress that has been made continues.	Medium	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	**Updated Management Response**. This is an ongoing challenge, with renewed efforts being made to recruit skilled individuals to join the Directorate, in parallel with the development and retention of existing analytical staff. The demand and capacity work related to Bridgend will be integrated into the Cwm Taf led IMTP process for 2019/20. The demand and capacity work will therefore be led by Cwm Taf, but supported by ABMU staff who currently hold the data. The Directorate is fully engaged in the Transition Programme to ensure the appropriate level of resource transfer for April 1st 2019. May 2019 Update – There is still difficulty currently with having sufficient members of staff within the P&I team that are conversant with D&C procedures and developments and with finding new members. We are currently working on the development of existing staff for the commencement of this year's D&C development (to start in late Aug/Early Sept 2019). Any resource implications of the merger with Bridgend would likely depend upon the service/directorate arrangements that are being made in those areas and whether models will need to be developed separately across sites, services or both (or even sub-services). It is impossible to judge this until the look of the split is known. In the meantime, the Directorate will continue to support via existing Business Partner arrangements and internal support to team members.	Ongoing. Recruitment and retention of key staff remains a key challenge, with a further recruitment drive underway. Ongoing. The recruitment drive and Department structuring changes are ongoing

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Updated Recommendation - The Health Board should consider whether phasing of demand and capacity plans would be beneficial in terms of providing a more co-ordinated planning approach.	Low	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	The next iteration of the plans will look to incorporate a way of dynamically updating the assessment every month. Whilst the phasing suggested is sensible, the time constraints associated with dedicating analytical resource to coincide with the IMTP process may not facilitate such a change to the current process. The regular updating of demand and capacity plans in a dynamic way will be the UHB approach to phasing, which will highlight changes in any one Directorate that other Directorates will be able to take account of in their planning. May 2019 Update – A draft for the suggested staging approach has now been completed – it would require a more considered approach to flesh out for inclusion in formalised proposals, however the process has been sufficiently practiced over the past four to five years for confidence in their relevance.	Ongoing. This remains a medium term objective for the P&I directorate. Ongoing
Facilities management	The review of the historical roster templates that are being used should be progressed with revised rosters realigned to meet the current demands of the services at both hospital sites. It should be ensured that suitable systems are in place to accurately capture the work undertaken by the porters, to better inform future roster amendments and to allow monitoring of staff productivity. Rosters should be prepared further in advance in order for staff to know their core shifts and overtime shifts, if any, thus reducing the need for staff to swap shifts if they are unavailable for the overtime they have been allocated. Where there is a need to make use of overtime, efficient use should be made of all available staff.	High	Chief Operating Officer	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers.	March 2019 update : Will be fully completed when the Porter redesign scheme is fully implemented. Porter redesign includes rota design that will complement existing staff establishment and support services trends and demands. Porter Trac system will be utilised to support this. Progress to date, currently in Stage 3 grievance policy process with staff and trade unions over the implementation of the new rotas and Facilities is being supported with this by workforce business partners. May 2019 Update – Attempts to resolve the issues surrounding the rotas have now reached an impasse as the grievance process has been exhausted. It is anticipated that arbitration may be requested (subject to confirmation) which is expressed in the Grievance Policy as part of a Collective Grievance process once the normal final appeal stage has been completed. A meeting will be held on 29 May to discuss the rotas which are central to all three grievances and key to progression. It will be an inclusive meeting involving the Deputy Director of Workforce and OD and staff side colleagues as well as senior management and staff representation. The final outcome for the other two grievances have been planned for after the meeting on 29 May 2019.	In progress In progress Revised completion date July 2019

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cwm Taf Morgannwg University Health Board

INTERNAL AUDIT PROGRESS REPORT

Audit Committee - May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction 1
2. Outcomes from completed audit reviews 1
3. Delivery of the 2018/19 Internal Audit plan 2
4. Delivery of the 2019/20 Internal Audit plan 2

Appendix A:

Table 1: Status of 2018/19 assignments

Table 2: Status of 2019/20 assignments

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Local Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

1.1. This progress report provides the Audit Committee (the 'committee') with the current position regarding the work undertaken by Internal Audit as at 7 May 2019.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the 2018/19 and the 2019/20, and any required updates.

2. Outcomes from completed audit reviews

2.1 Since the April meeting of the committee five assignments have been finalised. The finalised reports along with the allocated assurance rating are set out in the table below. The full versions of these reports are included in the committee's papers as separate items.

Assignments 2018/19	Assurance rating
Commissioning	Reasonable
Mobile Phones	Reasonable
EASC – Governance Arrangements	Reasonable

Assignments 2019/20	Assurance rating
Annual Quality Statement	Reasonable
Sustainability Reporting	Reasonable

3. Delivery of 2018/19 Internal Audit plan

3.1 The detail of the scheduling and current progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A.

3.2 The schedule includes the timing of the audits. These dates may be subject to change as the audit work progresses, and any alterations will be communicated to the committee via future progress reports.

4. Delivery of 2019/20 Internal Audit plan

4.1 Our plan for the 2019/20 programme of work was approved at the Audit Committee on 1 April 2019. We have set out the progress against the plan in Table 2 of Appendix A.

Table 1: Status of 2018/19 assignments to be reported in May Audit Committee or later

Assignment	Days in plan	Status	Assurance	Timing	Notes
Commissioning	15	Final	Reasonable	Q4	-
Mobile phone arrangements	-	Final	Reasonable	-	-
Water safety	15	Draft	Reasonable	Q3	Original issue 14.03.19, then update issued 19.04.19
Cyber security	15	Draft	Limited	Q3	Draft report was issued on 22.03.19
Directorate reviews – Surgery - Management arrangements	30	WIP	-	Q3	Debrief meeting scheduled for 10 May
Directorate reviews – Surgery - Compliance	15	WIP	-	Q3	Debrief meeting scheduled for 10 May
Directorate reviews – Radiology - Management arrangements	30	WIP	-	Q4	Fieldwork on going
Directorate reviews – Radiology - Compliance	15	WIP	-	Q4	Fieldwork on going
Data quality review	15	WIP	-	Q4	Fieldwork on going
Health & Care standards	20	WIP	-	Q4	Fieldwork on going

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
EASC					
Governance and performance	15	Final	Reasonable	Q2	-
Additional work					
Bridgend project	15	Support Ongoing	-	Q2	HoIA has attended governance work stream meetings
Changes made to 2018/19 plan					
Consultant job planning	15	-	-	Q3	Agreed at October 2018 Audit Committee that this review will be rescheduled for 2019/20
GP Out Of Hours (OOH)	20	-	-	Q4	Workforce element of OOH considered in primary care directorate review
Private & Overseas patients – Follow up	-	Final	Reasonable	-	Additional review not in 2018/19 plan
EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review	-	Final	N/A	-	Additional review not in 2018/19 plan

Reviews already reported

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Sustainability reporting	10	Final	Substantial	Q1	-
Annual Quality Statement	7	Final	Reasonable	Q1	-
JAG accreditation – Follow up	5	Final	Reasonable	Q1	-
General Data Protection Regulation (GDPR)	15	Final	Reasonable	Q1	-
Governance arrangements of Board committees	15	Final	Substantial	Q1	Focus on Primary Care committee
Carbon reduction commitment	10	Final	Substantial	Q2	Mandatory review
Directorate reviews - Facilities – Compliance	15	Final	Reasonable	Q1	-
Performance management – follow up	5	Final	Reasonable	Q2	-
Retention of staff	15	Final	Limited	Q1	-
Directorate reviews: Facilities - Management arrangements	30	Final	-	Q1	Reported as 'draft' at the October 2018 committee

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
• Risk management and governance			Reasonable		
• Performance and planning			Reasonable		
• Workforce			Limited		
Raising concerns	15	Final	Limited	Q1	-
Well-being of Future Generations Act (Wales) 2015	10	Final	Reasonable	Q2	-
Continuing Health Care	15	Final	Reasonable	Q2	-
Medical equipment and devices	15	Final	Limited	Q2	-
IT systems	10	Final	Reasonable	Q2	-
Management of absence target	15	Final	Reasonable	Q3	-
Private & Oversea patients – Follow up	N/A	Final	Reasonable	-	-
Mandatory training	15	Final	Reasonable	Q2	-
Directorate reviews – Primary Care - Management arrangements	30	Final	-	Q2	-
Risk management and governance			Reasonable		

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Performance and planning			Substantial		
Workforce			Reasonable		
Management of major capital	25	Final	Limited	Q4	-
Patient experience	15	Final	Reasonable	Q3	-
Welsh risk pool	2	Final	Substantial	Q4	-
Directorate reviews – Primary Care - Compliance	15	Final	Reasonable	Q2	-
Risk management	10	Final	Reasonable	Q3	-
Service Change Plans	15	Final	Reasonable	Q3	-
Core financial systems – cash management	10	Final	Substantial	Q4	-
WHSSC					
High cost drugs	15	Final	Reasonable	Q1	-
Review of network groups and advisory boards	10	Final	Reasonable	Q2	-
Risk management	10	Final	Reasonable	Q3	-

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Governance arrangements	10	Final	Reasonable	Q4	-
EASC					
EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review	N/A	Final	N/A	-	Additional review requested by EASC

Table 2: Status of 2019/20 Quarter 1 assignments

Assignment	Days in plan	Status	Assurance	Timing	Notes
Sustainability	10	Final	Reasonable	Q1	-
Annual Quality Statement	5	Final	Reasonable	Q1	-
Management of Prince Charles Capital Project	-	WIP	-	Q1-4	Work on going to follow up on issues raised in 2018/19 report
Pathology Directorate Review – Management Arrangements	30	Planning	-	-	Scoping meeting on 16.05.19
Pathology Directorate Review – Compliance	15	Planning	-	-	Scoping meeting on 16.05.19
Raising Concerns - Follow up	5	Planning	-	-	Fieldwork scheduled for June 2019
Consultant Job Plans	20	Planning	-	-	Fieldwork scheduled for June 2019
Retention of Staff Follow up	5	Planning	-	-	Fieldwork scheduled for June 2019
Governance Arrangements of Board Committees – Quality, Safety and Risk committee	15	-	-	-	Fieldwork scheduled for July 2019

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
Incident Reporting / Putting things right	20	-	-	-	Fieldwork scheduled for June 2019
Freedom of Information	13	-	-	-	-
Primary Care Cluster Plans	15	-	-	-	Fieldwork scheduled for June 2019
Management of Major Capital	25	-	-	-	Scoping
Medical Equipment review including follow up	20	-	-	-	Rescheduled to start in Q2 as implementation dates of previous recommendations not yet due.
WHSSC					
WHSSC – Directorate review of Cardiac	15	-	-	-	Fieldwork scheduled for June 2019
EASC					
None planned for Q1	-	-	-	-	-

Mobile Phone Arrangements

Internal Audit Report

Cwm Taf University Health Board

2018/19

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 7
6. Summary of Audit Findings 8
7. Summary of Recommendations 9

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-12
Report status:	Internal Audit Report
Fieldwork commencement:	13 March 2019
Fieldwork completion:	25 March 2019
Draft report issued:	27 March 2019
Management response received:	26 April 2019
Final report issued:	7 May 2019
Auditors:	Emma Samways, Deputy Head of Internal Audit Sian George, Auditor
Executive sign off:	John Palmer - Chief Operating Officer
Distribution:	Richard Cahn - Assistant Director of ICT Steve Webster - Director of Finance
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

As part of our work relating to core financial systems we agreed to undertake a high level review of control arrangements in place in relation to mobile phones. The review seeks to provide Cwm Taf University Health Board (the 'UHB' or the 'Health Board') with assurance that there are effective processes in place to manage the risk associated with mobile phone allocation and usage.

Following a concern raised regarding the use of a Health Board owned mobile phone, it was agreed that an exploratory piece of work would be undertaken to gain an understanding of the processes and controls the Health Board has in place for the issuing and ongoing management of mobile phones provided to staff.

The Health Board has a contract in place with Vodafone for the provision of its mobile phones. There are approximately 1,200 active phones in use, with 85% of these being basic handsets, only capable of making calls and sending text messages. The remaining 15% are IPhones that have data as part of their package.

The relevant lead for the review is the Chief Operating Officer.

2. Scope and Objectives

While the objectives set out below were agreed as part of the scope of our core financials review, we have taken the view that it is more appropriate to report our findings in relation to mobile phones in a separate document.

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's processes for mobile phones and managing the Health Board's Audit Committee that risks material the system’s objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- An up to date, comprehensive mobile phone policy in place that provides clear criteria for when staff may be issued with a work mobile phone and has guidance for appropriate usage of phones.
- A system for allocating mobile phones is in place and is in line with criteria set out in the policy.
- Named account holders are in place who are authorised to undertake actions such as setting up new phones and activating phones on behalf of the Health Board.
- All phones are attributed to named individuals within the Health Board, who have formally agreed to use the terms and conditions of use.
- Processes are in place for reviewing bills, ensuring relevant usage and recharging phone holders for usage outside of what is required for the role.

- Oversight and monitoring of the number of phones in use and overall expenditure is undertaken.

3. Associated Risks

The potential risks considered in the review were as follows:

- Inappropriate expenditure is incurred by the Health Board where phones are used for non-work related matters.
- Value for money is not achieved if phones are not allocated through a central contract in line with an approved policy.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with mobile phones is Reasonable assurance.

RATING	INDICATOR	DEFINITION
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 assurance rating attributed and the recommendations that have been made are based on our assessment of processes and controls outlined in those meetings and of the documentation available. Further work may be carried out in future years.

The Health Board has a 'Statement of Need' document to be completed and authorised prior to a mobile phone being issued. There is also a terms and conditions form for users to compete and sign prior the phone being activated. Both of these forms are available to staff via SharePoint. The forms are clear as to when IPhones with data can be provided, as opposed to the basic handsets.

Whilst both of these documents provide guidance, there is no overarching mobile phone policy in place within the Health Board. Though we note that the Statement of Need document does make reference to a mobile phone policy, we could not trace this and the Business Communications Manager was not aware of it.

Completed 'Statement of Need' and Terms and Conditions forms are retained in paper format by the ICT team. As such, we are concerned that should the documents need to be referred to, they may not be accessible or traceable in a timely manner given the volume of forms held.

Access to the Vodafone online mobile phone account is restricted to a limited number of staff within the ICT department. This ensures no unauthorised changes can be made to phone packages and usage. All contracts are set with unlimited calls and texts at a minimal monthly cost, therefore removing the risk that personal use of mobile phones may bring a cost to the Health Board. We also note that phones are blocked from making international and premium rate calls and those with data as part of their package are capped at a limited amount of data usage each month.

Management monitor the usage of mobile phones and any inactive numbers are reallocated to new users.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Existence of a policy			✓	
2	Allocation of phones				✓
3	Named account holders				✓
4	Phones attributed to named staff			✓	
5	Relevant usage				✓
6	Monitoring and oversight				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for mobile phones.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control mobile phones.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review and summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective one: An up to date, comprehensive mobile phone policy in place that provides clear criteria for when staff may be issued with a work mobile phone and has guidance for appropriate usage of phones.

We note the following area of good practice:

- Documents are in place for staff to complete when applying for a Health Board mobile phone. The Statement of Need and terms and conditions forms for the use of a mobile phone are available to staff via SharePoint.

We identified the following finding:

- There is currently no formal policy in place for the use of Health Board issued mobile phones.

Objective two: A system for allocating mobile phones is in place and is in line with criteria set out in the policy.

We note the following area of good practice:

- There is an appropriate system for the allocation of mobile phones, with the criteria set out which staff must meet in order to be eligible for a mobile phone.

We did not identify any findings under this objective.

Objective three: Named account holders are in place who are authorised to undertake actions such as setting up new phones and activating phones on behalf of the Health Board.

We note the following area of good practice:

- Controls are in place to prevent unauthorised changes to contracts or handsets. Such changes can only be undertaken by named individuals who access the Vodafone 'VCOL' business account online. Access to the online account is via a user ID and password.

We did not identify any findings under this objective.

Objective four: All phones are attributed to named individuals within the Health Board, who have formally agreed to use the terms and conditions of use.

We note the following areas of good practice:

- A record is kept of all mobile phones and the numbers allocated to each member of staff who holds a mobile phone.

- All mobile phone holders must complete a Terms and Conditions form before they are issued with a phone.

We identified the following finding:

- Currently all terms and conditions forms and statements of need forms relating to mobile phones is held in paper format, which can affect the timeliness of retrieval of a form for reference purposes.

Objective five: Processes are in place for reviewing bills, ensuring relevant usage and recharging phone holders for usage outside of what is required for the role.

We note the following areas of good practice:

- Phone contracts are on capped tariffs to prevent excessive calls or data use. International calls and roaming are barred on phones to prevent additional costs being charged to the Health Board.
- Monthly bills are downloaded and sent to Finance for payment. The processes in place for reviewing bills is devolved to directorates.

We did not identify any findings under this objective.

Objective six: Oversight and monitoring of the number of phones in use and overall expenditure is undertaken.

We note the following area of good practice:

- In addition to the mobile phone log maintained by the ICT team, they exercise oversight and monitoring of the numbers of phones as they look to identify inactive phone numbers when setting up new contracts.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**0**	**0**

Finding 1 – Mobile phone policy (Control Design)	Risk
There is guidance available to staff on SharePoint in relation to the use of Health Board issued mobile phones. This is in the form of a Statement of Need and Terms and Conditions document. Both provide background information and guidance for obtaining a Health Board mobile phone. However, there is no formal mobile phone policy, even though the Statement of Need makes reference to one. In other Health Boards we have seen mobile phones incorporated into a general telephone usage policy.	Inappropriate expenditure is incurred by the Health Board where phones are used for non-work related matters
Recommendation	**Priority Level**
The Health Board should introduce a formal policy and procedure that outlines the organisational approach to, and management of, Health Board provided mobile phones.	**Medium**
Management Response	**Responsible officer/deadline**
The Health Board accepts that a policy is needed. ICT will produce the policy.	ICT Responsible Officer Chris Ball June 2019

Finding 2 – Documentation storage and access (Operating effectiveness)	Risk
When applying for a Health Board mobile phone, a Terms and Conditions form and Statement of Need form are completed by the individual and authorised by the Directorate Manager. This ensures that the applicant meets the requirements for a mobile phone and also has signed to say that they agree to comply with the terms and conditions of holding a mobile phone for work purposes. Currently completed documentation is held in paper form and storage of these forms is in such a way that could make it difficult to use the forms for reference of an agreement with a phone holder. Given there are approximately 1,200 staff members with a mobile phone, the tracing of paperwork may be difficult.	Inappropriate expenditure is incurred by the Health Board where phones are used for non-work related matters
Recommendation	**Priority Level**
Documentation should be stored electronically to allow for easy referral to forms if necessary. This would allow for more historical forms to be accessed easily.	**Medium**

Management Response	Responsible officer/deadline
The Health Board has recently procured an electronic document management system for the scanning and storage of medical records. This system can be used for administrative documents as well. However, this is currently outside the scope of the project as funded in the business case (December 2018). ICT will write a proposal for expanding the scope of the project to include corporate documents.	ICT Responsible Officer Rachel Williams July 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

**Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

**Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

**No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Commissioning

Internal Audit Report

Cwm Taf University Health Board

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 7
6. Summary of Audit Findings 8
7. Summary of Recommendations 10

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-13
Report status:	Internal Audit Report
Fieldwork commencement:	19 November 2018
Fieldwork completion:	10 April 2019
Draft report issued:	17 April 2019
Management response received:	3 May 2019
Final report issued:	7 May 2019
Auditors:	Emma Samways Stuart Bodman
Executive sign off:	Ruth Treharne, Deputy Chief Executive and Director Of Planning and Performance
Distribution:	Julie Keegan, Assistant Director of Commissioning, Planning and Performance Alison Moroz, Finance Manager - Commissioning
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

In line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board') a review of the procedures and the arrangements for the services Powys Teaching Health Board (PtHB) commission from the Health Board was undertaken.

In recent years the Health Board commissioned £102m worth of services per annum from neighbouring health boards, English NHS bodies and private providers in order to provide a range of services for Cwm Taf residents. During the same the period the Health Board provided £53m worth of services to neighbouring health boards.

The contracting and commissioning service sits across both the Planning and Performance Directorate, and the Finance Directorate. As such, the relevant leads for the review are the Deputy Chief Executive/Director of Planning and Performance, and the Director of Finance.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's commissioning process. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

Following our planning discussions with management we agreed to focus our review on the commissioning arrangement that the Health Board has in place with Powys Teaching Health Board. Over the past few years the Health Board has provided a range of general inter-health board services to PtHB via an LTA and more specific outreach services through a Service Level Agreement. The outreach services provided include general surgery, rheumatology, acute services and gynaecology. Professional support has also been provided in areas such as audiology, radiology and theatres. The review aimed to establish if the commissioner/provider relationship with PtHB was robust, and is a model that should replicated with other partners.

The areas that the review sought to provide assurance on were:

- Processes and controls are in place for the development of Long Term Agreements (LTAs) and Service Level Agreements (SLAs) with PtHB, covering all services provided by the Health Board and in line with an approved commissioning and contracting plan.
- There is appropriate monitoring, challenge and scrutiny to ensure that the services provided are in line with agreements and are invoiced for appropriately.
- Sufficient and timely information is supplied to PtHB in order for them to assess that the services provided have been delivered in accordance with respective agreements.

- Escalation procedures in place are adequate when services fall short of performance or quality requirements, with the option to decommission if necessary.

3. Associated Risks

The potential risks considered in the review were as follows:

- Reputational damage if the Health Board is unable to provide quality commissioned services in line with the LTAs/SLAs.
- Performance cannot be measured if effective arrangements detailing required levels of productivity and quality are not in place.
- Ineffective systems are in place to capture the appropriate data in respect of commissioned services being provided.
- Volatility of income and consequent budget variance.
- Effective oversight cannot take place if SLAs are entered into directly by directorates with no corporate oversight.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls over services commissioned by PtHB is Reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

Commissioning processes are in place between the Health Board and PtHB for the development and ongoing management of its LTAs and Outreach Services SLAs that cover all services provided in line with the intentions documented in the Health Board's 2018/19 IMTP. However, there are no

documented procedures that underpin the processes that are to be followed.

Sufficient and timely performance monitoring information is provided by the Health Board on a monthly basis in respect of the LTA in order for both parties to assess that the services provided have been delivered in accordance with the respective agreements. Our testing identified that the income in respect of these agreements is received by the Health Board on a timely basis and accounted for correctly. Where queries or issues arise these are remedied efficiently and there are formal escalation procedures in both the LTA and SLA should services fall short of performance or quality requirements, with the option to decommission if necessary.

Additionally there are KPI's mandated by Welsh Government as part of the NHS Outcomes Framework covering financial, patient experience and quality data which are included within the LTA, and are discussed within the Health Board and PtHB's Contracts Quality & Performance Review (CQPR) Group meetings.

However, we identified a number of key issues that require management attention that relate to governance and oversight of the LTA, but more specifically that of SLAs between the Health Board and PtHB. In summary these relate to the absence of specific, formally documented processes relating to Health Board commissioning and the lack of a register of LTAs and SLAs.

Concerns that directorates may enter into SLAs without involving the corporate Commissioning Team were raised by the corporate team and their concerns were confirmed via our testing, which identified an SLA relating to Resuscitation Services. Further detail behind the SLA was requested but not provided during the course of the audit.

The Outreach Services SLA Activity Monitoring Reports have not been provided to the Health Board by PtHB during 2018/19 in accordance with the terms of the agreement. The CQPR had not met bi-monthly in 2018/19 in accordance with the agreement, and this had impacted on the ability to raise this as a concern.

The Outreach Services SLA does not include any requirements to provide any KPIs in respect of the performance of contracted services provided or quality and patient safety and experience unlike the LTA.

Furthermore, we recommend that with the responsibility of commissioning of health services for the Bridgend populace transferring to the Health Board from April 2019, management should ensure that appropriate resources are in place to manage commissioning arrangements between it and Swansea Bay UHB.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Development of LTAs & SLAs			✓	
2	Monitoring, challenge and scrutiny of services provided to PtHB			✓	
3	Provision of sufficient and timely information is supplied to PtHB			✓	
4	Escalation & decommission procedures				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted four issues that are classified as weakness in the system control/design for Commissioning.

Operation of System/Controls

The findings from the review have highlighted two issue that is classified as a weakness in the operation of the designed system/control for Commissioning.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Processes and controls are in place for the development of Long Term Agreements (LTAs) and Service Level Agreements (SLAs) with Powys THB, covering all services provided by the Health Board and in line with an approved commissioning and contracting plan.

We note the following areas of good practice:

- The Health Board has a Commissioning Framework, which forms part of the 2018/19 IMTP and states its commissioning intentions with regard to service provision to PtHB during the year.
- The PtHB LTA and Outreach Clinical Services SLA for 2018/19 set out the level of service that they expected to provide in the year. These included a breakdown of agreed rates and tariffs and were signed off by the Chief Executive of PtHB and the Director of Finance of the Health Board on behalf of the Chief Executive.
- 2018/19 commissioning arrangements with Powys THB were presented to the Health Board's Financial Performance and Workforce Committee in March 2018.

We identified the following findings:

- The Health Board does not maintain a register of LTAs and SLAs that it has in place with other health boards or private providers. As such, the Commissioning Team are concerned that there may be SLAs that have been wholly arranged and agreed between directorates and other health bodies without the oversight of the corporate Commissioning Team.
- There are no specific, documented procedures in place relating to the management of commissioning within the Health Board.

Objective 2: There is appropriate monitoring, challenge and scrutiny to ensure that the services provided are in line with agreements and are invoiced for appropriately.

We note the following area of good practice:

- The income from services provided within the PtHB LTA and Outreach Services SLA that we tested was fully accounted for.

We identified the following findings:

- Our testing identified an SLA is in place between PtHB and the Health Board relating to Resuscitation Services. This was not known to the

Commissioning team and therefore sits outside of their monitoring and governance processes.

- Activity Monitoring Reports in relation to Outreach Services SLA have not been regularly provided to the Health Board by PtHB during 2018/19 in line with the LTA and SLA requirements.
- The Contracts Quality & Performance Review (CQPR) meetings between the Health Board and PtHB have not met bi-monthly as they should have during the year. Meetings were only held in September, November and January.

Objective 3: Sufficient and timely information is supplied to Powys THB in order for them to assess that the services provided have been delivered in accordance with respective agreements.

We note the following areas of good practice:

- Monthly activity monitoring data is provided to PtHB that enables them to assess and feed back to the Health Board the performance and quality of services provided as stated with the respective LTAs and SLAs.
- KPI's mandated by Welsh Government as part of the NHS Outcomes Framework covering financial, patient experience, and quality data are included within the LTA and are discussed within CQPR Group meetings.

We identified the following finding:

- The Outreach Services SLA does not include the requirement to provide any KPIs in respect of the performance of contracted services provided, or quality and patient safety and experience.

Objective 4: Escalation procedures in place are adequate when services fall short of performance or quality requirements, with the option to decommission if necessary.

We note the following area of good practice:

- Both the PtHB LTA and Outreach Services SLA document the means of escalation, dialogue and remedy, and the terms of cessation of the arrangement in the event that services provided to PtHB falling short of performance or quality requirements. No issues that required escalation were raised in 2018/19 in respect of PtHB LTA or the Outreach Services SLA.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**4**	**1**	**6**

Finding 1 – Commissioning Register (Control Design)	Risk
The Health Board does not hold and maintain a register of LTAs and SLAs that have been entered into by the commissioning team or by directorates. As such, comprehensive monitoring of the arrangements in place with other Health Bodies or private providers cannot take place. We understand that the commissioning team are concerned that SLAs may be in place that have been arranged and agreed between directorates and other health bodies without their oversight and monitoring.	Ineffective systems are in place to capture the appropriate data in respect of the commissioned services being provided.
Recommendation	**Priority level**
The Health Board should develop a register of the commissioning arrangements it has in place via LTAs and SLAs in order to allow clear and comprehensive oversight and monitoring.	**High**
Management Response	**Responsible Officer/ Deadline**
Whilst we recognise that there is no Health Board wide register of SLA's and LTA's, we acknowledge the benefits this would bring to the organisation and we will be having further discussion on how best to achieve this. SLA's: Our preferred model for SLA's is that this is held and owned at Directorate Level, to reflect the ownership of the SLA's alongside budgetary and Performance	Contracting and Commissioning Finance manager Deadline: June 2019

Responsibility of them, with appropriate oversight of the Commissioning and Contracting function. LTA's: With regards to LTA's, all agreements are held centrally by the contracting team and we will develop this further into a LTA register.	

Finding 2 - Contracts Quality & Performance Review (CQPR) Meetings (Operating effectiveness)	Risk
In accordance with SLA CQPR meetings should be held between the Health Board and PtHB to discuss activity, governance, performance and financial management of the LTA and Outreach Services SLA. The group forms the start of the dispute resolution process, should it be required. During 2018/19 three meetings were held: September; November; and January 2019. However, the LTA stipulates that CPQR meetings should be scheduled to be held every two months. We understand that throughout the year the commissioning team were under resource pressure due to the transfer of services for Bridgend from Abertawe Bro Morgannwg UHB; hence, a number of meetings were cancelled, though issues were dealt with as necessary via email.	Performance cannot be measured if effective arrangements detailing required levels of productivity and quality are not in place. Issues arising from either party may not be addressed and resolved in a formal setting and documented.
Recommendation	**Priority level**
All future CPQR meetings between the Health Board and PtHB should be held on a regular basis in accordance with the terms of the LTA, supported by a mutually agreeable timetable.	**Medium**
Management Response	**Responsible Officer/ Deadline**
3 meetings were held in 2018/19, regular meetings have been scheduled already for 2019/20 on a bi-monthly basis.	Assistant Director of Commissioning Deadline: Complete

Finding 3 - Commissioning procedures (Control Design)	Risk
While we acknowledge that the Health Board has a commissioning framework in place and Standing Financial Instructions and the Scheme of Delegation that provides some guidance around entering into LTAs and SLAs, there are no specific, formally documented procedures in place relating to the processes that underpin the creation and ongoing review and management of commissioning within the Health Board.	Reputational damage if the Health Board is unable to provide a quality commissioned services in line with LTAs / SLAs.
Recommendation	**Priority level**
The Health Board should implement procedures that outline the compilation, development and active management of LTAs and SLAs and a process that ensures the capture of any currently led directorate managed SLAs with a view to future joint working between the Commissioning Team and directorates to ensure the robust management and monitoring of LTAs and SLAs.	**Medium**
Management Response	**Responsible Officer/ Deadline**
We recognise the benefit to the wider organisation outside Commissioning and contracting in ensuring consistency of approach to the development and management of SLA's.	Assistant Director of Commissioning Deadline: September 2019

Finding 4 - Resuscitation Services Directorate SLA with PtHB (Control Design)	Risk
Our testing identified a directly managed service level agreement between the resuscitation services department and PtHB with an annual income of £58,105. While we confirmed that a signed SLA is in place between PtHB and the Health Board relating to these services, the Health Board's commissioning team were not aware of the SLA and therefore it sits outside of their monitoring and governance processes. We could not be provided with any documentary evidence to support the agreement process between the Resuscitation Services department and PtHB. We were informed by Finance Officer that the 2010–2013 SLA has not been updated and had been 'rolled forward' each year. Additionally documentary evidence could not be provided to confirm that the 2018/19 SLA has been formally authorised by the Directorate and Health Board in accordance with the Health Board's Scheme of Delegation.	Performance cannot be measured if effective arrangements detailing required levels of productivity and quality are not in place.
Recommendation	**Priority level**
a) The Commissioning Team should investigate the existence of SLAs that sit outside of their monitoring and scrutiny processes. b) Additionally, the Commissioning Team should meet with the Resuscitation Department to ascertain the review, approval and authorisation process relating to the SLA to ensure compliance with the Health Board's Scheme of Delegation.	**Medium**

Management Response	Responsible Officer/ Deadline
a) Investigation of existence of SLA's: This action will be picked up as part of the process of developing the SLA register under Finding no 1. b) A plan to now bring this into the overall Powys LTA/SLA process and will agenda it for the first meeting of the CQPR of 2019/20 to ensure a wrap-around governance process around the SLA.	Part A Assistant Director of Commissioning/ Contracting and Commissioning Finance Manager/Directorate Managers Deadline: March 2020 Part B Contracting and Commissioning Finance Manager Deadline: May 2019

Finding 5 - Outreach Services SLA Activity Monitoring Reports (Operating Effectiveness)	Risk
In 2018/19 the contract value of income from the PtHB LTA was £1,140,000 and from the Outreach Services SLA £658,678. While we understand that the Health Board's finance department have requested information, in 2018/19 only one activity monitoring report was provided to the Health Board. This related to month 11 of 2018/19 to facilitate the year end settlement and reconciliation process between the Health Board and PtHB. Given the importance of this information to ensure and confirm regular and accurate ongoing monitoring of services provided in accordance with the terms of the SLA, the Health Board must ensure that this data is obtained on a quarterly basis as prescribed in the SLA.	Performance cannot be measured if effective arrangements detailing required levels of productivity and quality are not in place.
Recommendation	**Priority level**
The Health Board must ensure that SLA Activity Monitoring Reports are provided in accordance with the stated terms of the SLA.	**Medium**

Management Response	Responsible Officer/ Deadline
To clarify the position regarding regular monitoring information, LTA monitoring for the £1.14m is provided monthly by the Health Board to Powys and there have been no issues raised with queries responded to on a timely basis. With regards to the SLA monitoring for the 0.7m, Powys are responsible for providing this monitoring information. We acknowledge that Powys have not sent it to us and we will pursue the regular provision of this in 19/20 via the CQPR meetings.	Contracting and Commissioning Finance Manager Deadline: Quarterly 19/ 20

Finding 6 - Outreach Services SLA KPIs (Control Design)	Risk
The Outreach Services SLA does not include the requirement to provide any KPIs in respect of the performance of the contracted services provided, or any metrics relating to quality of service, patient safety and patient experience. Given the value of this agreement, we would have expected performance measures to be considered in the SLA.	Opportunities for improvement are either not identified or implemented.
Recommendation	**Priority level**
Future SLAs should include KPIs in respect of contracted service performance activity, quality and patient safety and experience.	**Low**
Management Response	**Responsible Officer/ Deadline**
The outreach services with Powys relates to CTMHB providing clinical staffing sessions to Powys Teaching Health Board to enable Powys to deliver services to their local population. As Powys is the Provider of these services, the activity, reporting and performance management requirements lie with Powys, therefore any KPI's would need to be developed and monitored by them. We will raise this with Powys Teaching Health Board.	Assistant Director of Commissioning Deadline June 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

**Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

**Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

**No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cyber Security

Final Internal Audit Report

2018/19

Cwm Taf University Health Board

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 1
2. Scope and Objectives 2
3. Associated Risks 3

Opinion and key findings

4. Overall Assurance Opinion 4
5. Assurance Summary 5
6. Summary of Audit Findings 6
7. Summary of Recommendations 7

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-18
Report status:	Final
Fieldwork commencement:	4 February 2019
Fieldwork completion:	7 March 2019
Draft report issued:	20 March 2019
Management response received:	9 May 2019
Final report issued:	9 May 2019
Auditor:	Martyn Lewis
Executive sign off:	Chief Operating Officer
Distribution:	Assistant Director of Informatics
Committee:	Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

A review of the arrangements in place for the management of cyber-security within Cwm Taf University Health Board (the 'Health Board' or the 'organisation') has been completed in line with the 2018/19 Internal Audit Plan.

Cyber-security is the protection of information assets by addressing threats to information processed, stored, and transported by internetworked information systems. It is the protection of computer systems from the theft or damage to their hardware, software or information, as well as from disruption or misdirection of the services they provide.

Cyber-security includes controlling physical access to the hardware, as well as protecting against harm that may come from malware, viruses and unauthorised or inappropriate software.

A strong cyber awareness culture is one of the best defences against cyber-attacks. Forthcoming regulations such as the Network and Information Security (NIS) Directive and the General Data Protection Regulation (GDPR) will increase the burden on organisations to ensure they have effective cyber-security strategies and culture in place, in addition to robust controls and policies, to prevent and remediate attacks.

In October 2017, Stratia Consulting was commissioned by Velindre NHS Trust, on behalf of NHS Wales, to carry out external cyber security assessments for its organisations.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

The relevant lead for the assignment is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the audit was to provide assurance to the Health Board that the mechanisms in place for ensuring cyber-security are appropriately designed, and procedures and controls have been implemented within the previously agreed timeframes as outlined within the recent external review of cyber-security.

The areas the review sought to provide assurance on were:

- governance: An appropriate governance and management structure is in place to ensure cyber-security;
- external review awareness: Information contained within the Health Boards' cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee; and
- implementing actions: Any actions contained within the previous cyber-security report and SIP have been completed within the agreed timeframes.

3. Associated Risks

The potential risks considered in the review were as follows:

- poor or non-existent stewardship in relation to cyber-security;
- failure to comply with regulations such as the GDPR and NISD;
- loss of data and inappropriate access to information from entities internal to the organisation;
- risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities; and
- inappropriate unauthorised software installed / increased risk of infection from introduction of malware.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with cyber-security is Limited assurance.

RATING	INDICATOR	DEFINITION
Limited assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The Health Board has a framework for the ongoing development of cyber security with an IT Security Manager in place, and additional funding for staff being provided. There is an Information Governance web page and an ICT web page. We also note that a cyber-security status report has been developed, with appropriate KPIs.

Progress has been made against all the items identified in the Stratia report. Work is ongoing to replace out of date software, a patch process in place, a cyber incident response plan is in draft, and the change management process has been improved, with a more active change advisory board (CAB) now operating.

However, our testing identified some issues. These generally relate to the incompleteness of some of the actions identified within the Stratia report, mainly due to lack of resource. These include the continued use of old software, the lack of a formal patch procedure, and the lack of hardening of the organisations network with the firewalls being open to all of NHS Wales.

We identified two findings that we would consider to be high priority during our audit fieldwork. These are:

- The visibility of the Stratia report at a senior level is minimal, with no record in the minutes of the organisation's Board, Quality & Safety Committee, or Information Governance Group, and no process to formally track actions identified within the improvement plan in the report. In addition, there is a lack of clarity over the mechanism for monitoring the status of cyber-security within the organisation, with no clear reporting or tracking of status or risks.
- A paper identifying the need for additional resources has fed into the IMTP planning process, however only one of the identified three posts has been agreed, this means that the organisation cannot fully undertake the actions needed to ensure cyber-security is maintained. In particular, the organisation is not able to maximise the use of the security tools that it has.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance		✓		
2	External review awareness		✓		
3	Implementing actions			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

Our findings from the review did not identify any issues that would be classified as a weakness in the system control/design for cyber-security.

Operation of System/Controls

Our findings from the review have highlighted seven issues that are classified as weaknesses in the operation of the designed system/control for cyber-security.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the high and medium priority findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

An appropriate governance and management structure is in place to ensure cyber-security.

We note the following areas of good practice:

- there is a framework for monitoring / directing the work of ICT;
- there is an IT Security Manager in place;
- funding for additional cyber-security staff resource has been provided;
- there is a IG web page and an ICT page; and
- a cyber-security status report has been developed, with appropriate KPIs.

We note the following findings in relation to this objective.

- A paper identifying the need for additional resources has fed into the IMTP planning process, however only one of the identified three posts has been agreed, this means that the organisation cannot fully undertake the actions needed to ensure cyber-security is maintained. In particular the organisation is not able to maximise the use of the security tools that it has.
- A review of the Health Board's website showed that there are no policies or procedures relating to cyber-security, no news items relating to cyber-security, or flagging of national policies. As such, there is currently limited guidance for staff on cyber-security.

Information contained within the Health Boards' cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee.

We note the following high priority finding:

- The visibility of the Stratia report at a senior level is minimal, with no record in the minutes of the organisation's Board, Quality & Safety Committee, or Information Governance Group and no process to formally track actions identified within the improvement plan in the

report. In addition, there is a lack of clarity over the mechanism for monitoring the status of cyber security within the organisation, with no clear reporting or tracking of status or risks.

Any actions contained within the previous cyber-security report and SIP have been completed within the agreed timeframes.

We note the following areas of good practice:

- progress has been made against all the items identified in the Stratia report;
- System Centre Configuration Manager (SCCM) patch management is in use to ensure desktops are appropriately updated;
- a patch process for 3rd party imaging systems has been agreed;
- the organisation has security tools such as Nessus, Cisco Firepower, Solar winds, Castlerock;
- the change management process has been improved, with a more active CAB in place;
- there is a cyber incident response plan in draft; and
- work is ongoing to replace out of date software / equipment.

We note the following medium priority findings:

- Although patching of desktops and servers is undertaken in a structured manner, this is carried out by an external contractor and there is no formal procedure for this. In addition, the patching / updating of firmware in network hardware is only on an *ad hoc* basis, without a formal structure.
- The organisation continues to contain a number of devices running old software and is using old hardware such as switches. Although these are known there is no formal, resourced plan to remove all of these.
- There has been no additional resource provided to the data communications team, this means that the Health Board continues to have weaknesses within its network in that the firewall rules have not been enacted to restrict access from NHS Wales, and there is no device level access control in place. In addition, data across the network is not always encrypted.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority are outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**4**	**1**	**7**

Finding 1 – Monitoring (Operating effectiveness)	Risk
The visibility of the Stratia report at a senior level has been minimal, with no record in the minutes of the organisation's Board, Quality & Safety Committee, or Information Governance Group, and no process to formally track actions identified within the improvement plan in the report. In addition, there is a lack of clarity over the mechanism for monitoring the status of cyber-security within the organisation, with no clear reporting or tracking of status or risks. Without appropriate monitoring and reporting in place the organisation will not be fully aware of its risk position in relation to cyber-security, and may not take effective action to mitigate this.	Poor or non-existent stewardship in relation to cyber-security
Recommendation	**Priority level**
Reporting on cyber-security should be a regular inclusion within the ICT management and governance structure and this should then feed into the organisational governance framework for assurance.	**High**

Management Response	Responsible Officer/ Deadline
Cyber security is discussed regularly at the Digital Strategy Steering Group and ICT Corporate Business Management meetings. However, it has been recognised by the Health Board that ICT governance needs to be strengthened with increased visibility at the Board. The Board has therefore agreed the establishment of a Board level ICT Committee, which will be chaired, by the recently appointed Independent Board Member, who takes up post in May/June 2019.	Robert Williams / John Palmer July 2019

Finding 2 – Active monitoring (Operating effectiveness)	Risk
A paper identifying the need for additional resources has fed into the IMTP planning process, however only one of the identified three posts has been agreed, this means that the organisation cannot fully undertake the actions needed to ensure cyber-security is maintained. Although the organisation has security tools in place, it is not maximising the benefits of these due to lack of staff resource within ICT: • Nessus (a vulnerability scanner) is not being run due to the resource needed to analyse the results and enact relevant fixes. • Firepower (a firewall with intrusion detection capability) is not enacted as it led to problems with backups and there is no resource to identify the reason and fix. In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and the Health Board's incident response plan is only in draft. Without these products being used, the organisation in not fully able to quantify and fix its vulnerabilities, and there is no intrusion detection running which would make it difficult to identify and prevent a malicious actor gaining access to the network.	Loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.

Recommendation	Priority level
ICT should formally define the cyber-security tasks that cannot be undertaken within the current resource envelope and the associated risks. This should be reported through the organisational governance structure so that a decision on risks and priorities can be made. The organisation should seek to provide staff resource to enable ICT to use the security products. The organisation should approve and finalise the incident response plan as soon as practically possible.	**High**
Management Response	**Responsible Officer/ Deadline**
A report defining the cyber tasks for which the new posts were required was discussed at the ICT Corporate Business Meeting (CBM). As a result, three cyber posts have now been funded, one from health board funds and 2 more from national funds. One person is now in place and two more will be advertised.	Chris Ball / July 2019

Finding 3 – Patching (Operating effectiveness)	Risk
Although patching (applying updates and fixes for security weaknesses) of desktops and servers is undertaken in a structured manner, this is carried out by an external contractor and there is no formal procedure for this. In addition, the patching / updating of firmware in network hardware is only on an *ad hoc* basis, without a formal structure. Without a formal procedure that defines the patching mechanism for all items within the UHB, there is a risk that vital updates will be missed and the UHB will be exposed to unnecessary risk.	Loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.
Recommendation	**Priority level**
A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June.	Chris Ball / June 2019

Finding 4 - Old Software (Operating effectiveness)	Risk
The organisation continues to use a number of devices running old software, and is also using old hardware such as switches (devices that connect the network). Although these are known to IT, there is no formal, resourced plan to remove all of these. Until these are updated / removed the organisation will be at risk of cyber attack as older devices contain security vulnerabilities and are no longer have manufacturer support.	Loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.
Recommendation	**Priority level**
A formal, resourced plan for the removal of old software and devices should be established.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The existing plan will be updated and brought to DSSG for formal approval in June.	Chris Ball / June 2019

Finding 5 - Resources (Operating effectiveness)	Risk
There has been no additional staff resource provided to the data communications team, this means that the Health Board continues to have weaknesses within its network in that the firewall rules have not been enacted to restrict access from NHS wales, and there is no device level access control in place to prevent unauthorised devices (e.g. laptops) connecting to the network. In addition, data across the network is not always encrypted. These issues leave the Health Board open to unauthorised access and attack.	Loss of data and inappropriate access to information from entities internal to the organisation.
Recommendation	**Priority level**
The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Data communications security will be addressed by the new posts discussed in finding 2.	Chris Ball / July 2019

Finding 6 - Policies and procedures (Operating effectiveness)	Risk
Our review of the Health Board's website showed that there are no policies or procedures relating to cyber-security, no news items relating to cyber-security, or flagging of national policies. As such, there is currently limited guidance for staff on cyber-security. Without staff guidance being readily available, there is a risk that staff may make errors and open the organisation to unnecessary risk.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
The IG / ICT pages on the Health Board's website should include information on cyber-security and reference to appropriate policies and procedures.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Updates to the Health Board's website will be made to include relevant cyber security policies, procedures and news.	Chris Ball / July 2019

Finding 7 – Change management (Operating effectiveness)	Risk
There is no formal IT change management procedure or policy for the Health Board to ensure that changes to IT are appropriately assessed and approved, with the current Change Advisory Board (CAB) referring to the NWIS process.	Loss of data and inappropriate access to information from entities internal to the organisation.
Recommendation	**Priority level**
The Health Board should develop its own IT change management procedure.	**Low**
Management Response	**Responsible Officer/ Deadline**
NWIS process was meant to be appropriate for local health board use and Cwm Taf Morgannwg chairs the national service board. A review of the NWIS process will be undertaken to ensure no local tailoring is required.	Mark Evans / July 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

**Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

**Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

**No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Governance and Performance

Internal Audit Report

Emergency Ambulance Services Committee

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 8

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-39
Report status:	Internal Audit Report
Fieldwork commencement:	4 March 2019
Fieldwork completion:	10 April 2019
Draft report issued:	18 April 2019
Management response received:	2 May 2019
Final report issued:	3 May 2019
Auditors:	Paul Dalton – Head of Internal Audit
	Emma Samways – Deputy Head of Internal Audit
	Murray Gard – Principal Auditor
Executive sign off:	Stephen Harrhy - Board Director/Chief Ambulance Service Commissioner
Distribution:	Anthony Hayward – Assistant Director
Committee:	Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Emergency Ambulance Services Committee and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of governance and performance within the Emergency Ambulance Services Committee ('EASC' or the 'organisation') was completed in line with the 2018/19 Internal Audit plan.

Emergency ambulance services in Wales are commissioned by the seven local health boards on behalf of the people of Wales through the Emergency Ambulance Service Committee (EASC). The Emergency Ambulance services are provided by a single national organisation – Welsh Ambulance Services NHS Trust (WAST).

EASC was established on the 1 April 2014 and is hosted by Cwm Taf Morgannwg University Health Board. EASC acts on behalf of the health boards in holding WAST to account as the provider of emergency ambulance services.

The relevant lead for the assignment is the Chief Ambulance Service Commissioner.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for governance and performance management, in order to provide assurance to the Audit Committee that risks material to the achievement of the system's objectives are managed appropriately. The purpose of the review is to establish if appropriate governance and performance management arrangements are in place to ensure that EASC operates effectively and WAST performance is effectively monitored and managed.

The main areas that the review sought to provide assurance on were:

- Appropriate governance arrangements are in place, and are consistent with what was intended when EASC was established and are operating effectively.
- The governance framework is subject to periodic and appropriate review, giving consideration for future changes in the organisation.
- The Joint Committee is operating in accordance with regulations and meetings are being held with the correct frequency, composition and membership.
- Appropriate sub-committees are in place and these are operating effectively and reporting onto the Joint Committee.
- Appropriate mechanisms are in place for monitoring and reporting WAST's performance and actions are taken to address any identified issues.

3. Associated Risks

The potential risks considered in the review were as follows:

- The objectives of the Committee are not achieved.
- Areas of poor performance are not identified and addressed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with governance and performance is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

We identified that overall there are functioning arrangements in place for control and governance within EASC, with a good structure in place for the monitoring of ambulance quality indicators.

However, we identified issues surrounding the attendance of key members, and ensuring appropriate quorum requirements are met throughout the various groups and committees of EASC.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate governance arrangements are in place.			✓	
2	The governance framework is subject to periodic and appropriate review.				✓
3	The Joint Committee is operating in accordance with regulations.			✓	
4	Appropriate sub-committees are in place and these are operating effectively.			✓	
5	Appropriate mechanisms are in place for monitoring and reporting WAST's performance.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the control design for governance and performance.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed control for governance and performance.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1 - Appropriate governance arrangements are in place, and are consistent with what was intended when EASC was established and are operating effectively.

We note the following areas of good practice:

- Operational arrangements have been evolving since EASC's establishment and version controls have been maintained. These include various delivery plans for service development.

We identified the following finding:

- The current version of the standing orders is not fully complete. For example, the scheme of delegation to emergency ambulance services team and officers is not complete.

Objective 2 - The governance framework is subject to periodic and appropriate review, giving consideration for future changes in the organisation.

We note the following area of good practice:

- The Quality and Delivery Framework for Emergency Ambulance Services was last updated and presented to the Joint Committee for approval/ endorsement in March 2018 to cover the 2018/19 financial year.

We did not identify any findings under this objective.

Objective 3 - The Joint Committee is operating in accordance with regulations and meetings are being held with the correct frequency, composition and membership.

We note the following areas of good practice:

- The purpose and delegated functions of the Joint Committee are documented within the standing orders and include the Committee's roles, membership and quorum requirements, member's responsibilities and accountability and reporting activity.
- The Joint Committee meetings follow a structured approach and the committee receives regular reports on items including action logs, Chair's reports, finance, quality indicators and updates from sub groups.

We identified the following finding:

- We identified that key members of the Joint Committee meeting were not always in attendance.

Objective 4- Appropriate sub-committees are in place and these are operating effectively and reporting onto the Joint Committee.

We note the following areas of good practice:

- Two sub groups have been established (Joint Management Assurance Group and Planning Development and Evaluation Group) with detailed terms of reference highlighting, for example, scope and duties, authority, membership, quorum requirements and frequency of meetings.
- Both of the sub groups report formally, regularly and on a timely basis to the Joint committee, this includes verbal updates and written reports.

We identified the following findings:

- We identified that key members of the sub-committee meeting were not always in attendance.
- The structure of meetings does not include items such as declarations of interest.

Objective 5 - Appropriate mechanisms are in place for monitoring and reporting the Welsh Ambulance Services performance.

We note the following areas of good practice:

- Thirty nine Ambulance Quality Indicators were developed to monitor and improve performance across the 5 Step Ambulance Care Pathway. These indicators are all made publically available on a quarterly basis.
- The Joint Committee receives regular overview reports of the most recent quarterly data and also the full published data sets. In addition where specific reviews have taken place, e.g. Amber review the joint committee has considered the issues and concerns of the report.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**4**	**0**	**4**

Finding 1 Standing Orders (Operating effectiveness)	Risk
The Emergency Ambulance Services Committee is a joint committee of each Local Health Board in Wales, established under the Emergency Ambulance Services Committee (Wales) Regulations 2014. We confirmed with the Interim Board Secretary that revised Standing Orders were approved at the February 2019 EASC Joint Committee. We requested a copy of the Standing Orders and were provided with a version that had varying dates throughout (February 2017 and February 2018). Based on the version of the Standing Orders provided, the following points were noted: • The dates relating to the Memorandum of Agreement and hosting agreement have not been completed. • The scheme of delegation to emergency ambulance services team and officers is not completed. • The terms of reference for the advisory groups and expert panel section has not been completed. • The delegation of powers to committees' does not reflect the current sub-committee set up.	The objectives of the Committee are not achieved.

Recommendation 1	Priority level
The Standing Orders should be reviewed and updated where appropriate to reflect currently operations within EASC.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Management agree with the findings and will review the Standing Orders to reflect the current operations within EASC.	Stephen Harrhy - July 2019

Finding 2 - Joint Committee (Operating effectiveness)	Risk
We reviewed four sets of Joint Committee papers for the period March – November 2018 to ensure the committee was operating in accordance with requirements. We identified the following points during our review: • Over the four meetings that we sampled, two out of the three associate members (both Chief Executives) did not attend any of the meetings. This issue has been previously identified in other audit reviews. • The Independent Chair appointed by Welsh Ministers ceased involvement with the Joint Committee following the March 2018 meeting and at the November 2018 meeting had not been replaced. However, in the interim, the Joint Committee was chaired by the Chief Executive of Cwm Taf University Health Board. Whilst this individual was not independent, it did allow meetings to continue until the new Independent Chair was appointed.	The objectives of the Committee are not achieved.
Recommendation 2	**Priority level**
Members should be reminded of the need to attend joint committee meetings in accordance with the requirement set out in the EASC Standing Orders.	**Medium**

Management Response	Responsible Officer/ Deadline
Management agrees with the findings and recommendation and this was completed after the EASC March 2019 meeting.	Dr Chris Turner - Complete

Finding 3 - Joint Management Assurance Group (Operating effectiveness)	Risk
We reviewed three sets of minutes for the Joint Management Assurance Group over the period March to November 2018 to ensure the group was operating in accordance with requirements. We identified the following points during our review: • The quorum requirements for the group states that a minimum of 10 members should be in attendance. From our review of minutes during 2018 a quorum was not met for the April and November meetings. We also note a quorum was also not met for November 2017, although this demonstrates that April and November were not isolated incidences. • Attendance at the meetings was particularly poor, with six members not attending any of the meetings sampled, though this only effected quoracy at the April and November meetings. • From our review of the minutes, there was no section where declarations of interest were noted, good governance would be to have a nil return noted if none declared. • No review date was visible on the terms of reference for the group.	The objectives of the Committee are not achieved.

Recommendation 3	Priority level
1. Members should be reminded of the importance of attending meetings. Expand to include wider review of the Terms of Reference. 2. Management should consider noting declarations of interest within the meetings.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. Management agrees with the findings and recommendation and will remind members of their respective responsibilities to attend the Joint Management Assurance Group. 2. A review of the existing Terms of Reference will be conducted and an ongoing review date established. 3. Declarations of interest will be included as part of the meeting requirements.	Stephen Harrhy – September 2019

Finding 4 - Planning Development and Evaluation Group (Operating effectiveness)	Risk

We reviewed three sets of minutes for the Planning, Development and Evaluation Group over the period March – November 2018. We identified the following points during our review:
• The terms of reference for the group has no members nominated from the following NHS organisations:
  ○ Powys Teaching Health Board;
  ○ Public Health Wales NHS Trust; and
  ○ NHS Wales Informatics Service.
• Attendance at meeting during the period was particularly low, with eight members not attending any of the meetings that we sampled and additional five members only attending one meeting.
• Minutes (Action Notes) from meetings do not have a section for declarations of interest, this should be a standard item that is recorded as a nil return if not indicated by members.
• No review date was visible on the terms of reference.
• The requirements of the group sets out that 12 members, one of whom must be the Chair or in the absence of the Chair, another member will be nominated to Chair, to be quorate. However, our review of the minutes of
	The objectives of the Committee are not achieved.

the March meeting identified only 10 individuals attending and therefore the quorum requirements were not met. On this occasion, this had no impact as no decisions were made during the meeting.	
Recommendation 4	**Priority level**
1. Management should review the Terms of Reference for completeness. 2. Management should remind members of the importance of attending meetings. 3. Management should consider noting declarations of interest at the meetings.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. A review of the existing Terms of Reference will be conducted and an ongoing review date established. 2. Management will remind members of their respective responsibilities to attend the Planning Development and Evaluation Group. 3. Declarations of interest will be included as part of the meeting requirements	Stephen Harrhy – September 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

**Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

**Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

**No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Sustainability Reporting

Final Internal Audit Report

2019/20

April 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 9

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTMU-1920-03
Report status:	Internal Audit Report
Fieldwork commencement:	28 March 2019
Fieldwork completion:	9 April 2019
Draft report issued:	17 April 2019
Management response received:	30 April 2019
Final report issued:	30 April 2019
Auditors:	Emma Samways, Deputy Head of Internal Audit Elizabeth Vincent, Principal Auditor
Executive sign off:	John Palmer, Chief Operating Officer
Distribution:	Russell Hoare, Acting Assistant Director OSS (Facilities) David Williams, Governance and Compliance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Our review of the Sustainability Report prepared by Cwm Taf University Health Board (the 'Health Board') was be completed in line with the 2019/20 Cwm Taf Morgannwg University Health Board Internal Audit Plan. The review seeks to provide the Audit Committee with assurance regarding the process for the production and approval of the Sustainability Report (the 'report').

The Government Financial Reporting Manual (the 'FReM') requires that entities falling within the scope of reporting under the Greening Government commitments, and which are not exempted by the *de minimis* limit, or other exemptions under Greening Government (or other successor policy), shall produce a sustainability report to be included within the Management Commentary in accordance with HM Treasury issued Sustainability Reporting in the Public Sector guidance.

Wales is unique in the UK in having sustainable development as its central organising principle. Sustainable reporting is an essential part of organisational governance in the public sector in Wales and the Welsh Government's aim is to enable integrated reporting.

From 2012/13 public bodies in Wales that report under the FReM and meet the FReM *de minimis* are required to produce a FReM sustainability report.

Guidance for the completion of sustainability reporting can be found on HM Treasury website. The format within the IFRS NHS Wales 2018/19 Manual for Accounts provides a recommended structure for NHS Wales bodies sustainability reports, including minimum requirements.

The 2013 Francis Report identified that Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.

The relevant lead for the review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of management arrangements for the production of the Sustainability Report within the Annual Report. The audit focussed upon the Health Board's 2018/19 report. The scope of the audit review was limited to the following aspects:

- There are appropriate arrangements for the preparation, approval and publication of the Sustainability Report including checks to ensure compliance with relevant guidance.
- The form and content of the report complies with the requirements of guidance published by the Welsh Government.
- Testing a sample of selected indicators to ensure the underpinning data is robust and reliable, conforms to specified data quality

standards and prescribed definitions, and is subject to appropriate scrutiny and review.

- Whether the information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake.

3. Associated Risks

The potential risks considered in the review were as follows:

- Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
- Reputational risk that the published information does not present a fair and balanced picture to stakeholders of the performance in the year.
- Data quality risk that published information is either incomplete or inaccurate due to a lack or failure of information governance controls overall or system controls over reported information for individual data elements.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Sustainability Reporting is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

We note that the Sustainability report for 2018/19 complies with the required format set out in the HM Treasury guidelines, and the information

published within the report provides a reasonable, detailed and consistent account of the Health Board's sustainability performance for 2018/19.

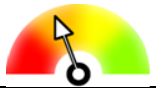
Suitable documented processes are in place for the capture of data, and evidence is kept to support individual and combined figures within the report. However, our sample testing identified slight differences when comparing the figures shown in the report to the source data. The discrepancies occurred due to human error, which would have been detected had the figures been checked by a second officer at the time of composing the report. We also identified some areas within the narrative of the document that required minor changes, these were discussed at the time of our audit fieldwork with the relevant managers.

The changes that we recommended have been made, and we understand that the final report will be presented to the Quality, Safety and Risk Committee for approval in June 2019.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate Arrangements			✓	
2	Compliance with Welsh Government				✓
3	Robust and Reliable Data			✓	
4	Information Provides and Accurate and Representative Data				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as weakness in the system control/design for Sustainability Reporting.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Sustainability Reporting.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate arrangements for preparation, approval and publication of the Sustainability Report.

We note the following areas of good practice:

- Overall responsibility for preparing the report remains with the Acting Assistant Director of Operational Support Services. The report was drafted by the Facilities and Estates team, and coordinated by the Facilities Governance and Compliance Manager.
- There are procedures in place for Environmental Sustainability reporting, which give clear instructions on how the figures are entered into the report. They describe the method to record, monitor, and retain the data that is input into the annual Environmental Sustainability Report.
- Version 1 of the Environmental Sustainability Report was presented at the March 2019 Environmental Management Steering Group for review and feedback. Version 2 of the report was reviewed by all the relevant managers and the Acting Assistant Director Facilities prior to submission to Audit and Assurance.

We identified the following finding:

- A second officer is not verifying the figures entered into the tables before the draft report it is submitted to Internal Audit for review.

Objective 2: The form and content of the report complies with the requirements of guidance published by the Welsh Government.

We note the following areas of good practice:

- The report details the environmental governance structure.
- The format of the report is in accordance with the guidance contained in the NHS Manual for Accounts.

- There is a summary of environmental performance, which includes key achievements during 2018/19 and key deliverables for 2019/20.
- The future planning and assurance section within the report is new to 2018/19. It explains the significant changes that the Health Board will be facing in the coming year, with the Bridgend boundary change transition and changes to national objectives and targets.
- Commentary on other environmental sustainability issues have been included, which summarises the objectives and targets that have been agreed by the Environmental Management Group to take forward as future projects.

We did not identify any findings under this objective.

Objective 3: Testing a sample of selected indicators to ensure the underpinning data is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

We note the following area of good practice:

- We were able to confirm that combined figures within the table for water had been calculated correctly, and were supported by appropriate evidence.

We identified the following finding:

- Our testing identified discrepancies in the data recorded within the first draft of the report for greenhouse gas emissions and waste management, when compared to the source documentation.

Objective 4: Whether the information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake.

We identified the following areas of good practice:

- The Health Board is compliant with ISO14001 for the main acute sites: Royal Glamorgan Hospital; and Prince Charles Hospital, and all community premises. The report includes tables that show how the Health Board is performing against the $C0_2$ emissions and water consumed targets.
- As part of its governance arrangements the Health Board has devised compliance scorecards, which detail legislative, statutory, and best practice requirements relating to environmental activities.
- As part of the ISO14001 programme the Health Board has developed a number of objectives and targets, which have been agreed and monitored by the Environmental Management Group (EMG) and are now part of a three year delivery plan.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**0**	**2**

Finding 1 - Validation by second officer (Operating effectiveness)	Risk
While we saw evidence that the narrative aspects of the report were reviewed by second officers, the validation of the data by a second officer does not appear to be taking place at the early stages of the production of the report. We identified a number of discrepancies in the data contained in the tables in version 2 of the report. We note that we reported similar findings in previous years.	Reputational risk that the published information does not present a fair and balanced picture to stakeholders of the performance in the year.
Recommendation	**Priority level**
Management should ensure that the figures that are entered into the sustainability report are carefully reviewed and confirmed by a second officer during the early stages of the production of the report. Crosschecks should be made to WG guidance issued to ensure all requirements are met.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. The Facilities Governance & Compliance Manager will act as a second officer and undertake diarised quarterly spot checks with the waste management team as an appropriate verification process. The spot check will involve the following:	Facilities Governance & Compliance Manager May 2019

• The second officer selecting a random sample of waste data from the master sheet and tracking this data back to the specific waste stream and site spreadsheet *(Check 1)*. • The second officer then tracking the same data back to the original waste consignment note / invoice that it originated from *(Check 2)*. • A record of the check, with date, will then be recorded as a comment on the spreadsheet. • For the quarter spot check before the Annual Sustainability Report submission a larger sample of waste data will be selected. The Facilities Governance & Compliance Manager and the waste management team will work together on the following improvements: • Increasing the efficiency of the waste invoice payment process by maintaining all documentation electronically, which allows more time to concentrate on inputting data into the waste spreadsheets and avoids discrepancies occurring due to human error. • Reducing the need for double input of waste data by adding formulas that allow the data to be automatically replicated accurately into the relevant spreadsheets. • Adding automatic checks to the relevant spreadsheets at key stages of the waste data input and replication process, in order to eliminate any discrepancies occurring.	

Finding 2 - Discrepancies in the figures reported (Operating effectiveness)	Risk
We tested two data items from each of the performance categories of greenhouse gas emissions, waste management, and the use of resources. Our testing identified discrepancies in the data reported for greenhouse gas emissions and waste management when compared to the source documentation. The error in the waste management figure had a wider impact as it was used to calculate other figures in the report. It appears that the discrepancies occurred due to human error. These differences were discussed at the time of our audit fieldwork with the relevant managers in order for the necessary amendments to be made to the draft report. While we confirmed that the necessary changes were made in a later iteration of the report, we have made similar findings in previous years.	Reputational risk that the published information does not present a fair and balanced picture to stakeholders of the performance in the year.
Recommendation	**Priority level**
Management should introduce an appropriate verification process to ensure that the data included in the Environmental Sustainability Report is accurate and can traced back to source records.	**Medium**

Management Response	Responsible Officer/ Deadline
Accepted. The Facilities Governance & Compliance Manager will act as a second officer and undertake diarised quarterly spot checks with the waste management team as an appropriate verification process. The spot check will involve the following: • The second officer selecting a random sample of waste data from the master sheet and tracking this data back to the specific waste stream and site spreadsheet *(Check 1)*. • The second officer then tracking the same data back to the original waste consignment note / invoice that it originated from *(Check 2)*. • A record of the check, with date, will then be recorded as a comment on the spreadsheet. • For the quarter spot check before the Annual Sustainability Report submission a larger sample of waste data will be selected. The Facilities Governance & Compliance Manager and the waste management team will work together on the following improvements: • Increasing the efficiency of the waste invoice payment process by maintaining all documentation electronically, which allows more time to concentrate on inputting data into the waste spreadsheets and avoids discrepancies occurring due to human error.	Facilities Governance & Compliance Manager May 2019

• Reducing the need for double input of waste data by adding formulas that allow the data to be automatically replicated accurately into the relevant spreadsheets. • Adding automatic checks to the relevant spreadsheets at key stages of the waste data input and replication process, in order to eliminate any discrepancies occurring.	

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings


Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.


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


Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.


No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Annual Quality Statement

Internal Audit Report

2019/20

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 8

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTMU-1920-15
Report status:	Internal Audit Report
Fieldwork commencement:	25 March 2019
Fieldwork completion:	17 April 2019
Draft report issued:	30 April 2019
Management response received:	7 May 2019
Final report issued:	7 May 2019
Auditors:	Emma Samways, Sian George
Executive sign off:	Professor Angela Hopkins, Interim Director of Nursing, Midwifery and Patient Services
	Greg Dix, Executive Director of Nursing Midwifery and Patient Care
,Distribution:	Alison Davies, Assistant Director Quality & Patient Experience
	Rebecca Thomas, Senior Nurse Professional Standards and Quality Improvement
	Allison Thomas, Business Manager, Quality & Safety
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Our review of the Annual Quality Statement (AQS) for Cwm Taf University Health Board was completed in line with the 2019/20 Cwm Taf Morgannwg University Health Board Internal Audit Plan. Cwm Taf Morgannwg University Health Board (the 'Health Board'), is the new name for the Health Board following the transfer of health services for the Bridgend area in April 2019. The review seeks to provide the Audit Committee with assurance regarding the process for the production and approval of the AQS.

The Health Board is required to publish an AQS reporting on the 2018/19 year, by 31 May 2019 in line with the annual accounting and reporting timetable. The AQS is a statement from the Health Board to the public. It provides an opportunity for the Health Board to let its local population know, in an open and honest way, how it is doing to ensure all its services are addressing local needs and meeting high standards.

The relevant lead Executive for the assignment is the Interim Director of Nursing, Midwifery and Patient Services.

2. Scope and Objectives

The overall objective of this review is to assist the Health Board with accuracy checking, including the triangulation of data and evidence, before the publication of the AQS.

The scope will be limited to assisting the Health Board to ensure that the AQS is accurate, complete and consistent with information reported to the UHB Board over the period. In addition, we will consider the Health Board's compliance with Welsh Government guidance for 2018/19.

The main areas that the review sought to provide assurance on were:

- The timetable for the production and publication of the AQS is appropriate.
- There has been appropriate stakeholder engagement in the production and review of the AQS.
- Planned developments and stated challenges from the 2017/18 AQS are appropriately reported within the 2018/19 AQS.
- Performance indicators detailed in the AQS are accurate and can be validated back to source information.
- Performance information and data within the AQS that demonstrates 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the Health Board.
- The AQS is compliant with 2018/19 Welsh Government guidance.

Limitation of scope

In a break from the approach undertaken in previous years, the Health Board has decided not to include quantitative data within its AQS for 2018/19. As such, we have not undertaken validation testing.

3. Associated Risks

The potential risks considered in this review were as follows:

- Failure to follow Welsh Government guidance.
- The public is not clearly informed of any improvement and challenges experienced in the range of services being provided, as well as improvement priorities for the forthcoming year; and
- The information detailed in the Annual Quality Statement is incomplete and / or incorrect.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Annual Quality Statement is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

Our review of the AQS process focused on the 'draft version thirteen' of the statement, as this was the iteration available at the time of our audit fieldwork.

A timetable had been created for the development of the AQS, which set deadlines for the various tasks for the AQS to be completed by the given publication date. The timetable took into account periods such as long Bank Holiday weekends, which would affect the number of days available. The timetable also included an outcomes column which was updated with brief notes following any meetings held, however this had not been completed from March onwards.

The draft document that we reviewed showed the Health Board's progress on a number of the improvement objectives which were set out in the 2017/18 AQS. In addition, we saw evidence of improvement objectives for 2019/20 being set out.

At the time of our fieldwork the draft AQS should have been distributed to external stakeholders for feedback, however the document was not in a position to be sent out, therefore external feedback was not sought as planned.

The AQS draft contained articles and pieces relating to work either being carried out or supported by the Health Board. These were relevant to the document and were supported with pictures and graphics. However, this year, unlike previous years, the report does not contain any quantitative data. We understand that as an alternative the document 'signposts' the reader to data. As such, there was no significant data for us to test within the AQS.

We were able to confirm that, in accordance with Welsh Government guidance, the Health Board's disclosure on 'Wales for Africa' has been included.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Timetable				✓
2	Stakeholder Engagement			✓	
3	Developments and Challenges				✓
4	Performance information				✓
5	Compliance				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as weaknesses in the system control/design for Annual Quality Statement.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Annual Quality Statement.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The timetable for the production and publication of the AQS is appropriate.

We note the following area of good practice:

- An appropriate timetable has been created for the production of the AQS. The timetable takes into account all aspects of the production of the AQS, including stakeholder engagement, translation and dates for submission to the relevant committees.

We did not identify any findings under this objective.

Objective 2: There has been appropriate stakeholder engagement in the production and review of the AQS.

We identified the following finding:

- At the time of our audit fieldwork external stakeholder engagement should have taken place with external partners and the Citizen Engagement Group. However, this had not taken place due to the AQS document not being in a refined state.

Objective 3: Planned developments and stated challenges from the 2017/18 AQS are appropriately reported within the 2018/19 AQS.

We note the following area of good practice:

- Developments and challenges for 2018/19 have been referenced in the AQS. New challenges and objectives have been set for 2019/20 which do not repeat the previous year's challenges and developments.

We did not identify any findings under this objective.

Objective 4: Performance information and data within the AQS that demonstrates 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the Health Board.

We note the following area of good practice:

- Performance information within the AQS demonstrates achievements and challenges during 18/19 is appropriate and consistent with our knowledge of the Health Board during the year.

We did not identify any findings under this objective.

Objective 5: The AQS is compliant with 2018/19 Welsh Government guidance.

We note the following area of good practice:

- The AQS document in its current draft format is compliant with Welsh Government guidance. It is 'jargon-free', clear and easy to understand. The document is well structured, and contains relevant information.

We identified the following finding:

- Unlike previous years, the 2018/19 AQS does not contain any quantitative data, instead it 'signposts' readers to data sources. Whilst this does not go against the Welsh Government guidance, there is a concern that some reader's ability to access such information electronically may be restricted, therefore impacting on information being 'accessible to all'.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**1**	**2**

Finding - 1 - Lack of external stakeholder engagement (Operating effectiveness)	Risk
The AQS drafting timetable gives the dates of 15–29 March 2019 for engagement with external partners, host organisations and the Citizen Engagement group. At the time of our audit fieldwork in April 2019, there had been no external stakeholder engagement. The reason given for this by the Senior Nurse Professional Standards and Quality Improvement, who was drafting the document, was that additional information needed for the document had not been received, and therefore the document was not in a state to be shared with these groups. In previous years we have raised similar recommendations regarding the way the stakeholder engagement is carried out, for both internal and external stakeholders. We note that when engagement with the stakeholders has taken place the feedback has been limited, often due to time constraints.	The public is not clearly informed of any improvement and challenges experienced in the range of services being provided, as well as improvement priorities for the forthcoming year

Recommendation	Priority level
The timetable for development of the AQS should be reviewed to ensure enough time is allowed to undertake external stakeholder engagement, and enough time for meaningful responses to be received from internal stakeholders. The approach to carrying out engagement with other parties and requesting feedback should be reviewed to ensure that those being engaged are able to provide meaningful feedback in a timely manner.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Following discussions at the All Wales AQS Group it is expected that the process for the development of the AQS going forward will change, this may affect how the timeline looks however, the timeline/development process will be reviewed and updated in line with WG guidance and monitored monthly through the AQS Editorial Group.	Senior Nurse Professional Standards and Quality Improvement. July 2019 (dependant on direction from WG)

Finding - 2 – Inclusion of quantitative data (Operating effectiveness)	Risk
This year, unlike previous years, the report does not contain any quantitative data. We understand that as an alternative the document will 'signpost' the reader to data. As such, there was no significant data for us to test within the AQS. A Welsh Health Circular (WHC) providing guidance to health organisations in relation to the 2018/19 AQS was issued by Welsh Government in January 2019. The WHC is not prescriptive on the use of quantitative data, but suggests that health organisations use a number of ways of 'telling the story', which could be through a mix of narrative and quantitative data presented 'clearly and succinctly'. We note that if the Health Board had worked with stakeholders prior to our audit fieldwork, it may have been able to gauge how not including quantitative data effected the WHC requirement for the document to be 'accessible to all'.	The public is not clearly informed of any improvement and challenges experienced in the range of services being provided, as well as improvement priorities for the forthcoming year
Recommendation	**Priority level**
The Health Board should work with stakeholders to understand if by not using quantitative data the AQS is achieving its objective of letting the resident population know how it is doing to ensure its services are addressing local need and meeting high standards.	**Low**

Management Response	Responsible Officer/ Deadline
Welsh Government's directive for how the AQS should be reported for 2019/20 is expected to change; It is anticipated that the WG directive will include direction on the objectives in order to inform the resident population and let them know how and what we are doing to ensure our services are addressing local need and meeting high standards. Once received this guidance will enable the AQS Editorial Group to discuss and ensure the inclusion of multiple information formats which may include quantitative data.	Senior Nurse Professional Standards and Quality Improvement. September 2019 (dependant on receipt of guidance from WG)

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

**Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

**Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

**No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Cwm Taf University Health Board

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2018/19

DRAFT

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS

Ref	Section	Page
1.	**EXECUTIVE SUMMARY**	**3**
1.1	Purpose of this Report	3
1.2	Head of Internal Audit Opinion	3
1.3	Delivery of the Audit Plan	3
1.4	Summary of Audit Assignments	4
2.	**HEAD OF INTERNAL AUDIT OPINION**	**5**
2.1	Roles and Responsibilities	5
2.2	Purpose of the Head of Internal Audit Opinion	5
2.3	Assurance Rating System for HIA Opinion	6
2.4	Head of Internal Audit Opinion	7
2.5	Required Work	10
2.6	Statement of Conformance	11
2.7	Completion of the Annual Governance Statement	11
3.	**OTHER WORK RELEVANT TO THE HEALTH BOARD**	**13**
3.1	NHS Wales Shared Services Partnership (NWSSP)	13
3.2	Hosted bodies of the Health Board	13
4.	**DELIVERY OF THE INTERNAL AUDIT PLAN**	**15**
4.1	Performance against the Audit Plan	15
4.2	Service Performance Indicators	15
5.	**RISK BASED AUDIT ASSIGNMENTS**	**16**
5.1	Overall summary of Health Board results	16
5.2	Substantial Assurance	17
5.3	Reasonable Assurance	18
5.4	Limited Assurance	22
5.5	Audits not undertaken	24
5.6	Audits undertaken at WHSSC	25
5.7	Audits undertaken at EASC	26
6.	**ACKNOWLEDGEMENT**	**27**

Appendix A Conformance with Internal Audit Standards
Appendix B Audit Results Grouped by Health Board Assurance Domain and Hosted Body
Appendix C Performance Indicators
Appendix D Audit Assurance Ratings
Appendix E Overall Opinion Criteria
Appendix F Responsibility Statement

Report status: Draft
Draft report issued: 8 May 2019
Final report issued: X May 2019
Author: Head of Internal Audit
Executive Clearance: Director of Audit and Assurance
Audit Committee: 13 May 2019

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Cwm Taf University Health Board's (the 'Health Board' or the 'organisation') Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year for the Health Board and its two hosted bodies, Welsh Health Specialist Services Committee (WHSSC), and the Emergency Ambulance Services Committee (EASC).

The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board, which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is biased towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion has been formed by summarising audit outcomes across eight key assurance domains. The overall opinion is based upon these grouped findings with all domains carrying equal weighting.

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

1.3 Delivery of the Audit Plan

The Internal Audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. Regular audit progress reports have been submitted to the Audit Committee during the year.

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards for 2018/19. We are now able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from the Internal Audit plan undertaken in the year and recognising audit provides a continuous flow of assurance that may include the results of legacy audit work reported subsequent to the prior year opinion. This report also references assurances received through the internal audit of control systems operated by NHS Wales Shared Services Partnership (NWSSP) for transaction processing on behalf of the Health Board.

The audit coverage in our plan that was 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.

In overall terms, we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Financial Governance and Management;
- Corporate governance, risk management and regulatory compliance;
- Strategic planning, performance management and reporting;
- Clinical governance quality and safety;
- Operational services and functional management;
- Information governance and security; and
- Workforce management.

However, the significance of the matters raised where there are clearly improvements to be made in governance, risk management and control impacts upon our overall audit assessment in the Capital and Estates domain. This specifically relates to our work in relation to the capital project at Prince Charles Hospital to redevelop the ground and first floor.

Management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where appropriate.

Please note that our assessment across each of the domains has also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (see also Sections 2.4.1 and 5.7).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit Opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Annual Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Cwm Taf University Health Board, which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Wales Audit Office (WAO) in the context of their external audit.

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

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide the forming of the opinion for 2018/19.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at Appendix D.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the eight assurance domains that were used to frame the internal audit plan at its outset. The aggregation of audit results by these domains gives a better picture of assurance to the Board and provides a rational basis for drawing an overall audit opinion.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the assurance domain ratings and overall opinion are consistent with the underlying audit evidence and in accordance with the criteria for judgement at Appendix E.

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk based audit plan, which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the limited assurance reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the opinion the Head of Internal Audit has applied both professional judgement and the Audit & Assurance '*Supporting criteria for the overall opinion'* guidance produced by the Director of Audit & Assurance and shared with key stakeholders (Appendix E).

The Head of Internal Audit has concluded *reasonable assurance* can be reported for the eight assurance domains.

The audit work undertaken during 2018/19 and reported to the Audit Committee has been aggregated at Appendix B.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews, which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

As stated above these detailed results have been aggregated to build a picture of assurance across the eight assurance domains around which the risk-based Internal Audit plan is framed. In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported.

During the year, for one review, relating to GP out of hours, the audit resource was re-allocated to a review of management arrangements within the primary care directorate. In addition, the proposed review of consultant job planning was deferred and the audit resource re-assigned to directorate reviews.

Further, we undertook two reviews that were not in the original plan for 2018/19. One related to a non-emergency patient transfer service baseline follow up review within the Emergency Ambulance Services Committee (EASC) programme of work. The second review was a follow up of the private and overseas patient review that was a limited assurance report in 2017/18.

Where changes were made to the audit plan, the reasons were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review; the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings in each of the domains is set out below. Each domain heading has been colour coded to show the overall assurance for that domain.

Corporate Governance, Risk Management and Regulatory Compliance

This year we have undertaken six reviews where the work lies within this domain.

TO BE UPDATED

Strategic Planning, Performance Management & Reporting

We have undertaken five reviews where the work lies within this domain.

TO BE UPDATED

Financial Governance and Management

We have completed three reviews in this domain.

TO BE UPDATED

Clinical Governance Quality & Safety

This year we have undertaken five reviews within this domain.

TO BE UPDATED

Information Governance & IT Security

We have undertaken three reviews in this domain.

TO BE UPDATED

Operational Service and Functional Management

We have undertaken three reviews within this domain in 2018/19.

TO BE UPDATED

Workforce Management

We have undertaken seven reviews where the work lies within this domain.

We also reviewed the recruitment process for mandatory training, and the management of absence targets. We issued a 'reasonable assurance' opinion for both of these reviews.

We looked at the retention of staff and issued a 'limited assurance' report.

TO BE UPDATED

Capital & Estates Management

This year we have completed four reviews in this area.

We gave 'substantial assurance' for the two mandated reviews in this domain: environmental sustainability, and carbon reduction commitment.

However, we gave 'limited assurance' for our review of water safety in which we identified five high priority, and eight medium priority recommendations. The high priority findings included monitoring and reporting to the water safety group and the infection prevention and control committee, and testing, sampling and monitoring in accordance with the water safety plan.

We also gave 'limited assurance' in our review of the Prince Charles hospital redevelopment project, which focused on the redevelop of the ground and first floor. We reviewed the approach to cost management, programme management, programme governance, and appointments and contracts. We had particular concerns in relation to cost management and programme management.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the Head of Internal Audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with Public Sector Internal Audit Standards (PSIAS) and with the agreement of senior management and the Board Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and subject to the key financials and other mandated items being completed in-year the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, all other work in progress will be rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2018/19 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews that remain relevant to the reporting of the Health Board's Annual Report required to be published by 30 June 2019. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance work completed as part of this current year's plan albeit relating to the 2017/18 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2018/19 Annual Report and Quality Statement.

2.5 Required Work

There are a number of pieces of work that Welsh Government has required previously that Internal Audit should review each year, where applicable. These pieces cover aspects of:

- Health & Care Standards, including the Governance, Leadership and Accountability standard;
- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report;

- Carbon Reduction Commitment; and
- Welsh Risk Pool.

Where appropriate, our work is reported in Section 5 – Risk based Audit Assignments and at Appendix B.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Cwm Taf University Health Board in conformance with the Public Sector Internal Audit Standards for 2018/19.

Our conformance statement for 2018/19 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2017/18 which will be reported formally in the Summer of 2019;
- the results of the work completed by Wales Audit Office; and
- the results of the External Quality Assessment undertaken by the IIA.

We have set out, in Appendix A, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2018/19 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;

- Results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS organisations there are a number of audits that we undertake each year, which while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. The Head of Internal Audit has had regard to these audits, which are listed below.

3.1 NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

- Primary Care Payments:
  - General Medical Services (Substantial)
  - General Dental Services (Substantial)
  - General Pharmacy Services (Substantial)
  - General Ophthalmic Services (Reasonable);
- Employment Services – Payroll (Reasonable);
- Procurement Services – Accounts Payable (Reasonable) (Draft); and
- Information Governance – General Data Protection Regulation (GDPR) (Substantial) (Draft).

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report.

3.2 Hosted bodies of the Health Board

In addition, as part of the internal audit programme at the Health Board a number of audits were undertaken in relation to both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialist Services Committee

- High cost drugs - We provided reasonable assurance for this review. We identified one medium priority, and one low priority recommendation. We identified good practice in relation to monitoring and recording of the agreed financial commitments per patient.
- Review of network groups and advisory boards - We gave reasonable assurance for this review. We identified three medium priority recommendations and identified good practice regarding the information available relating to the groups and boards on the WHSSC website.

- Risk management - We gave reasonable assurance for this review. We identified good practice in relation to WHSSC's integrated risk management framework, which defines its risk appetite. We identified three medium and one high priority recommendation. The high prior recommendation related to the need to ensure that organisational risks such as workforce related matters are clearly documented in departmental risk registers.
- Governance arrangements - We gave this review reasonable assurance as we identified three medium priority and one low priority recommendation. We identified good practice in relation to the regular monitoring and reporting of performance through the Joint Committee to Welsh Government.

Emergency Ambulance Services Committee

- Governance and performance - We gave reasonable assurance for this review. While we identified good practice relating to the establishment of sub-committee reporting into the Joint Committee, we identified four medium priority recommendations.
- Non-Emergency Patient Transport Service (NEPTS) Follow up of baseline position review – This review followed up on work that we had undertaken in 2016/17. We did not give an opinion for this review, but we concluded that good progress had been made in developing schedules for each of the components of the collaborative commissioning approach.

While the audit work undertaken at WHSSC and EASC has not been included in the domain opinions (identified in section 2.4.2), or in the overall Head of Internal Audit Opinion for the Health Board, the Head of Internal Audit has been mindful of the governance responsibility given to the Health Board with regards to the hosted bodies when considering if any issues raised in these audits could impact on the content of our annual report.

NHS Wales Informatics Service (NWIS)

We have also undertaken two audits relating to the processes and operations of NWIS. These were:

- Business Continuity (Reasonable)
- Change Control (Limited).

These audits are listed here for completeness as they may impact on the Health Board's activities, the Head of IA does consider if any issues raised in the audit could impact on the content of our annual report.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report, and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report along with the NWIS audits; the WHSSC and EASC audits are detailed in the Cwm Taf UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits which remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2018/19 operational audit plan.

The assignment status summary is reported at section 5 and Appendix B.

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. The key performance indicators are summarised in the Appendix C.

Post audit questionnaires are issued following the finalisation of audit assignments. As at 8 May 2019 the response rate has been 50% (15 out of 30) (2017/18, 67%). Where respondents have made specific comments, these have been reviewed by the Head of Internal Audit and/or Director of Specialist Services Unit for any necessary action.

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of Health Board results

In total 36 audits were reported to the Health Board's Audit Committee during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings

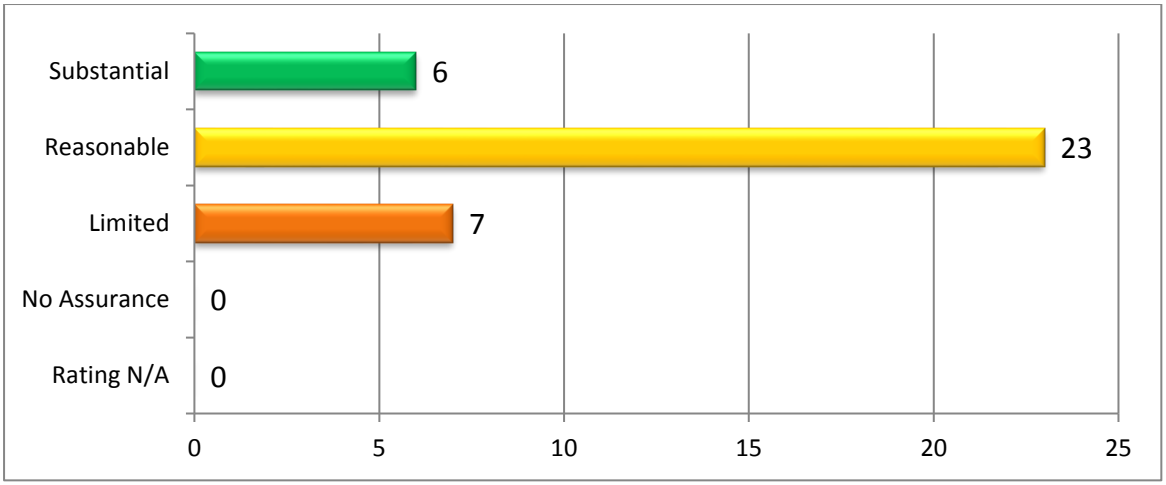


Figure 1 above does not include the audit ratings for the reviews undertaken at the two hosted bodies.

The assurance ratings and definitions used for reporting audit assignments are included in Appendix D.

In addition to the above, there was one audit, consultant job planning, that was brought forward and will be undertaken as part of the 2019/20 plan, and one audit relating to GP out of hours, where this was considered as part of a wider directorate review of primary care services.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance



In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Environmental sustainability	The overall objective of our review was to assess the adequacy of management arrangements for the production of the Environmental Sustainability report within the Health Board's Annual Report.
Welsh Risk Pool claims reimbursement	The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of claims reimbursement. Our review included checking that schedules had been completed appropriately and that claims had been accurately recorded in Datix.
Core financial system – Cash management	The objective of our review was to evaluate and determine the adequacy of the systems and controls in place for the management of cash.
Governance arrangements – Primary and Community Care committee	This review focused on the application of the terms of reference of the committee, the link to the IMTP, timely information flow, and scheduling of meetings.
Carbon reduction commitment	The emphasis of this review, whilst taking into account our previous review on the systems and processes applied, was on the verification and accuracy of data.
Directorate review – Primary Care – management arrangements – Planning and performance	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.

5.3 Reasonable Assurance



In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Annual Quality Statement (AQS)	The overall objective of our review was to assist the Health Board with accuracy checking, including the triangulation of data and evidence, before the publication of the AQS.
JAG accreditation process – follow up	The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the original JAG accreditation audit undertaken in 2017/18.
Performance management, monitoring and reporting – follow up	The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the original performance management, monitoring and reporting audit undertaken in 2017/18.
Private and overseas patients – follow up	The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the original private and overseas patient audit undertaken in 2017/18.
Patient experience	This review focused on the mechanisms, resources, and reporting of patient experience.
Directorate review – Facilities – management arrangements – Planning and performance	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.

Review Title	Objective
Continuing Health Care	We sought to assess the adequacy of the systems and controls in place in relation to CHC. We focused on the approval process, monitoring arrangements, changes to care packages, dispute resolution, and performance monitoring.
Service Change Plan	With a specific focus on the Early Cancer Diagnosis programme, the overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's management of processes for service change plans.
Directorate review – Facilities – Compliance	The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to compliance with key documents such as the financial control procedures. We also considered the directorate's compliance with the Health Board's scheme of delegation.
Directorate review – Primary Care – Compliance	The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to compliance with key documents such as the financial control procedures. We also considered the directorate's compliance with the Health Board's scheme of delegation.
Directorate review – Facilities – management arrangements – Governance and risk	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.
Risk management	The objective of this review was to look at the Health Board's strategy and policy to ensure that they were being appropriately applied. We also looked and the monitoring and scrutiny of the organisational risk register and Board Assurance Framework.

Review Title	Objective
Wellbeing of Future Generations Act (Wales) 2015	Our review considered how the Act had been incorporated into the Health Board's well-being objectives, and reflected in the IMTP.
Directorate review – Primary Care – management arrangements – Governance and risk	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.
General Data Protection Regulation (GDPR)	The overall objective of the audit was to provide assurance that controls were in place to enable compliance with GDPR, and that an information asset register was in place.
IT systems - continuity	The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place in relation to IT continuity. We specifically focused on back up arrangements, dependency on NWIS, and that departments understand their responsibilities.
Mandatory training	Our review focused on the Health Board's strategic approach, staff access to training platform, and monitoring and reporting.
Directorate review – Primary Care – management arrangements – Workforce	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.
Management of absence target	We focused our review on reporting and monitoring of sickness, training and guidance to staff, and the key documents that are in place to manage absence.
Directorate review – Surgery – management arrangements – Workforce (DRAFT)	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.

Review Title	Objective
Directorate review – Radiology – management arrangements – Workforce (DRAFT)	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.
Commissioning	Our review focused on the commissioning arrangement that the Health Board has in place with Powys Teaching Health Board. Over the past few years the Health Board has provided a range of general inter-health board services to PtHB via an LTA and more specific outreach services through a Service Level Agreement.
Mobile phone arrangements	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's processes for mobile phones.

5.4 Limited Assurance



In the following review areas the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Medical equipment and devices	Our review focused on policies and procedures, managing and updating medical equipment records, risk assessments and incident monitoring, training, and staff access to information.
Water safety	Our review evaluated the processes and procedures that support water safety management and control. The review assessed compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01, Safe Water in Healthcare Premises.
Management of major capital	This review focused on the project to redevelop Prince Charles Hospital. The review focused on the cost control system, project management and governance, and appointments and contracts.
Raising concerns	We assessed the adequacy of the systems and controls in place in relation to raising concerns. Our review specifically focused on management responsibilities and arrangements, the process in place, and the monitoring and reporting process.
Cyber security	The overall objective of the audit was to provide assurance to the Health Board that the mechanisms in place for ensuring cyber-security are appropriately designed, and procedures and controls have been implemented within the previously agreed timeframes as outlined within the recent external review of cyber-security.

Review Title	Objective
Retention of staff	Our review of the retention of staff process focused on data analysis, monitoring and reporting, and the strategy, policy and plan in place.
Directorate review – Facilities – management arrangements – Workforce	The overall objective of our review was to assess the adequacy of management arrangements with a particular focus on governance, risk, workforce, and planning and performance.

5.5 Audits not undertaken

Additionally, the following audits were not undertaken for the reasons outlined below.

Review Title	Objective
Consultant job planning	The 2018/19 Internal Audit plan included a review of consultant job planning. Following discussion with the Health Board, we agreed to undertake an expanded approach to our directorate reviews which considered consultant job planning. As such, we agreed with the Audit Committee to delay this review until 2019/20. The Head of Internal Audit assessed the potential impact of delaying this review on the overall Head of Internal Audit opinion and considered that there would be no impact on the opinion as an appropriate amount of audit work has been undertaken in other reviews within the operational service and functional management domain.
GP Out of Hours	We undertook work in relation to GP out of hours as part of our primary care directorate review.

5.6 Audits undertaken at WHSSC

We undertook the following reviews at WHSSC:

Review Title	Objective
High cost drugs	The objective of the audit was to evaluate and determine the adequacy of the systems and control in place for the approval and payment of high cost drugs. The audit focused on policies and procedures, monitoring, and checks on purchase orders and invoices. We issued a **reasonable assurance opinion** for this review.
Review of network groups and advisory boards	The objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the advisory groups that provide advice to WHSSC. The review focused on the terms of reference and reporting mechanisms. We issued a **reasonable assurance opinion** for this review.
Risk management	The objective of this audit was to evaluate and determine the adequacy of the systems and controls in relation to risk management. We focused on the application of the strategy and policy, and the monitoring and scrutiny of the organisational risk register and corporate risk assurance framework. We issued a **reasonable assurance opinion** for this review.
Governance arrangements	We looked at the governance arrangements operating within WHSSC. The particular focus related to the operation of the Joint Committee and its sub-committees. We issued a **reasonable assurance opinion** for this review.

5.7 Audits undertaken at EASC

We undertook the following reviews at EASC:

Review Title	Objective
Governance arrangements	The purpose of the review was to establish if appropriate governance and performance management arrangements are in place to ensure that EASC operates effectively and WAST performance is effectively monitored and managed. We looked at the application of the governance framework and the operation of the Joint Committee. We issued a **reasonable assurance opinion** for this review.
Non-Emergency Patient Transport Service – Follow up of baseline position review	The overall objective of our review was to provide EASC with an updated position of the information received from the ten health organisations at the time of our audit fieldwork as at October 2018, to ensure that this was being provided in line with the agreed action plan so that the phased transfers can be delivered. This was a follow up of a baseline review and did not issue an assurance opinion of this review. This review was not included in our plan for 2018/19, but was requested by EASC as an additional review.

6. ACKNOWLEDGEMENT

In closing, I would like to acknowledge the time and co-operation given by directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2018/19 plan.

Paul Dalton
Head of Internal Audit

Audit and Assurance Services
NHS Wales Shared Services Partnership

May 2019

ATTRIBUTE STANDARDS:	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. WAO complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS:	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan

	gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.
2100 Nature of work	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with WAO, HIW and LCFS.
2200 Engagement planning	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
23000 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition, audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.

2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

AUDIT RESULTS GROUPED BY HEALTH BOARD ASSURANCE DOMAIN AND HOSTED BODY

Draft Audit Summary by Assurance Domain							
Assurance domain	**Audit count**	**Overall rating**	**Not rated**	**No assurance**	**Limited assurance**	**Reasonable assurance**	**Substantial assurance**
Corporate Governance, Risk and Regulatory Compliance	6		-	-	• Raising concerns	• Risk management • Wellbeing of Future Generations Act • Primary care directorate - management arrangements • Facilities directorate - management arrangements	• Primary Care Committee – Governance arrangements
Strategic Planning, Performance Management and Reporting	5		-	-	-	• Facilities directorate - management arrangements • Continuing Health Care • Performance management – follow up • Service Change plan	• Primary Care Directorate – Management arrangements
Financial Governance and Management	3		-	-	-	• Commissioning	• Main financial systems • Welsh risk pool claims

Clinical Governance, Quality and Safety	5		-	-	• Medical equipment and devices	• JAG accreditation – follow up • AQS • Patient experience • Private and overseas patients – follow up	-
Information Governance and Security	3		-	-	• *Cyber Security (Draft)*	• GDPR • IT systems - continuity	-
Operational Service and Functional management	3		-	-	-	• Facilities directorate - Compliance • Primary Care directorate – Compliance • Mobile phone arrangements	-
Workforce Management	7		-	-	• Retention of staff • Facilities directorate management arrangements -	• Mandatory training • Primary care directorate - management arrangements • Management of absence targets • *Surgery directorate - management arrangements (Draft)* • *Radiology directorate - management arrangements (Draft)*	-

Capital and Estates Management	4		-	-	• *Water safety (draft)* • Management of major capital - PCH	-	• Environmental sustainability • Carbon reduction

WHSSC

Assurance	Audit count	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
WHSSC	4	-	-	-	● High cost drugs ● Review of network groups and advisory boards ● Risk management ● Governance arrangements	-

EASC

Assurance	Audit count	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
EASC	2	Non-Emergency Patient Transport Service – follow up of baseline review	-	-	● Governance and performance arrangements	-

Key to symbols:

● Audit undertaken within the annual Internal Audit plan

Italics Reports not yet finalised but have been issued in draft

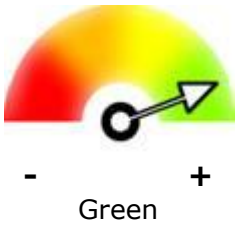
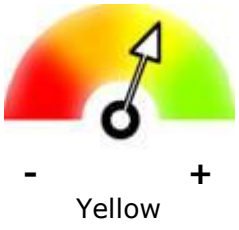
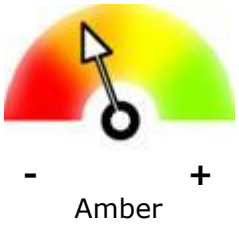
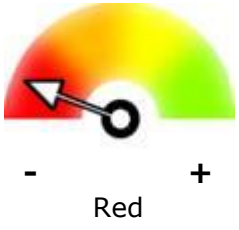
PERFORMANCE INDICATORS as at 7 May 2019

Indicator Reported to NWSSP Audit Committee*	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	February 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2018/19	TBC	85%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	TBC	85%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	TBC	67%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	TBC	100%	80%	v>20 %	10%<v<20%	v<10%

*Includes reports for the Health Board's two hosted bodies, WHSSC and EASC.

Key: v = percentage variance from target performance

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Overall opinion assessment matrix

Supporting criteria for the overall opinion

Criteria	Substantial Assurance	Reasonable Assurance	Limited assurance	No assurance
Audit results consideration				
Overall results				
Assurance domains rated green	≥5 green; and			
Assurance domains rated yellow	≤3 yellow; and	≥5 yellow; and		
Assurance domains rated amber	No amber; and	≤ 3 amber; and	≥5 amber; and	
Assurance domains rated red	No red	No red	≤3 red	≥4 red
Audit scope consideration				
Audit spread domain coverage	All domains must be rated	No more than 1 domain not rated	No more than 2 domains not rated	3 or more domains not rated

Note: The overall opinion (see section 2.4.2) is subject ultimately to professional judgement notwithstanding the criteria above.

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a

substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.



GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership
Audit and Assurance Services

Office details: Audit and Assurance Services
4-5 Charnwood Court
Heol Billinglsey
Parc Nantgarw
Cardiff
CF15 7QZ

Contact details: (01443) 848538