GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Annual Report and Accounts

2016 / 2017

The Annual Report and Accounts are part of the Health Board's public annual reporting and set out our service delivery, environmental and financial performance for the year and describe our management and governance arrangements.

The Annual Governance Statement, which is provided as an Appendix to this document, forms part of the Accountability Report section of this Annual Report, and provides a detailed report on our governance, arrangements for managing risk and systems of internal control.

The Annual Quality Statement, published separately, provides information on the quality of care across our services and illustrates the improvements and developments we have taken forward over the last year to continuously improve the quality of the care we provide.

Copies of all these documents can be downloaded from the Health Board's website at www.wales.nhs.uk/sitesplus/861/page/40903 or are available on application to the Health Board's Communications Team at BCUHB, Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG, by telephone on 01248 384776 or by e-mail to bcuhbpressdesk@wales.nhs.uk.

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Chairman's Foreword

I am pleased on, behalf of the Board, to present our Annual Report for 2016/17.

I am also pleased to report that the Board made good progress in many areas during the year and responded to the improvements that we need to make as part of 'Special Measures'.

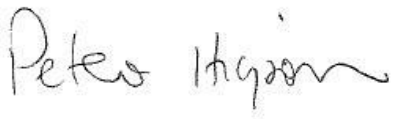
However, significant challenges remain, and we need to deliver improvements in a number of areas, including some areas of service/quality performance, and in our financial position.

We also continued to progress the investigations into Tawel Fan during the year.

The Board continued to engage widely on our developing strategy for the Health and Wellbeing of the people of North Wales over the next few years. This work will come to fruition in the current year and we will publish our Strategy and Three Year Plan before the end of March 2018.

Several new Directors joined the Board in 2016 and 2017. In addition to Gary Doherty who started at the end of February 2016, five new Directors joined the Board during the year: Andy Roach (Director of Mental Health and Learning Disability Services), Gill Harris (Executive Director of Nursing and Midwifery), Dr Evan Moore (Executive Medical Director), Teresa Owen (Executive Director of Public Health) and Adrian Thomas (Executive Director of Therapies and Health Sciences).

Our Annual Report is also an opportunity to acknowledge and recognise the huge commitment and dedication of our staff and to thank them. The results of our Staff Survey show we have made improvements in every area, but we know we still have much to do to improve further.



Dr Peter Higson OBE
Chairman

PART ONE – Performance Report

Overview

Chief Executive's Statement

The last year has seen the Health Board make good progress, but there is much still to do.

We have been able to demonstrate substantial progress against the requirements within the Special Measures Framework and have submitted evidence to support this to Welsh Government, Health Inspectorate Wales and the Welsh Audit Office.

This includes demonstrating that we are on track to develop a comprehensive three-year Integrated Medium Term Plan by the agreed date of April 2018. It is crucial that we maintain this progress, as moving away from a single year Operational Plan will provide the clarity and stability we need going forward.

As part of developing our Integrated Medium Term Plan and as part of our response to the requirements under Special Measures we have established more effective ways of engaging with our public and partners. During the year we held and attended over 300 engagement events across North Wales with local communities, stakeholders and staff, talking and listening to people about or services. We have made a particular effort to base our new Mental Health Strategy on an extensive engagement process.

Over the last twelve months there has been a substantial refresh of the Health Board's leadership team. The new appointments include a Director of Mental Health & Learning Disabilities, a Director of Nursing and Midwifery, a Medical Director, a Director of Therapies and a Director of Public Health. Two new Independent Members were appointed at the start of the year.

During 2016/17 the NHS Staff Survey took place across Wales. It was pleasing to see the results for the Health Board showed material improvements across every area, supporting the view that we are moving in the right direction. But we must aim for further improvement as the morale and commitment of our workforce are key priorities both in themselves and as a means to improve the care we give to patients.

It is also very important to recognise that, while there were areas of particular challenge, across North Wales the dedication and skills of our staff mean tens of thousands of patients have continued to benefit from high class care and treatment. Particular areas of note are:

- our exceptional performance in diagnostic tests, where there has been a significant increase in the number of tests carried out (over 10,000 more just in radiology) and at the end of the year only one patient had not been seen within the eight week target.
- some of the quickest performance in Wales for starting treatment for patients with cancer.
- reducing the number of times patients living with chronic health conditions have to come into hospital thanks to better support at home.

Just as important to me are the developments and improvements that are happening across North Wales thanks to the initiative and commitment of local teams and individuals. Things like the work of the team at Dolgellau Community Hospital to reach out to the local community and make people aware of ways to protect their own health and well being, the Hafod Community Mental Health team in Denbighshire who are the first in Wales to gain Community Mental Health Services accreditation from the Royal College of Psychiatrists or the podiatrist at Ysbyty Alltwen who has developed her skills and experience so she can provide many more services locally.

Looking ahead, over the next year it is important that we make progress to tackle waiting times in areas where patients are waiting longer then they should for treatment. Whether this is trying to get an appointment with a GP, waiting to complete treatment in our hospital Emergency Departments or waiting for clinic appointments and surgery, we know that there is a need for improvement. Orthopaedics and ophthalmology are two key areas where we will be focusing our efforts.

Our financial position also remains a cause of concern. Health Boards are required to balance their income with expenditure over a rolling three-year period; a requirement which we have been unable to meet. In 2016/17 we overspent by £29.8m pounds. The Health Board's performance against our financial duties has been the subject of a narrative report by the Auditor General for Wales, which can be viewed at the end of this report (page 66). Moving to a position of financial stability and sustainability is a key priority for the Health Board which we must address through our Integrated Medium Term Plan.

Gary Doherty
Chief Executive

Our purpose and activities

The Health Board is responsible for improving the health and wellbeing to a population of around 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham). This encompasses prevention of ill health as well as treating illness and providing excellent healthcare services.

The Health Board is responsible for the provision of primary, community and mental health as well as acute hospital services. It operates three main hospitals (Ysbyty Gwynedd in Bangor, Glan Clwyd Hospital in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases. The Health Board also coordinates the work of 109 GP practices and NHS services provided by dentists, opticians and pharmacists in North Wales.

In 2016/17 the Health Board had a revenue income of £1.3 billion and employed approximately 16,800 people (14,400 whole time equivalents).

Our Vision

- We will improve the health of the population, with a particular focus upon the most vulnerable in our society.
- We will do this by developing an integrated health service, which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.
- We will develop our workforce so that it has the right skills and operates in a research-rich, learning culture.

Our Strategic Goals

- Improve health and wellbeing for all and reduce health inequalities.
- Work in partnership to design and deliver more care closer to home.
- Improve the safety and outcomes of care to match the NHS' best.
- Respect individuals and maintain dignity in care.
- Listen to and learn from the experiences of individuals.
- Support, train and develop our staff to excel.
- Use resources wisely, transforming services through innovation and research.

Our purpose, vision and strategic goals set out the long terms aims of the Board. We have further work to do to translate these into specific objectives for improvement in population health and health services which we will include in our plans going forward.

Our Quality Improvement Strategy for 2014 to 2017 focuses on three domains including the patient experience, the safety of our services to improve health outcomes and the quality of outcomes delivered through clinical excellence. The strategy builds upon the Health Board's stated values which were identified during a thorough engagement process including patients, staff and other key stakeholders. A review of this work is now underway and we are engaging with staff about the second phase of the Quality Improvement Strategy for the period 2017-2020.

As well as improving health and delivering clinical and care services, the Health Board has a wider public sector duty to support national policy, for example in respect of matters such as promoting equality and human rights, the environment, sustainable development and the Welsh Language.

To achieve our goals we work closely with partner organisations such as local authorities and the voluntary sector, to discuss and address health inequalities, promote community engagement and exploit joint working opportunities. The bodies include:

- Welsh Ambulance Services Trust;
- Public Health Wales;
- North Wales Community Health Council;
- Local Authorities (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham);
- Neighbouring NHS bodies in England and Wales;
- The Community Voluntary Councils;
- Partnership Service Boards / Regional Leadership Boards.

Planning framework

The NHS Wales Planning Framework requires Health Boards to prepare and submit three-year Integrated Medium Term Plans (IMTPs) to the Welsh Government.

As a result of Special Measures, Welsh Government has confirmed that the Board will not be expected to submit a three year Integrated Medium Term Plan for 2016-19. Instead, for 2016/17, an Annual Operational Plan was agreed. This Annual Operational Plan focused on the core elements of service delivery and identified the following areas for service improvement:

- Improving health and tackling health inequalities
- Primary care development and improving chronic conditions management
- Planned care
- Unscheduled Care
- Quality and safety
- Mental Health and Learning Disabilities
- Children's services
- Maternity services
- Listening and engagement
- Strategy and Service Planning
- Responding to concerns.

Alongside this there is a clear timeline for developing the Health Board's overall strategy 'Living Healthier, Staying Well' and to ensure that an IMTP is in place by March 2018. An extensive programme of engagement with a wide range of stakeholders has taken place to underpin the development of the strategy and IMTP.

As part of the development of this overall strategic direction and plan, the Health Board has developed three Strategic Framework documents (covering Primary care and Community Services, Mental Health Services and Maternity, Neonatal and Paediatric services) to meet the requirements of Phase 2 of Special Measures.

Key issues & risks affecting delivery of objectives

The Health Board has a challenging risk profile resulting from the diversity of services provided, ranging from primary and community services through to acute hospital wards as well as mental health services and a medium secure unit. In addition, the Health Board has a wide geographical spread, cultural diversity and significant provision of services from England. It also has to be capable of dealing with peaks in demand as a result of North Wales being a holiday destination of choice for many.

During the year the Board approved an Audit Committee recommendation to move to an integrated Corporate Risk and Assurance Framework approach that brought together the former Board Assurance Framework document and Corporate Risk Register.

The Health Board has determined nine principal risks to achieving its corporate goals:

- Failure to maintain the quality of patient services
- Failure to maintain financial sustainability
- Failure to manage operational performance
- Failure to sustain an engaged and effective workforce
- Failure to develop coherent strategic plans
- Failure to deliver the benefits of strategic partnerships
- Failure to engage with patients and reconnect with the wider public
- Failure to reduce inequalities in health outcomes
- Failure to embed effective leadership and governance arrangements.

In addition, during the year one new risk in relation to Safeguarding has been identified and is now included on the Corporate Risk and Assurance Framework (CRAF). The Board has also requested that the risk in relation to the preparation of the IMTP be divided into two elements, separating out the development of the Health Board's overall strategic intentions and direction from the drawing up of the three year integrated plan.

Each risk area noted on the CRAF is linked to one of these principal risk areas. The details of the current controls and the further actions being taken for each of the risks identified is detailed within the Health Board's CRAF which is publicly available via the BCUHB website.

Four specific risk areas relating to Special Measures are detailed in sections 18-20 of the Annual Governance Statement, which is appended to this report.

Performance Analysis

Summary

Our performance is measured across seven key domains or areas, aligned to the Welsh Government's Health Care Standards and National Performance Frameworks.

The summary dashboard below shows our performance across the range of indicators the Welsh Government use to measure all Health Boards in Wales. Whilst performance against the Staying Healthy domain has remained broadly unchanged, overall our performance has improved across the domains of Safe Care, Dignified Care and Individual Care, but worsened across the domains of Effective Care, Timely Care and Staff & Resources.

Each month we provide detailed briefings to our Board on our performance, explaining where we are, what we are doing about areas which need to improve, and when we expect to be back on track.

	Improved performance	Sustained performance	Decline in performance	Target Summary
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health	5 measures	0 measures	5 measures	
SAFE CARE - I am protected from harm & protect myself from known harm	7 measures	0 measure	2 measures	
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same	2 measures	0 measures	1 measure	
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful	1 measures	0 measures	7 measures	
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care	9 measures	0 measures	12 measures	
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities	3 measure	1 measure	2 measures	
OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on use of resources & I can make careful use of them	10 measures	0 measures	1 measures	
SUMMARY	**37 measures**	**1 measures**	**30 measures**	

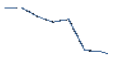
We include both national and local indicators in our reporting to reflect our local priorities and improve the health, care and experience of the North Wales population.

Staying healthy

This area of our performance ensures that we work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

We want our citizens to be empowered to take responsibility for their own health and wellbeing, and to make sure that carers of individuals who are unable to manage their own health and wellbeing are supported.

We have many goals in this area to improve the health of the population; from ensuring that children have a healthy start in life to ensuring that patients who have had lifelong chronic conditions are well supported to live in the community.

Our performance indicators		Period	Value		Trend
Uptake of the national influenza vaccination for:	Over 65 years of age	Mar-17	68.7%		
	Under 65 years of age in at risk groups	Mar-17	49.3%		
	Pregnant women	Mar-17	75.3%		
	Healthcare workers	Mar-17	49.4%		
Rate of emergency hospital admissions within a year for 8 chronic conditions, per 100,000 of the population.		Rolling 12m Dec-16	976		
Rate of emergency hospital readmissions within a year for 8 chronic conditions, per 100,000 of the population.		Rolling 12m Dec-16	215		
% of estimated LHB smoking population treated by NHS smoking cessation services.		Q3 16/17	3.10%		
% of smokers treated by NHS smoking cessation services who are CO-validated as successful.		Q3 16/17	29%		
% of pregnancies where initial assessment carried out by 10 weeks of pregnancy		Mar-17	77%		
% of children who received their scheduled vaccinations at age 4		Q4 16/17	88.6%		

Immunisation

Protecting people against the risk of flu is a major element in helping the NHS reduce the demand for emergency care over the winter period. The national target is for 75% of the eligible groups (people aged over 65, and those aged below 65 who are at greater risk from infection) to be vaccinated. The number of people eligible to be vaccinated has increased from last year, and our services have worked hard to promote the need for vaccination.

As a result, by 31st March 2017, over 6,000 more people in North Wales had been vaccinated compared to the year before. North Wales had the second highest take up rate in Wales, but at 68.7% for those over 65 and 49.3% for those under 65 we need to continue our efforts to encourage people to protect themselves.

Compared to the same point in previous year's campaign		Eligible	Immunised	% Uptake
65 years +	2015-2016	153,997	103,074	66.9%
	2016-2017	158,298	106,432	67.2%
6 months to 64 years	2015-2016	76,986	33,657	49.3%
	2016-2017	77,598	36,576	47.1%

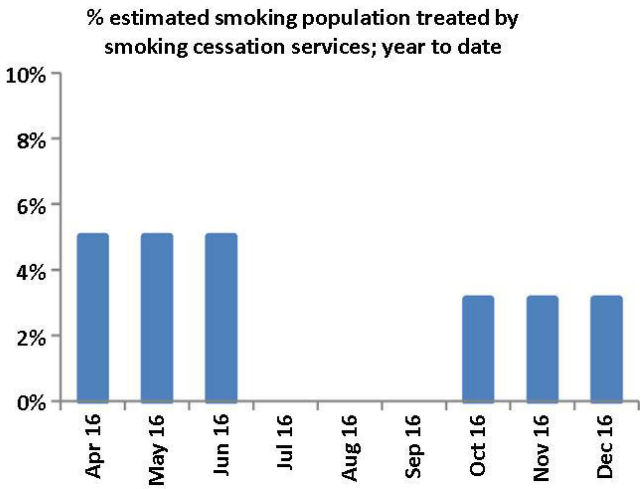
Hospital admissions

Health teams working in the community in both primary and secondary care collaborate on a number of initiatives which are designed to reduce the number of times patients living with chronic conditions have to be admitted into hospital. We monitor this by looking at how many times patients with any of eight common conditions have been admitted (reported as a rate per 100,000 population over the preceding 12 months).

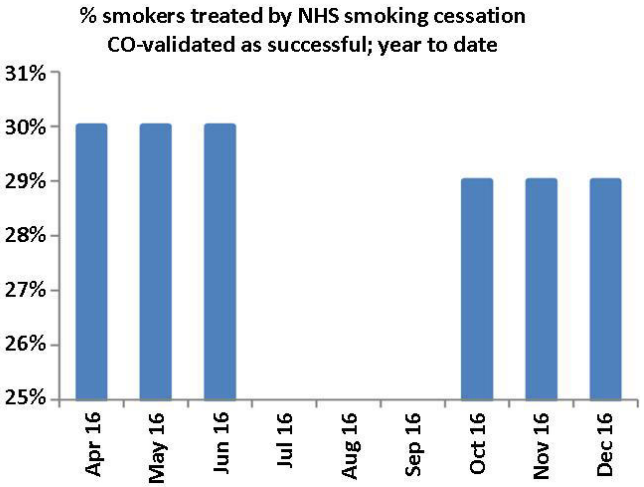
The most recent data (as at 31st December 2016) shows that BCUHB had the lowest rate of admissions (976 per 100,000 people) in Wales, and the third lowest rate of re-admissions (215 per 100,000), which is ahead of our planed performance for the year.

Smoking cessation

The Health Board aimed to get 5% of the smoking population to access smoking cessation services during the year. As at 31st December 2016 (the latest available data), the Health Board's Smoking Cessation Services had treated 3.1% of the smoking population which was the best performance in Wales, despite not reaching the 5% target.



Of those people who were treated by the smoking cessation services, 29% went on to be validated as having stopped smoking. This was some way below the 40% target and it is clear that we need to do more work ensure that a larger proportion of those who access our smoking cessation services are able to successfully escape from their smoking habit and this will be a key priority and this will be a key area of focus for 2017/18.



Safe care

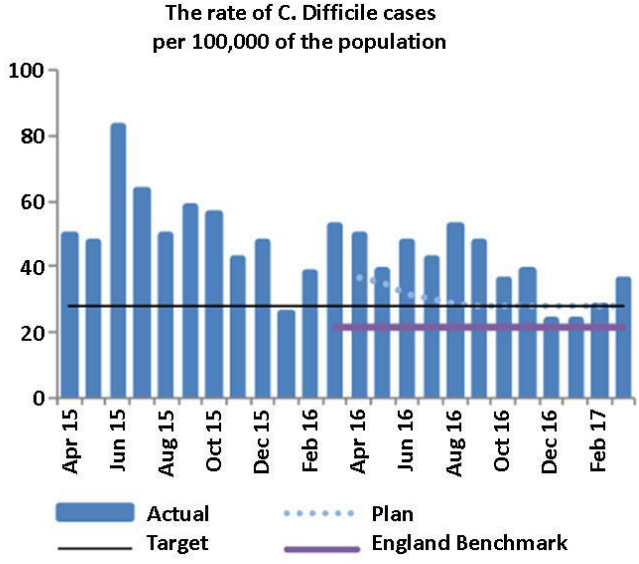
This area measures the safety of our services and includes how we minimise risk and maximise safety. It covers areas such as preventing pressure ulcers and tissue damage, falls prevention, infection prevention and control, nutrition and hydration, medicines management, safeguarding children and adults at risk and complaints.

Our performance indicators	Period	Values		Trend
Number of cases of C Difficile per 100,000 of the population.	Mar-17	35.6		
Number of cases of Staphylococcus aureus per 100,000 of the population.	Mar-17	18.7		
Fluoroquinolone items as a % of total antibacterial items prescribed	Q4 16-17	2.08		
Cephalosporin items as a % of total antibacterial items prescribed	Q4 16-17	3.93		
Co-amoxiclav items as a % of total antibacterial items prescribed	Q4 16-17	2.57		
NSAID average daily quantity per 1,000 STAR-Plus	Q4 16/17	1,524		
% GP practices >= national target for submission of yellow cards that monitor the safety of medicines	16 /17	16.2%		
Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescales	Mar-17	33%		
Number of Patient Safety Solutions Wales Notices that were not assured within the agreed timescales	Mar-17	6%		
Of the Serious Incidents due for assurance within the month, the % which were assured within the agreed timescale.	Mar-17	68.1%		
Number of new Never Events.	Mar-17	1		

Infection prevention

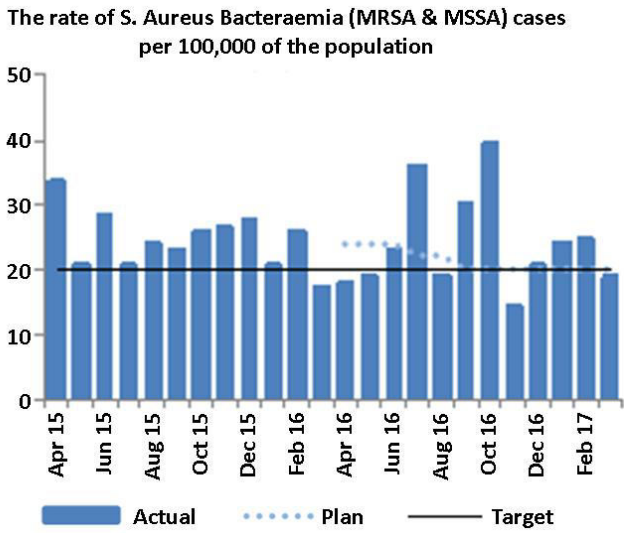
We continue to work hard on reducing the number of healthcare associated infections that affect our patients and we continued to see a downward trend on the number of infections for *Staphylococcus aureus* (Meticillin-resistant *Staphylococcus aureus* and Meticillin-sensitive *Staphylococcus aureus*) and *Clostridium difficile*.

The number of people across North Wales with *Clostridium difficile* infection has reduced by 25% from 355 in 2015/16 to 268 in 2016/17.



Reducing this infection remains a priority focus for us. In 2016-17 BCUHB completed a research study on *Clostridium difficile* infection. This confirmed that approximately 75% are directly linked to antibiotic use, and we are increasing our efforts to ensure antibiotics are used only when they are needed in hospitals and by GPs.

For *Staphylococcus aureus* bloodstream infections we reduced the number of people affected slightly from 168 in the preceding year to 165, of these 31 people had Meticillin-resistant Staphylococcus aureus (MRSA). The Welsh Healthcare Associated Infection programme has highlighted that for the national reduction target period BCUHB has the second lowest rate of these infections, 22% better than the all-Wales rate.

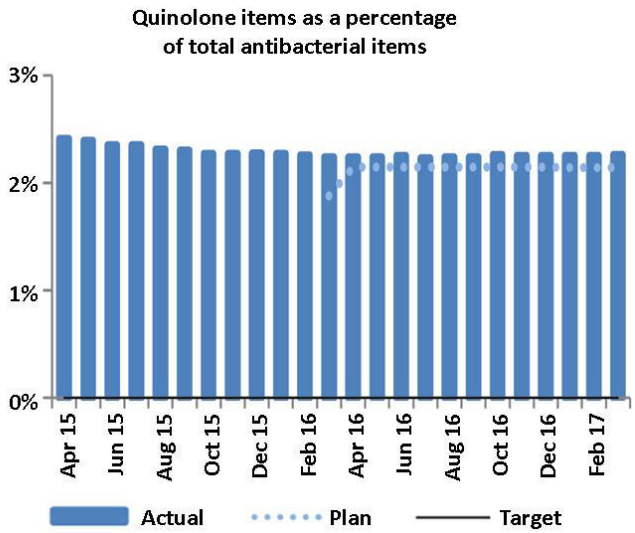


In order to achieve a significant reduction in the number of people developing these infections in 2017-18, we are focussing on improving the care of medical devices, especially those that break the skin such as intravenous cannulae (drips) and urinary catheters, and improving our MRSA screening practices.

Antimicrobial prescribing

With microbes becoming increasingly resistant to antimicrobial treatments, we are trying to reduce the number of prescriptions for three antimicrobial drugs: Quinolone, Co-amoxiclav and Cephalosporin.

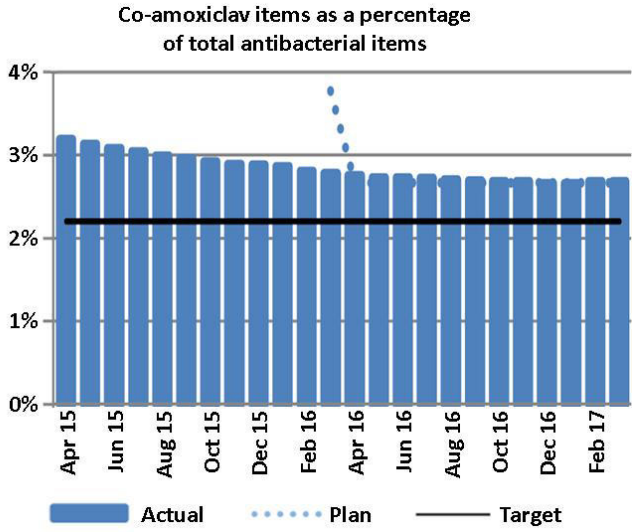
Performance is expected to continue on an improving trajectory. At 31st March 2017 the Quinolone prescribing rate at 2.3%; although just above the target threshold of 2.1%, this was the lowest rate in Wales.

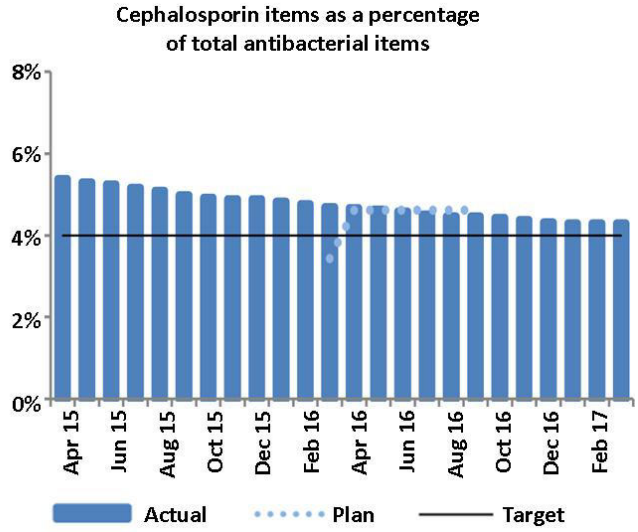


Our pharmacists are working closely with GP practices to develop a new chart to assist GPs with reducing their antimicrobial prescribing.

Work continues to permanently expand the antimicrobial pharmacist team. This will enable them to have a greater presence within GP Practices, carrying out targeted investigations to understand the factors that drive prescribing patterns and identify where prescribing rates can be appropriately reduced.

Events to address public expectation of prescribing and engage key stakeholders to improve education for the public and healthcare staff are also planned.



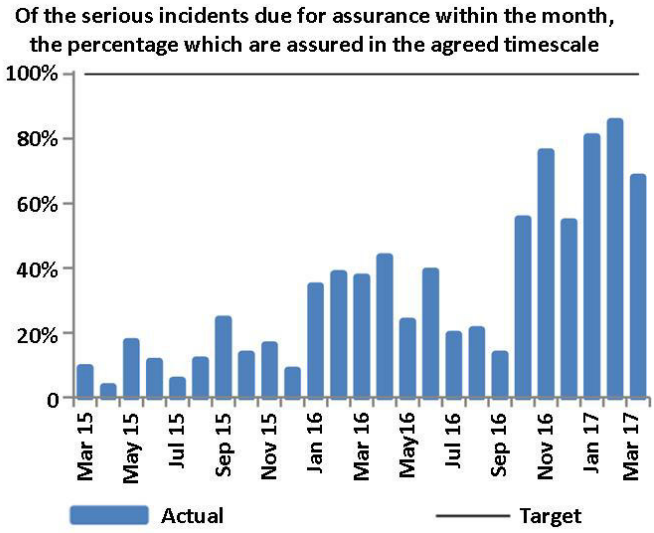


Welsh Government reportable serious incidents

Where serious adverse incidents occur, it is important that these are thoroughly investigated, that we learn from what has happened and put in place measures to prevent them recurring and improve patient safety.

We are required to report serious incidents to the Welsh Government and to demonstrate, within an agreed timescale, that we have taken appropriate measures to reduce the risks of similar incidents happening in future.

This is an area where the Health Board has not always responded as quickly as it should. However over the course of the last year, despite a temporary drop in performance over the summer, there has been a sustained focus on this work, resulting in a significant improvement over the course of the year.



Never events

Never Events are serious adverse incidents that our systems and processes should ensure are never able to happen and we are committed to achieving this. One never event was reported during the year, in June 2016, compared to six reported in 2015/16.

All Never Events are reported directly to our Clinical Executives as soon as possible following the incident, and are fully investigated by the Health Board. The investigation is chaired by a Director and carried out by the Senior Investigation Managers with support from the Welsh Government' Delivery Unit. This ensures that robust investigations are carried out, all relevant lessons are learned and shared across the organisation, and any necessary actions are taken to prevent an incident from recurring.

Dignified care

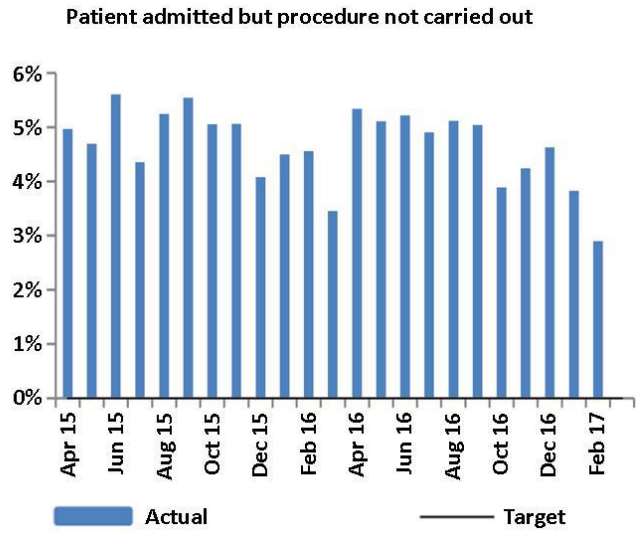
Our goal is that people's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs

Our performance indicators	Period	Value		Trend
% patients who had their procedure postponed more than once & had their procedure within 14 days or the patient's earliest convenience	Mar-17	25%		
% of people with dementia, aged >=65 years, who are diagnosed	2015/16	49%		
% GP practice teams that have completed mental health Direct Enhanced Services in dementia care or other directed training	2015/16	56.3%		

Patient admitted but procedure not carried out

We try very hard not to cancel a patient's surgery after they have been admitted, and our aim is for this to never happen for non-clinical reasons.

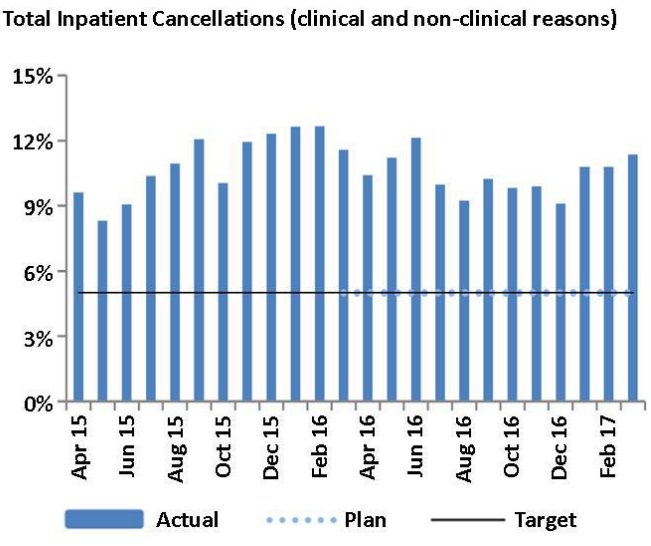
Between June 2015 and June 2016 around 5% of operations were postponed after patients had come into hospital. However since then we have achieved a sustained reduction and by December 2016 (latest available data) the rate was down to 2.0%. We will endeavour to continue this rate of improvement and to achieve our aim by the end of summer 2017.



Total inpatient cancellations (clinical & non-clinical reasons)

Reducing the number of operations cancelled after patients have been admitted has also helped to bring down our overall cancellation rates.

With the exception of a spike of in June 2016, the overall trend during 2016/17 has been downwards, demonstrating sustained improvement in performance against this measure. For February 2017 (latest available data) we were still above the target rate of 5% at 9.1% however weekly planning and review meetings will ensure that performance will continually improve and the target rate of 5% will be achieved in 2017/18.



Caring for people with dementia

One of the biggest challenges facing the NHS is to provide the right care to the increasing number of people living with dementia when they need to use health services.

John's campaign, which allow carers and families to carry on supporting their relative with their daily routines while they are in hospital, in an effort to decrease anxiety levels is being rolled out across North Wales

The Health Board has now established ten standards to make life easier for patients and their families while in hospital and Ysbyty Alltwen is the first to take on the challenge of becoming fully dementia supportive. As well as implementing John's campaign, staff awareness training has been carried out, the Butterfly scheme helps staff identify patients with dementia has been introduced, new signs and colour schemes introduced to help patients find their way around the ward and links set up with Dementia Friends.

Effective care

These indicators demonstrate how our care, treatment and decision making reflects best practice based on evidence. They also reflect how our services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

We assess the effectiveness of our care using a number of measures including national indicators, as well as more locally focussed indicators. In this section of the report, we cover mortality, research and the accuracy of the information we use to make decisions. In addition we also report on how many patients have not been able to move on from hospital once they are clinically fit to do so, which is an indicator of how effectively the overall health and care system is working.

Our performance indicators	Period	Value		Trend
Rate of non-mental health delayed transfer of care per 10,000 of Local Authority population (aged 75+ years).	Rolling 12m Mar-17	207.5		
Rate of mental health delayed transfers of care per 10,000 of Local Authority population (all ages).	Rolling 12m Mar-17	2.9		
% Crude mortality rate (< 75 years of age)	Rolling 12m Mar-17	1.78%		
% episodes clinically coded within one month post episode end date	Mar-17	38.2%		
Number of Health & Care Research Wales Clinical Research Portfolio Studies	16/17	98		
Number of Commercially sponsored studies	16/17	6		
Number of patients recruited into Health & Care Research Wales Clinical Research Portfolio Studies	16/17	1540		
Number of patients recruited into commercially sponsored studies	16/17	553		

Delayed transfers of care

Delayed transfers of care continue to be a significant issue for the Health Board as they contribute to the overall pressures on our acute hospitals. The rate of delayed transfers was slightly higher at the end of this year than last, for patients in both our mental health and non-mental health services.

As part of our work to address this, in late 2016 a five day workshop was held, involving directors and senior colleagues from the Health Board and Social Services departments across North Wales and culminating in the involvement of the local authority and BCUHB Chief Executives. They carried out a detailed review of the current systems for providing ongoing nursing home, residential and domiciliary care to people leaving hospital and agreed how their organisations would work together to tackle the issues that were identified through this work.

Mortality

The Crude Mortality figure is based on the number of deaths in a specific period divided into the average total population of that period. For the year 2015 we reported a rate of 1.82%, while for 2016 we have seen a slight decrease (i.e. an improvement) to 1.79%.

The team in the Office of the Medical Director are looking at the way we review the care of patients who die, and are working with Abertawe Bro Morgannwg University Health Board to introduce an electronic system to support this work.

Timely care

Our aim is that all aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff. As the demand for services increases we face real challenges in maintaining high levels of access for our patients.

Our performance indicators		Period	Value		Trend
% of GP practices offering appointments between 17:00 and 18:30 hours on 5 days per week.		Q4 16/17	75.2%		
% of GP practices open during daily core hours within 1 hour of the daily core hours.		Q4 16/17	89.0%		
Of those practices set up to use My Health On-Line, % who are offering appointment bookings.		Q4 16/17	34%		
Of those practices set up to use My Health On-Line, % who are offering repeat prescriptions.		Q4 16/17	89%		
Patients treated by an NHS dentist in the last 24 months as % of population		Last 24m Mar-17	49.8%		
% of patients waiting less than 26 weeks for treatment (RTT).		Mar-17	87.2%		
Number of RTT 36 week breaches. (All residents)		Mar-17	4113		
% of patients waiting more than 8 weeks for specific diagnostics.		Mar-17	1		
Number of follow up appointments delayed past their target date (booked and not booked) (Reporting recommenced April 2017)		Apr-17	69,537		
% compliance with stroke quality improvement measures	Direct admission to Acute Stroke Unit (<4 hrs)	Mar-17	43.9%		
	CT Scan (<12 hrs)	Mar-17	90.24%		
	Assessed by a Stroke Consultant (< 24 hrs)	Mar-17	87.8%		
	Thrombolysis door to needle <= 45 mins	Mar-17	42.9%		
% of new patients spending no longer than 4 hours in A&E.		Mar-17	77.54%		
% of ambulance red call responses within 8 minutes.		Mar-17	74.9%		
Number of patients spending 12 hours or more in A&E.		Mar-17	1161		
Number of over 1 hour handovers.		Mar-17	856		
% of patients referred as non-urgent suspected cancer seen within 31 days.		Mar-17	98.6%		
% of patients referred as urgent suspected cancer seen within 62 days.		Mar-17	92.6%		
% of assessments by the LPMHSS undertaken within 28 days from the date of referral		Mar-17	82.34%		
% of therapeutic interventions started within 28 days following assessment by LPMHSS		Mar-17	77.32%		

Referral to Treatment

Referral to Treatment (RTT) measures the total time a patient waits after they have been referred by their GP until they start their active hospital treatment. This includes time spent waiting for outpatient appointments, diagnostic tests, scans, therapy services and inpatient or day-case admissions. The two targets for Wales are that 95% of patients are treated within 26 weeks and that no patients wait longer than 36 weeks.

We were not able to meet these targets during the year: at the end of March 2017 87.2% of patients were waiting for less than 26 weeks.

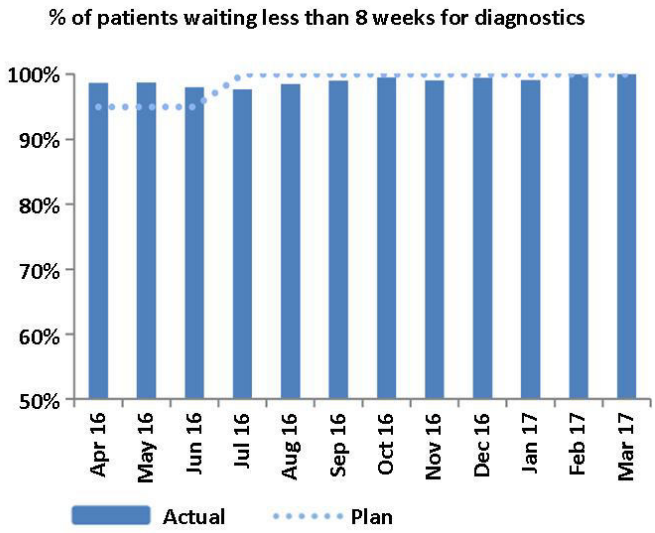
As we work to improve this performance, we agreed an interim target with Welsh Government that we would reduce the number of patients waiting for more than 36 weeks to 4,600 by the end of March 2017. As a result of significant investment and enormous commitment from our clinical and management teams, we surpassed the target by almost 500 patients and at the year's end 4,113 patients were waiting for more than 36 weeks.

Diagnostics

The target for diagnostic treatment covers a range of diagnostic procedures including x-rays and scans, endoscopies, physiological tests and neurological assessments. The target is that no patient should wait for more than 8 weeks before undergoing these tests and scans.

At the end of quarter 4 our performance against the target achieved 99.99%, which represents just one patient waiting over 8 weeks in March 2017.

Throughout the year the team has worked hard to secure additional capacity and provide additional clinic sessions where needed. Despite significant operational challenges the service has considerably reduced its waiting list. The service is recruiting to another substantive post to provide additional capacity allowing more flexibility for booking patients.



Emergency Department

We know this is an area where we need to find ways to improve our performance. Our position against the four hour waiting time standard is monitored daily through a report to the Chief Operating Officer so that we can actively manage and improve our performance. The proportion of patients spending less than 4 hours in our emergency department has improved from 73% at March 2016 to 77% at the end of March 2017. The number of patients spending more than twelve hours in our emergency departments has also been reduced over the last year.

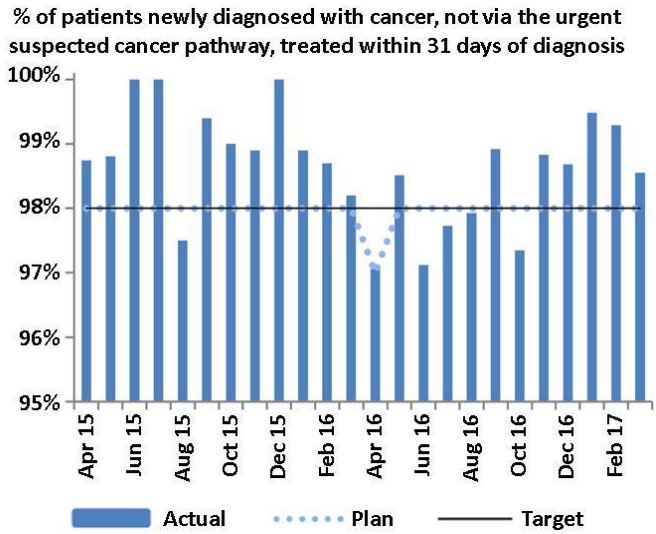
Over the last year we have improved the flow of minor injury category patients at Ysbyty Gwynedd, who are managed by Emergency Nurse Practitioners. We are working to increase the use of Minor Injury Units, both by patients who bring themselves to hospital and those conveyed by the Welsh Ambulance Service. This year we became the second NHS organisation in the UK to provide patients with live data on waiting times at all our emergency departments and minor injury units, through a smartphone app, helping people make an informed choice on where to attend for care.

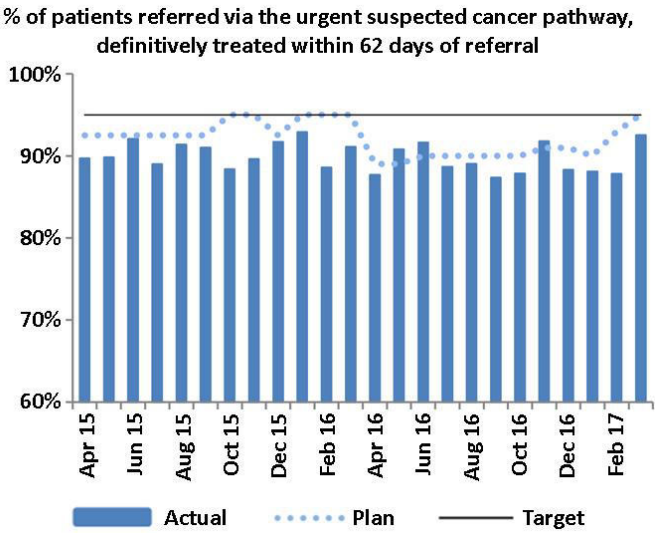
We have a strategic group which is studying the reasons why we are seeing an increase in the number of acutely ill people coming into our Emergency Departments, and what steps we can take to counter this trend, for example by changing the care and support available to people in the community. "Progress chasers" have been introduced at Ysbyty Gwynedd and Glan Clwyd Hospital. They have been working to identify the barriers that slow down how patients progress through the hospital system and introduce changes to overcome these causes of delay. If these prove to be successful a similar approach will be considered at Wrexham Maelor Hospital.

At the start of 2017 work began on improvements to the Emergency Department in Wrexham Maelor Hospital, including four new consulting rooms and a larger triage room. The Welsh Government has also approved £14million funding for the redevelopment of the Emergency Department at Ysbyty Gwynedd. The new department will provide a significantly larger and improved environment for emergency care and will support changes to the way unscheduled care is delivered to patients in North West Wales.

Cancer diagnosis and treatment

In 2016/17 99.3% of patients who were not referred as an urgent suspected cancer, but who were subsequently diagnosed with cancer, started their active treatment within 31 days of diagnosis, exceeding the Welsh target of 98% and making us the best performing Health Board in Wales with regards to this measure. We did not achieve the 95% target for patients referred with urgent suspected cancer starting treatment within 62 days of referral, but at 87.8% were the third best performer in Wales.

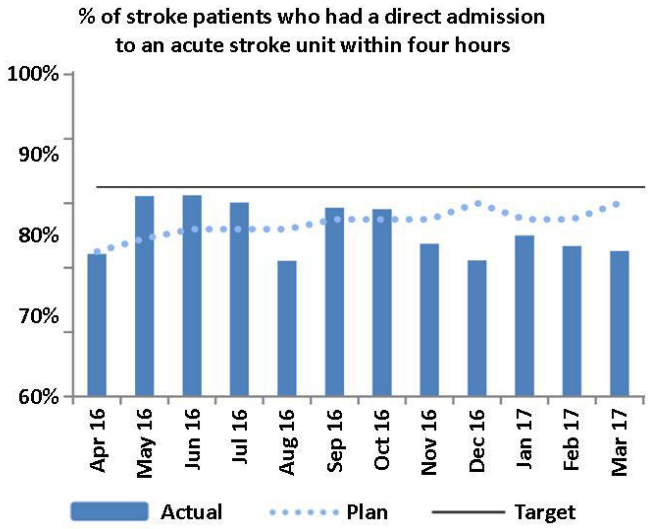




Weekly and bi-weekly escalation meetings continue to be held on each site with each specialty team to minimise delays. Managers receive a weekly cancer briefing outlining current and forecast performance to maximise opportunities to actively improve performance.

Stroke care

During the twelve months to March 2017, we achieved the target on the percentage of stroke patients who have been assessed by a stroke consultant within 24 hours and the percentage of stroke patients who have received a formal swallow assessment within 72 hours. However as at the end of March 2017, we were below the target performance levels for each of the four measures relating to stroke care.



Each of our three acute hospital sites are working on options for enforcing ring-fenced beds to ensure they are available quickly for patients who have suffered a stroke. We are working with the Royal College of Physicians (RCP) to investigate the differences in performance that occur across the three sites and issues around thrombolysis to identify ways we can improve the overall care pathway. In addition we are using the RCP report on Hyper Acute Stroke Services to consider how these can best be improved for patients in North Wales. Early feedback has demonstrated that we need to ensure our improvement work includes care after the acute phase and appropriate clinical governance arrangements.

Mental health assessments

The national target is for as many patients as possible to receive an assessment by our local primary care mental health support services within 28 days of being referred. Locally we aim to achieve this for at least 80% of people. At the end of December we were achieving a rate of 82.9%, however, between December 2016 and March 2017 our performance was affected by staffing issues resulting in an overall rate of 78.1%.

This target was introduced as part of the Mental Health (Wales) Measure during 2012 and staff within our mental health services have received full training on its requirement. Further improvement workshops took place during February 2017 to help us evaluate and standardise the processes we have introduced in response to the Measure.

Individual care

We want our services to be shaped by and meet the needs of the people we serve and to demonstrate that we learn and act on feedback.

It is especially important that we provide appropriate support to those who are more vulnerable or who may find it more difficult to access services.

Our performance indicators	Period	Value		Trend
Rate of Welsh resident calls to the mental health C.A.L.L helpline per 100,000 of Health Board population	Q4 16/17	192.1		
Rate of Welsh resident calls to the Wales Dementia helpline per 100,000 Health Board population (aged 40+)	Q4 16/17	7.5		
Rate of Welsh resident calls to the DAN 24/7 helpline per 100,000 Health Board population	Q4 16/17	43.9		
% of LHB residents receiving secondary mental health services (all ages) to have a valid CTP completed at the end of each month.	Mar-17	92.2%		
% of LHB residents assessed under the Mental Health Measure who have been sent their outcome assessment report within 10 working days after their assessment.	Mar-17	92.9%		
% of hospitals with arrangements in place to ensure advocacy available to all qualifying patients.	2016 /17	100%		

Care Treatment Plans (CTP)

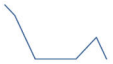
To improve the coordination of care between Health Boards and Local Authorities for people needing mental health services, the Mental Health (Wales) Measure requires that each person has a care and treatment plan drawn up. We aim to ensure that 90% of Mental Health and Learning Disabilities service users have a valid Care Treatment Plan (CTP) completed at the end of each month.

For March 2017 performance for this indicator was at 92.9%, which indicated significant progress compared to the position twelve months earlier when completed plans were in place for 85.9% of service users across the range of mental health services that we provide. Clinics have been held on the weekends in Anglesey to make sure that valid CTPs are in place for all services users.

Staff & resources

We are committed to ensuring that there are enough staff with the right knowledge and skills available at the right time to meet our patient's needs. Our performance measures also ensure our staff have an annual appraisal and a personal development plan; are appropriately recruited, trained, qualified and competent for the work they undertake.

Our other local performance indicators in this area measure our theatre productivity, outpatient efficiency as well as our financial management of agency and locum staff.

Our performance indicators		Period	Value		Trend
New Outpatient DNA rates for selected specialties.		Mar-17	5.6%		
Follow up appointment DNA rates for selected specialties.		Mar-17	6.4%		
% of inhaled corticosteroids prescribed in primary care that are low strength		Q4 16/17	64.9%		
Number of procedures that do not comply with NICE 'Do Not Do' guidance for procedures of limited effectiveness: **NOTE**: Coding incomplete as at January 2017	ENT	Jan-17	6		
	Ophthalmology	Jan-17	5		
	Orthopaedics	Jan-17	2		
	Urology	Jan-17	1		
% staff who felt their appraisal/review left them feeling their work was valued by their employer		2016	51%		
Overall staff engagement score		2016	3.51		
% staff absence due to sickness		Rolling 12m Mar-17	4.81%		
% of staff who would be happy with care provided by their organisation of their friend / relative needed treatment		2016	61%		

DNAs

We have established an internal target to reduce the number of patients who do not attend their outpatient appointments to ensure we make maximum use of our available clinic time. To support this we use a text message reminder service and our patient letters stress the need for patients to contact us if they will be unable to attend a booked appointment and need to reschedule this. Despite this, the number of patients who do not keep their appointments remains higher than the target level.

We do not routinely book new appointments for patients who fail to attend and who have not contacted us to change their appointment. Instead their case is returned to the health professional who made the referral (usually their GP), except where our clinical staff judge that this will cause delays that would be detrimental to the patient's care. This principle of 'DNA and Discharge' ensures that we only re-book patients who have not attended once we get confirmation that they still need their appointment so that we maximise capacity for other patients. Analysis has shown that further work is needed across our sites to ensure that this approach is being applied consistently.

During the year we have also been piloting new ways of running our appointment booking system and the results of this will be evaluated and if proved successful will be rolled out across the Health Board.

Our productivity

We have been working to improve the productivity of our operating theatres and our outpatient clinics during the year. Within our operating theatres, we have worked with our partners Alturos, to implement revised booking systems and reduce waste and all theatres will be booked to the Alturos model for 2017/18. An Outpatient Transformation Programme will be undertaken during 2017.

Our staff

We have maintained the reduction in staff sickness absence rates that has been achieved in recent years. Our sickness absence policies are designed to ensure that staff absence is managed actively with support provided through our CARE team to help colleagues return to work. The NHS Wales Staff Survey conducted in the autumn of 2016 showed improvements for BCUHB against nearly every indicator.

Our activity

Approximately 90% of NHS activity is delivered by GP practices, community pharmacies, local dental practices and opticians.

With the resources we were given by the Welsh Government we delivered over a million assessments, tests or treatments for the North Wales population within the hospitals run directly by the Health Board, as noted in the table alongside. In addition to this activity, the Health Board commissions services provided elsewhere in Wales and in NHS England for the population of North Wales.

Patient Type	Activity		
	Actual 2015/16	Contracted 2016/17	Actual 2016/17
Elective Daycases	26,242	33,287	**32,914**
Elective Inpatients	19,882	18,048	**18,524**
Endoscopies	21,495	21,495	**19,774**
Minor Outpatient Procedures (cleansed Day Cases)	2,009	2,009	**1,939**
Regular Day Attenders	47,890	47,890	**46,050**
New Outpatients Appointments	204,448	200,894	***185,595****
Review Outpatients Appointments	447,829	380,743	***397,897****
New Emergency Department Attendances	213,999	213,999	**215,985**
Review Emergency Department Attendances	12,254	12,254	**8,287**

***Caveat:**
Please note that, as a result of the implementation of the new Welsh Patient Administration System, at the time of reporting data for the Health Board's Central area was only available for the period April 2016 to October 2016 while work to resolve data accuracy continues.
Figures for West and East are for full year, April 2016 to March 2017.

Well-being of Future Generations (Wales) Act

Setting well-being objectives for the Health Board

During the year the Board continued to develop its response to the requirements, and spirit, of the Act and, in May, received a paper describing the implications of the Act. This stimulated discussion on the sustainable development principle and good governance frameworks.

Since July the Board has been developing its strategy for future health, well-being and healthcare in North Wales: **Living Healthier, Staying Well**. The strategy is set in the context of the Act and the need to refocus on delivering better outcomes and improving well-being, now and in the future. The first two phases have been completed, with extensive involvement of staff, partners, stakeholders and the population. The next phases will build on this to develop the strategy and begin to describe scenarios for specific areas.

The Board has previously adopted seven strategic goals, built on feedback gained from the public and partner organisations during our extensive listening exercise that began in 2015. These have been supported as a framework to guide our future actions by our Local Partnership Forum, Health Professionals Forum and Stakeholder Reference Group, and are being used as our interim objectives for improving well-being in 2017/18 while we continue to work through our strategy development process.

We are engaging with many people and groups to help shape our future strategy and objectives and as part of this work we will review our own strategic goals to ensure that they contribute to meeting the seven Well-being goals set out in the Act.

We have assessed our existing strategic goals as aligning to the Act's Well-being goals as follows:

		The Well-being of Future Generations Act Goals						
		Prosperous	Resilient	Healthier	More equal	Cohesive	Culture	Global
Our strategic goals	Improve health & well-being for all and reduce health inequalities							
	Work in partnership to design and deliver more care closer to home							
	Improve the safety and outcomes of care to match the NHS's best							
	Respect individuals and maintain dignity in care							
	Listen to and learn from the experiences of individuals							
	Use resources wisely, transforming services through innovation & research							
	Support, train and develop our staff to excel							

We have also moved towards using the Public Health Outcomes Framework to describe the health and well-being status of the population of North Wales. Many of the indicators used within the Framework match the national indicators included within the Well-being of Future Generations Act outcome indicators.

OUTCOMES	OUR CONTRIBUTION
Overarching Outcomes • Years of life and years of health • Mental well-being • A fair chance for health	These highest level, longer term outcomes describe changes in overall population health status over time and are particularly important for assessing progress in reducing inequalities.
Three sets of Intermediate Outcomes follow which illustrate overall changes in behaviour, practice and environments.	
Living conditions that support and contribute to health now and in the future • Children have the best opportunity for a healthy start • Families and Individuals have the resources to live fulfilled, healthy lives • Resilient, empowered communities • Natural and built environment that supports health and well-being	Although other public sector and government bodies play a leading role in achieving these outcomes, the Health Board also has an influential part to play as a key partner to these organisations and as a major employer and contributor to the wider economy of North Wales. This gives us a powerful voice in advocating for improvement in living conditions and considerable opportunity to make changes through our own policies and actions. Of particular importance here are education, skills and training, and the extent to which the way we plan and deliver our services enables and empowers people in local communities.
Ways of living that improve health • Healthy actions • Healthy starts	The many thousands of staff we employ and the contractors with whom we develop and implement primary care services gives us the potential to reach into the population of North Wales to influence, advise and support people to adopt the healthy actions and lifestyles that evidence has shown to be beneficial. We have a crucial role in influencing and supporting partners, from the earliest childcare settings right through the educational system, to ensure that critical aspects which impact on future health and wellbeing are delivered. We also have a duty to support our own staff in increasing the healthy actions they adopt and to use our influence and example with other employers across North Wales.
Health throughout life • Health in early years and childhood • Good health in working age • Healthy ageing • Minimising avoidable ill health	Our Strategy clearly recognises the importance of adapting our planning and delivery to the differing needs of people at each stage of life. As a planner, provider and commissioner of services, we can prioritise and visibly advocate a shift in focus towards prevention and early intervention at each stage.

Sustainability Report

The requirement to produce the figures contained in this report earlier due to a revised reporting timetable has proved problematic due to delays in receiving invoices etc. from suppliers, and this has been compounded by the absence of key staff who are ordinarily responsible for elements of the collation of environmental reporting figures. It is expected that the final validated information will be available by 1st September 2017 and will be published after that time.

The Health Board is the largest LHB in Wales, covering almost a third of the country's landmass. Our size and the nature of the services we provide mean we have an environmental impact which must be carefully managed to avoid significant financial and environmental consequence. As part of our corporate commitment towards reducing these effects we maintain a formal Environmental Management System (EMS) designed to achieve the following:

- Sustainable development.
- Compliance with relevant legal and government requirements.
- Prevention of pollution.
- Mitigation against the impact of climate change.
- A culture of continuous improvement.

Effective environmental management is achieved through:

- Promotion of the environmental policy to all relevant stakeholders.
- Identification of all significant environmental aspects and associated legal requirements, including those resulting from service change and new legislation.
- Establishing and monitoring objectives and targets aimed at reducing environmental and financial impacts, in line with those issued by the Welsh Government.
- Provision of appropriate training to all relevant personnel.
- Regular internal and external audits.
- Regular review of the effectiveness of the EMS by the Environmental Steering Group.
- Working with local, regional and national partners to achieve a consistent public sector approach to environmental management and ensure best practice procedures are identified and implemented.

Our performance is measured using a number of tools and through our involvement with a number of partnership bodies:

- BS EN ISO 14001 Environmental Management System.
- Carbon Reduction Commitment Annual Reporting.
- Annual Energy and Facilities Performance Monitoring System.
- NHS in Wales Low Carbon Strategy.
- Carbon Trust Management Review.
- Flintshire Carbon Reduction and Adaptation Group.(CRAG)
- Gwynedd Local Service Board. (LSB)
- NHS Wales Shared Services Partnership-Facilities Services.
- In-house, real-time utility consumption monitoring systems.

These arrangements ensure that effective environmental management is conducted to current best practice standards and that continuous improvement is embedded in the culture of the organisation.

The current Corporate Carbon Reduction Performance Target is a 3% year on year reduction in CO_2 emissions as required by the Welsh Government's Climate Change Strategy Delivery Plan for Emissions Reduction.

Environmental Management System (EMS)

The ISO 14001 environmental management system is a systematic and process driven approach to controlling those aspects of an organisation that have, or can have, a significant impact on the environment. The system is proven to make organisations more aware of their environmental responsibilities including legal and regulatory accountabilities, and enables associated risks to be managed more efficiently.

We achieved the Welsh Government's Directive final target stage for all District General Hospitals, Community Hospitals and Clinics to be certified to the BS EN ISO14001:2004 Environmental Management System (EMS) by December 2014 and this is now subject to regular audit and assessment by the British Standards Institution.

The standard has since been revised and we are working to implement the new ISO 14001:2015 version, with the aim of achieving certification to the new standard by April 2018. Changes in the new standard are summarised as follows:

- **Leadership:** Increased accountability with senior managers more involved in the Health Board's decision making in regards to the environment. Managers across all disciplines will be expected to understand the process/requirements of ISO14001 and this will be subject to audit.

- **Life Cycle Approach:** A requirement to consider environmental impacts throughout the Health Board's activities including procurement, waste, and managing contractors.

- **Rethinking impact:** Getting the Health Board thinking about the environmental impact on ourselves rather than the impact we have on the environment by considering how long term environmental change affects our activities, products and services.

- **Risks and Opportunities:** There is a specific requirement to demonstrate how significant environmental risks and opportunities are managed within the supply chain. The organisation will need to show that it has made the link between environmentally driven issues and how they relate to the business, and how the interfaces with the business are managed.

- **Pro-active reporting:** We will need to pro-actively consider the need for external reporting on environmental issues and demonstrate much greater control on how we use and manage environmental data.

- **Strengthened compliance:** Increased requirements to not only evaluate compliance, but to specify exactly how compliance is evaluated and recorded.

A three year Environmental Objectives programme has been produced and approved by the Management Review group. It includes the following targets:

- Minimise waste associated with activities and influence supply chain to reduce waste to landfill
- To operate and procure natural resources in an environmentally responsible manner
- Ethical and corporate social responsibility - to use products certified as ethically sourced
- Reduce CO2 emissions by upgrading boilers, controls and building fabric.
- Raise Energy Awareness
- Prohibit the disposal of food waste to sewer by end of 2017
- Raise awareness of environmental & waste information and topics
- Identify and create a biodiversity area
- Introduce segregation of Gypsum waste for incineration
- Keep airborne asbestos fibres at safe levels
- Monitor transport related CO2 emissions
- Reduce the risk of oil pollution by upgrading tanks and bunds by local controls and procedures
- Protect staff and patients from Radon, maintaining levels below 400Bq/m2 for work places and 200Bq/m2 in staff residences
- Eliminate the risk of ozone depleting and other damaging greenhouse gases
- Water Safety Management - Reduce the risk of contaminated aerosols

Energy & carbon management

A Carbon Action Plan has been developed in Welsh Government standard format. Most items on this plan are dependent upon resource allocation from Major Capital development and the annual Discretionary Capital Programme.

The Estates and Facilities team has implemented a quarterly reporting procedure where energy cost and consumption data is forwarded to the Executive Board for scrutiny.

The Sustainability report input data was audited in July 2016, and resulted in a “Substantial Assurance” indicator of performance.

A Standard Operating Procedure to manage the Carbon Reduction Commitment has been developed and implemented, and the most recent internal audit was conducted in July 2016 which resulted in a “Substantial Assurance” indicator of performance. The 2016/17 Annual Report was completed and submitted in compliance with the CRC protocols.

The strategy of pre-purchase of CRC allowances at a reduced rate has enabled savings of £54,000 to be achieved for the projected CO2 consumption during financial year 2016/17. This strategy has been continued for financial year 2017/18 to maintain this significant cost reduction.

Partnership arrangements and information sharing with other public bodies are pursued as part of the continuous development of our carbon reduction strategy. These arrangements include working with the Welsh Health Environmental Forum, Gwynedd & Ynys Mon Local Service Board and the Flintshire Carbon Reduction and Adaptation Group.

Major energy and water management projects conducted during 2016/17

- The refurbishment of Glan Clwyd Hospital has continued. Although energy technology improvements are incorporated in the design, overall carbon savings may be offset in the upgraded facilities by the increased area footprint and installation of new electrical consumers required for clinical treatment and patient comfort. Areas that opened this year comprised the Main Entrance, Fracture Clinic, Orthopaedic Outpatients, Head and Neck Outpatients, Discharge Lounge and three inpatient wards.

- An 'Invest to Save' bid for LED lighting of £225,000 was obtained for 2016/17, and over twenty projects have been completed in both community and acute hospitals. The lighting quality improvement has been appreciated by staff and patients, and the expected carbon savings are estimated to be 200 tonnes CO2 per annum, with an average financial payback period of 4-5 years. A further bid for £225,000 has been submitted for next year for continuation of this initiative.

- Rationalisation and improvements to Corporate Estate Assets have continued. Five energy-inefficient Health Centres were disposed of during 2016/17, with staff and services moving into more modern primary care premises.

- Triad management and Short Term Operating Reserve operations have continued at Ysbyty Gwynedd, making full use of the availability of the 3 MW standby generator facility. This provides a financial benefit, obtained by prevention of winter peak demand charges and payments for generated kWh when called upon by the network operator. Approximately £50,000 per annum net income can be achieved by this facility, and regular full load operation is also beneficial to the installation to regularly test its resilience and reliability.

- Both 335kWe main Combined Heat and Power units at Glan Clwyd Hospital have been extensively refurbished and were re-commissioned in November 2016. Further improvement to the heat rejection system design should enable full potential output to be realised from March 2017.

Patient / staff facility Improvements

2016/17 saw a major increase in the capital funding available to the Health Board with over £64m invested in our sites during the year. Significant achievements included:

- Significant further progress with the on-going redevelopment of Glan Clwyd Hospital. During the year we opened the re-modelled main entrance, the new fracture clinic and orthopaedic outpatients, head and neck outpatients, the new discharge lounge and a further three inpatient wards;

- Replacement the original Cardiac Catheter Laboratory at Glan Clwyd Hospital

- Installation a fourth Linear Accelerator in the North Wales Cancer Treatment Centre

- Completion of the development of Tywyn Hospital, with a new ward, accommodation for the town's GP Practice and the old ward redeveloped to provide outpatient clinics and therapy services;

- Starting work on the new Health Centres in Blaenau Ffestiniog, Flint and Prestatyn;

- Starting building the North Wales Sub-Regional Neonatal Intensive Care Centre at Glan Clwyd Hospital;

- Completion of work to upgrading of the accommodation for the Substance Misuse Service in Rhyl;

- Over £4million worth of improvements to the premises used by our Mental Health Services across North Wales;

- Started work on upgrades and expansion of the Emergency Department at Wrexham Maelor Hospital;

- Introduction of a new patient administration IT system in Glan Clwyd Hospital

- Investing in the WCCIS Welsh Community Care Information System and in telephone and Emergency Department information system

- We have also delivered a further £14million in a range of urgent estates, medical devices and informatics priorities.

Greenhouse gas (GHG) emissions

GHG emissions are calculated by collecting corporate consumption data and converting this data into carbon dioxide equivalents (CO_2e) by means of official Department of Energy and Climate Change conversion factors. The CRC Carbon Reduction Scheme issues the official conversion figures annually, and have been used to calculate corporate energy emissions.

The data quality from utility providers has improved, but year on year comparisons reflected in the Summary of Performance data figures have been compromised due to poor quality consumption and cost information delivered by Utility Providers between 2014 and 2016. The data quality for 2016-2017 and going forward is now of acceptable standard.

Waste

Waste is one of the Health Board's major environmental aspects; we have continued to improve our waste and recycling performance to meet legislative and best practice requirements. New waste related environmental objectives have been set and approved by the Environmental Management Review group, including:

- Prohibiting the disposal of food waste to sewer. Environmental officers will liaise with facilities to increase recycling and recovery of food waste materials.
- Increasing environmental and waste awareness training.
- Introducing segregation of gypsum waste for incineration in line with best practice guidance. Environment officers will liaise with the clinical waste contractor to meet this objective.

The recycling rate for all the Health Board sites has remained at approximately 80%. The Wrexham Maelor site started to bale cardboard and has successfully removed most cardboard from the general waste compactor, this reflects practice all ready in place at the other district general hospitals. All baled cardboard generates an income, and savings are also realised by reducing the amount of waste going into the general waste compactor.

The new All Wales Clinical Waste Contract for the collection, transportation and disposal of Clinical Waste commenced on 1st April 2017. The contractors are providing training to key staff and are coordinating delivery of new clinical waste bins to all sites affected by the move to the new contract.

BCUHB will benefit from this as the contractor has developed a commercially viable use for flock, which is the end product of the clinical waste treatment process. The flock is used as a fuel source and is shipped to Norway/Sweden where it is used as an additive to bind cement. This means that our alternative heat treated clinical waste will be 100% recyclable and will result in further improvements to our waste reuse/recycling targets.

Use of resources

We are committed to minimising our use of natural resources. Our performance in reducing CO2 emissions in terms of utilities, embedded CO2 in procurement and transport is reported in the Summary of Performance tables below.

Climate change adaptation and mitigation

We are an active member of the two pilot groups addressing climate change and adaptation in North Wales, Gwynedd Local Service Board and the Flintshire Carbon Reduction and Adaptation Group.

Biodiversity and natural environment

We are conscious of the impact of our service delivery on the natural environment. The main response to this is our commitment to BS EN 14001.

Travel, transport and logistics

We have completed a comprehensive review of our travel, transport and logistics arrangements, and produced a draft strategy to address areas where improvements can be made. In summary, the draft strategy and action plan objectives are:

- Business Travel – Monitor and reduce.
- Procurement – Identify the most cost effective methods of meeting corporate requirements.
- Safe Travel – Minimise risks associated with business travel.
- Maintenance – Maintain cost-effective and timely processes for repair and maintenance of the vehicle fleet.
- Replacement and Disposal – Ensure vehicles are updated by implementing optimum replacement cycles.
- Records and Performance Management – Develop and communicate performance indicators with budget holders and vehicle user groups.
- Sustainable Travel – Protect the environment by implementing green travel and fleet management options.
- Collaboration – Extend opportunities for collaboration between Health Boards, Trusts and other fleet managers, both regionally and nationally.
- Non-Patient Transport – Hold an overview of all vehicle movement patterns in the area, to enable efficiency savings to be identified and implemented.

A Green Travel Plan has been undertaken, and mangers and staff are required to make an assessment of travel mode prior to making each business journey using a "Travel Decision Wheel" of environmentally friendly options.

Budget holders are informed of mileage and cost data of their vehicles and alternative fuels to assist in their performance reviews.

The lease car policy introduced an upper limit of 140g/km for new and leased cars from 1st Oct 2015, and a limit of 100g/km for pool cars.

Feasibility studies have commenced in respect of introducing electric vehicles into the pool car fleet, and also providing on-site recharging facilities for pool vehicles, and pay as you go recharging facilities for staff and patients/visitors. The discussions are at an early stage, but will progress during 2017/18.

Sustainable procurement

The NWSSP Procurement Service has continued its progress in support of the Sustainable Procurement agenda over the course of 2016/17. This has included ongoing reviews of the organisation's Sustainable Procurement strategy though it's internal Sustainable Development Group, participation in the consultation and the roll out of Welsh Government policies on Ethical Employment in Supply Chains, The Modern Slavery Act and The Well Being of Future Generations Act.

We have also started the roll out of a sustainable procurement training programme to staff, including Carbon Workshops, and through the creation of a 'Sustainability portal' within the NWSSP Procurement Services website which acts as a resource centre for staff when they are looking to embed sustainable principles in to their contracts.

An example of the application of sustainable procurement iis the award of the clinical waste collection and disposal contract where a sustainability focused approach has also allowed for new innovations in waste to energy and subsequently considerable cost savings. Apart from incinerated waste, clinical waste is mainly treated by alternative heat treatment which results in a leftover residue or flock which can be used as an alternative, sustainable fuel source. The incumbent supplier has found alternative ways of disposing of this material, diverting it away from landfill sites to provide energy for cement kilns. This has proven very successful both environmentally and financially, with over 80% less waste produced by NHS Wales now going to landfill compared to 5 year ago.

Sustainable construction

In accordance with Welsh Government policy we have adopted a corporate requirement that all new-build projects meeting the criteria are constructed to BREEAM excellent standard. Recent projects have included installation of photo voltaic generation arrays at Glan Clwyd Hospital Mortuary and Llangollen Primary Care Centre Tri-Generation facilities were installed in the new Pathology Laboratory at Glan Clwyd Hospital.

Business case reports for construction work consider sustainability elements as an integral part of project evaluations.

People

The impact of the quality and location of our premises on patients and staff is a primary factor in corporate planning. Consultation procedures are conducted before implementing service delivery changes as an integral part of the decision making process. An example of this are the consultation exercises conducted prior to relocation of ophthalmology services from St Asaph to Abergele.

Governance

Governance of sustainability performance is managed by many elements of corporate reporting, including ISO14001, Energy and Facilities Performance and Monitoring System, CRC annual reports and BREEAM assessment of major capital schemes. The data used in producing these reports is verified by internal and external audit providers, e.g. BSi, Internal Audit and the Wales Audit Office.

Data collection is from a variety of sources, which include annual utility supplier statements, waste collection invoices, in-house real time utility monitoring systems and annual financial statements. The introduction of Automatic Meter Reading has been pursued to provide robust and accurate utility data.

Summary of performance

Greenhouse Gas Emissions		2014/15	*Change from previous year*	2015/16	*Change from previous year*	2016/17	*Change from previous year*
Non-Financial Indicators (tonnes of CO_2)	Total Gross Emissions	43,727	*-3.8%*	43,768	*0.1%*	39,334	*-10.1%*
	Total Net Emissions	43,727	*-3.8%*	43,768	*0.1%*	39,334	*-10.1%*
	Gross Emissions Scope 1* (Direct) Gas & Oil	20,235	*-6.1%*	22,467	*11.0%*	20,764	*-7.6%*
	Gross Emissions Scope 2 & 3** (Indirect)	23,492	*-1.8%*	21,301	*-9.3%*	18,570	*-12.8%*
Related Energy Consumption (tonnes of CO_2)	Electricity : Non-Renewable	0		0		0	
	Electricity : Renewable "Green" Supply Contract	23,492	*-1.8%*	21,301	*-9.3%*	18,570	*-12.8%*
	Gas	19,671	*-6.3%*	22,119	*12.4%*	20,358	*-8.0%*
	LPG	0		0		0	
	Other - Oil	564	*2.9%*	348	*-38.3%*	406	*16.7%*
Financial Indicators (£)	Expenditure on Energy	9,195,383	*4.0%*	8,816,324	*-4.1%*	8,437,285	*-4.3%*
	CRC Licence Expenditure (2010 Onwards)	120	*-87.4%*	120	*0.0%*	120	*0.0%*
	Expenditure on Accredited Offsets (e.g. GCOF)	0		0		0	
	Expenditure on Business Travel	9,264,147	*-9.5%*	8,478,417	*-8.5%*	8,823,883	*4.1%*

Energy consumption and cost data estimated where necessary

Notes

***Scope 1 - Direct Greenhouse Gas Emissions -** These occur from sources owned or controlled by the organisation and include. Examples include emissions as a result of combustion in heating boilers owned or controlled by the Health Board, emissions from our vehicles and fugitive emissions from refrigeration gas leakage.
****Scope 2 - Indirect Energy Emissions -** Emissions that result from the generation of electricity and steam which is supplied by another party for use in our buildings.
****Scope 3 - Other Indirect Greenhouse Gas Emissions -** Emissions which occur as a consequence of our activity, but are not directly owned or controlled by the Health Board, including those linked to consumption of waste and water, sustainable procurement, biodiversity action planning and emissions relating to official business travel directly paid for by the organisation.

Finite Resource Consumption		**2014/15**	***Change from previous year***	**2015/16**	***Change from previous year***	**2016/17**	***Change from previous year***
Non-Financial Indicators (m^3)	Water Consumption (All)						
	supplied	470,675	*0.9%*	461,278	*-2.0%*	486,407	*5.4%*
	abstracted	0		0		0	
	Water Consumption (Non-Office Estate)						
	supplied	0		0		0	
	abstracted	0		0		0	
Financial Indicators (£)	Water Supply Costs (All)	1,252,857	*0.5%*	1,181,257	*-5.7%*	1,279,850	*8.3%*
	Water Supply Costs (Non-Office Estate)	0		0		0	

Waste		2014/15	*Change from previous year*	2015/16	*Change from previous year*	2016/17	*Change from previous year*
Non-Financial Indicators (tonnes)	Total Waste	4,861	*18.9%*	4,997	*2.8%*	4,586	*-8.2%*
	Landfill	316	*-69.7%*	275	*-13.0%*	370	*34.5%*
	Reused / Recycled	2,658	*90.9%*	2,767	*4.1%*	2,258*	*-18.4%*
	Composted	0		0		0	
	Incinerated with energy recovery	0		0		0	
	Incinerated without energy recovery	256	*10.3%*	294	*14.8%*	260	*-11.6%*
Financial Indicators (£)	Total Disposal Cost	1,383,935	*16.5%*	1,417,029	*2.4%*	1,440,446	*1.7%*
	Landfill	72,480	*-64.1%*	34,524	*-52.4%*	51,613	*49.5%*
	Reused / Recycled	353,384	*111.5%*	391,811	*10.9%*	371,076*	*-5.3%*
	Composted	0		0		0	
	Incinerated with energy recovery	0		0		0	
	Incinerated without energy recovery	188,901	*17.2%*	200,012	*5.9%*	203,755	*1.9%*

Notes

AHT (alternative heat treated) waste is not identified as a separate waste stream for this report but is included in the total waste figures.

Waste figures are calculated from data obtained from the Health Board's three management areas - West, Central and East. Because of reporting deadlines, some data was not available at the time this report was being prepared.

Central & East were able to provide full waste data for the period April 2016 – March 2017.

Waste for the West area has been calculated as follows:
Incineration & AHT waste for hospital sites: April 2016 – March 2017 data used
Incineration & AHT waste for aggregate sites: April 2015 – March 2016 data used
*Recycling: incomplete April 2016 – March 2017 data used
(Some data relating to recycling of plastics, cardboard, paper, waste oil and toner cartridges was not available in time to be included so the figures in the table above understate recycling volume and value.)

Long term expenditure trends

The Health board is required to disclose the expenditure trends for the last five financial years. The Statement of Accounts provides a detailed analysis of expenditure which is classified under three main headings:

- Expenditure on Primary Healthcare Services. This comprises of expenditure on the Primary Care contracts for General Medical Services, Pharmaceutical Services, General Dental Services, General Ophthalmic Services, Prescribed Drugs and Appliances and other Primary Health Care Expenditure.

- Expenditure on Healthcare from Other Providers. This includes expenditure with other NHS organisations, Local Authorities, Voluntary Organisations, private providers and for NHS funded nursing and continuing healthcare.

- Expenditure on Hospital and Community Services. This expenditure includes all services delivered by the Health Board within the hospital and community settings.

The table below provides a summary of expenditure for each of the main headings for the last five financial years.

Expenditure heading	2012/2013 £'m	2013/2014 £'m	2014/2015 £'m	2015/2016 £'m	2016/2017 £'m
Primary Healthcare Services	284	284	295	297	300
Healthcare from other providers	284	284	301	310	324
Hospital and Community Health Services	809	780	837	869	915

Annual Quality Statement

The Health Board's Annual Quality Statement is published alongside the Annual Report and Accounts. A copy can be downloaded from the Health Board's website at www.wales.nhs.uk/sitesplus/861/page/40903.

The Annual Quality Statement provides greater information on the quality of our care and clinical services and the work being done to improve these.

PART TWO – Accountability Report

Corporate Governance Report

Directors' Report

The Board

The Health Board's Chairman is Dr Peter Higson, the Chief Executive is Mr Gary Doherty. During the year we welcomed seven new members to our Board:

- Dr Evan Moore, Executive Medical Director
- Mrs Gill Harris, Executive Director of Nursing and, Midwifery
- Mr Andrew Roach, Director of Mental Health and Learning Disabilities
- Ms Teresa Owen, Executive Director of Public Health
- Mr Adrian Thomas, Executive Director, Therapies and Health Sciences
- Cllr Cheryl Carlisle, Independent Member
- Mr John Cunliffe, Independent Member

The full membership of the Board is detailed within Appendix 1 of the Annual Governance Statement, and in the Remuneration Report on pages 49 to 53 of this document.

The Annual Governance Statement also sets out full details of the Board's supporting committee structure (Sections 13) and their membership (Appendix 1).

Audit Committee

In line with the standards of good governance required of the NHS in Wales, the Audit Committee has the key role of advising and offering assurance to the Board that the organisation has effective governance arrangements in place and supporting sound decision-making. Its membership during the year comprised:

Chair	Mr Ceri Stradling	Independent Member
Vice Chair	Mrs Marian W Jones	Independent Member (to 31 May 2016)
	Ms Jenie Dean	Independent Member (from 1 June 2016)
Members	Mr John Cunliffe	Independent Member
	Cllr Bobby Feeley	Independent Member
In attendance (Lead Director)	Mrs Grace Lewis-Parry	Board Secretary

Register of Director's interests

All Board members are required to declare any interest they have that could affect their impartiality with regard to their work within the Health Board.

The following Directors and Board Members have declared their interests for 2016/17 as listed below:

Name	Position	Interests
Dr R M Walker	Acting Medical Director (to 31/08/16)	• Employed as a salaried GP at Plas Menai Surgery, Llanfairfechan (currently taking unpaid leave) • Works as a Speciality Doctor within BCUHB • Spouse is a GP Partner in Bron Derw Surgery, Bangor • Undertakes ad-hoc work for Cardiff University as examiner for the Diploma of Practical Dermatology • Has run courses on minor surgery for the Royal College of Surgeons and has received payment for this work • Receives honorarium from All Wales Medicines Strategy Group
Dr E Moore	Executive Medical Director (from 01/09/16)	• Spouse is Clinical Director, Breast & Endocrine Surgery, Royal Liverpool University Teaching Hospital
Prof A Hopkins	Executive Director of Nursing and Midwifery (to 11/04/16)	• Engages in professional engagement and policy development of as an Executive Nurse Director in Wales with the RCN. No remuneration received. • Member of the National Cultural Alignment Group, sponsored by the RCN • Awarded an honorary chair at Bangor University School of Healthcare Sciences, October 2015
Mr G Lang	Director of Strategy	• Member of Board of Governors of Coleg Cambria
Mr A Thomas	Executive Director, Therapies and Health Sciences (from 1/02/17)	• Spouse employed by Boots UK Ltd as an Accuracy Checking Technician • Employed as a Panel Member of the Health Care Professions Council
Mr A Roach	Director of Mental Health and Learning Disabilities (from 01/06/16)	• Director, Thatchers Green (Treales) Residents Association Limited
Mr A P Jones	Director of Public Health (to 31/07/16)	• Spouse is an employee of the Betsi Cadwaladr University LHB • Trustee of Dolen Cymru (charitable/voluntary body part of the Wales for Africa programme)
Ms B Cuthel	Interim Director of Primary, Community and Mental Health Services (to 31/08/16)	• Governing Body Member of Nugent Care (third sector provider of services to vulnerable adults and children) • Family member works in Glan Clwyd Hospital
Mr C Wright	Director of Corporate Services	• Partner is a Director at University Hospital of South Manchester NHS Foundation Trust

Dr P Higson OBE	Chair	• Trustee of Cartrefi Cymru • Council member of Bangor University
Cllr C Carlisle, Independent Member	Independent Board Member	• County Councillor - Conwy County Borough Council • Carers Champion - Conwy County Borough Council • Member of Conwy & Denbighshire Joint Adoption Panel • Governor at Ysgol Bryn Elian
Mr J Cunliffe, Independent Member	Independent Board Member	• Director, Abernet Ltd • Spouse is an employee of the Betsi Cadwaladr University Health Board
Ms J Dean	Independent Board Member (TU)	• Partner is part-time employee of Bangor University
Cllr B Feeley	Independent Board Member	• County Councillor - Denbighshire County Council • Lead Cabinet Member for Social Care and Older People Champion, Denbighshire County Council • Chair of Cefndy Healthcare (run by Denbighshire County Council)
Mrs M W Jones	Independent Board Member	• Member of Snowdonia National Park Authority • Member of S4C Authority • Director of Canolfan Gerdd Williams Mathias • Member of Arts Council for Wales
Mrs L Meadows	Independent Board Member	• Employed at Bangor University (until 30 Sept 2016)
Mrs B Russell-Williams	Independent Board Member	• Chief Officer of Gwynedd County Voluntary Council which receives funding from the Health Board • Spouse chairs Gwynedd Community Health Council
Prof J Rycroft-Malone	Independent Board Member and University Representative	• Spouse is an employee of the Betsi Cadwaladr University Health Board • Chair of the NICE Implementation Strategy Group • Professor of Health Services and Implementation Research at Bangor University • Head of School for Healthcare Sciences and academic lead for impact at Bangor University • Sits on a number of national and international strategy, funding and think tank groups • Sits on the editorial Board of BioMed Central Implementation Science
Mr C Stradling	Independent Board Member	• Deputy Chair of Democracy and Boundary Commission for Wales • Chairs the audit and risk committee of the Democracy and Boundary Commission for Wales • Member of Snowdonia National Park Authority

Data security

Responsibility for information governance in the Health Board rests with the Director of Corporate Services who acts as the Senior Information Risk Owner (SIRO). The Executive Medical Director is the Caldicott Guardian. The Health Board self-reported 5 data security breaches that triggered referral to the Information Commissioner's Office and Welsh Government, however the Board did not incur any financial penalties during the year. Information on our information governance performance is included in section 31.7 of the Annual Governance Statement.

Compliance with cost allocation requirements

The Freedom of Information Act is part of the Government's commitment to greater openness in the public sector. The underlying principle is that all non-personal information held by a public body should be easily available, unless there is a cost or an exemption applies.

We are committed to comply with this Act and any associated Welsh Government guidance and endeavour to make information available to the public via our Publication Scheme: www.wales.nhs.uk/sitesplus/861/page/40808

Statement of the Chief Executive's responsibilities as Accountable Officer of the LHB

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.

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.

I confirm that I have taken all appropriate steps to make myself awar e of any relevant audit information and to establish that the Health Board's auditors are aware of that information. As far as I am aware, there is no relevant audit information of which the Health Board's auditors are unaware.

I confirm that the Annual Report and Accounts as a whole, comprising the Performance Report, the Accountability Report including the Remuneration Report and the Annual Governance Report, and the Financial Statements and notes, contained within this document, is fair, balanced and understandable and I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Gary Doherty
Chief Executive

Date: 14th July 2017

Statement of Directors' responsibilities in respect of the accounts

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

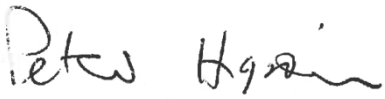
In preparing those accounts, the directors are required to:
- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been 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 Board:

Chairman:  Dated: 30th May 2017

Chief Executive:  Dated: 30th May 2017

Director of Finance:  Dated: 30th May 2017

Annual Governance Statement

Our Annual Governance Statement describes our governance arrangements, committee structure and the system of internal control. It also includes information about:

- The role and composition of the Board
- Our committee arrangements
- Our arrangements to manage risk
- How the Health Board is responding to being placed in Special Measures
- Quality and Governance processes
- The opinion of the Head of Internal Audit
- Our planning arrangements

The full Annual Governance Statement is provided as an appendix to the Annual Report and Accounts.

Remuneration Report

Policies for the Remuneration of Staff and Senior Managers

Senior Managers are defined as those who have authority or responsibility for directing and controlling the major activities of the Health Board as a whole, those employees and Independent Members who are regular attendees at the Board meetings.

From October 2004, the NHS Agenda for Change process was introduced to achieve consistency in contracts and terms and conditions across NHS Wales. An all-Wales contract is issued to all staff and managers (excluding directors) upon appointment. Medical and dental staff are governed by medical and dental terms and conditions which apply across NHS Wales.

Directors are not part of this process and a very senior manager pay scale has been introduced by the Welsh Government. Pay awards are determined nationally and applied locally based upon instructions from the Welsh Government. A pay award was not approved during 2016/17 and it is confirmed that the Health Board does not operate a performance related pay system. All contracts are permanent and notice periods for very senior managers are three months.

Independent Members are appointed for a term of up to four years (and can be appointed for a maximum of eight years). Independent Members receive nationally determined remuneration during their period of appointment.

The Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee was established on 1 January 2015, following the Health Board's Committee Review in December 2014. The Committee was routinely scheduled to meet five times within 2016/17, and otherwise as the Chair of the Committee deemed necessary. During 2016/17 the Committee met on seven occasions.

Chair	Dr Peter Higson	Chairman
Members	Mrs Margaret Hanson	Vice-Chair
	Mr Ceri Stradling	Independent Member
	Ms Jenie Dean	Independent Member
	Mr Gary Doherty	Chief Executive
Lead Officer	Mr Martin Jones	Executive Director of Workforce and Organisational Development

Remuneration Relationships

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 2016/17 was £200,000 - £205,000 (in 2015/16, £200,000 - £205,000). This was 7.11 times (in 2015/16, 7.29 times) the median remuneration of the workforce, which was £28,462 (2015/16 £27,760). The highest paid director post during 2016/17 and 2015/16 was that of the Chief Executive.

In 2016/17, seventeen (in 2015/16, eight) employees received remuneration in excess of the highest-paid director. Remuneration for the seventeen employees ranged from £200,000-£205,000 to £270,000-£275,000 (2015/16 £200,000-£205,000 to £275,000-£280,000); all of these employees are senior clinicians.

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

The remuneration ratio has decreased during 2016-17 which reflects that with the exception of Senior Managers (as defined in the opening paragraph of this Remuneration Report) all staff received an inflationary pay award. The pay award for 99.04% of staff was consolidated into their annual salary. In addition, 18.15% of staff received incremental pay progressing within their pay scales.

	2015/16	2016/17
Mid-point of Band of Highest Paid Director's Total Salary	£202,500	£202,500
Median Total Salary	£27,760	£28,462
Ratio	**7.29**	**7.11**

Senior Manager Salary and Pension Disclosures and Single Total Figure of Remuneration

The Total figures in the table below (the Single Total Figure of Remuneration) for each Senior Manager includes a figure for the in year pension benefit, calculated using information supplied by the NHS Pensions Agency. The figure does not represent the actual amount paid to an individual during the year and reflects an accounting assessment of the increase in long term benefits adjusted for inflation. These figures can be influenced by many factors including changes to a person's salary, additional contributions made by individuals and underlying valuation factors on the scheme as a whole.

	2016/17						2015/16					
Name and Role	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**
Prof. T Purt *(note 1)*, 01/04/16 - 31/08/16							35-40	700	1,000	0	**40-45**	*200-205*
Mr G Doherty, Chief Executive	200-205	0	26,000	0	**225-230**		15-20	0	0	0	**15-20**	*200-205*
Dr M Walker, Interim Executive Medical Director and Director of Clinical Services 01/04/16 - 31/08/16	70-75	2,200	*(note 2)*	0	**75-80**	*165-170*	10-15	200		0	**10-15**	*165-170*
Dr E Moore, Executive Medical Director 01/09/16 - 31/03/17	110-115	1,500	*(note 3)*	0	**110-115**	*195-200*						
Prof A Hopkins, Executive Director of Nursing and Midwifery 01/04/16 - 11/04/16	0-5	0	0	0	**0-5**	*125-130*	125-130	1,600	6,000	0	**130-135**	

	2016/17						2015/16					
Name and Role	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**
Mrs V Morris, Interim Executive Director of Nursing, Midwifery 01/04/16 - 31/07/16	40-45	0	18,000	0	**55-60**	*120-125*						
Mrs G Harris, Executive Director of Nursing and Midwifery 01/08/16 - 31/03/17	100-105	0	*(note 4)*	0	**100-105**	*150-155*						
Mr A Thomas *(note 5)*, Executive Director, Therapies and Health Sciences	65-70	0	201,000	0	**265-270**		65-70	0	9,000	0	**75-80**	
Mr A Roach, Director of Mental Health and Learning Disabilities 01/06/16 - 31/03/17	95-100	0	*(note 4)*	0	**95-100**	*110-115*						

	2016/17						2015/16					
Name and Role	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**
Mr A Jones, Executive Director of Public Health 01/04/16 - 31/07/16	40-45	0	0	0	**40-45**	*120-125*	120-125	0	0	0	**120-125**	
Ms T Owen, Executive Director of Public Health 01/01/17-31/03/17	30-35	0	7,000	0	**35-40**	*120-125*						
Ms M Olsen, Chief Operating Officer	140-145	0	21,000	0	**165-170**		140-145	0	13,000	0	**155-160**	
Mr R Favager, Executive Director of Finance	140-145	6,800	33,000	0	**180-185**		140-145	6,100	0	0	**150-155**	
Mr G Lang, Director of Strategy	125-130	0	*(note 3)*	0	**125-130**		125-130	0	0	0	**125-130**	

	2016/17						2015/16					
Name and Role	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**
Ms B Cuthel, Interim Director of Primary, Community and Mental Health Strategy 01/04/16 - 31/08/16	40-45	0	52,000	0	**95-100**	*100-105*	115-120	0	0	0	**115-120**	
Mr J M Jones, *(note 6)* Executive Director of Workforce and Organisational Development	125-130	1,500	*(note 3)*	0	**130-135**		125-130	1,200	4,000	0	**130-135**	
Mr C Wright *(note 7)*, Director of Corporate Services	95-100	0	*(note 3)*	0	**95-100**		100-105	3,500	0	0	**105-110**	
Mrs G Lewis-Parry, Board Secretary	95-100	0	14,000	0	**105-110**		95-100	900	6,000	0	**100-105**	
Dr P Higson, Chairman	65-70	0	0	0	**65-70**		65-70	0	0	0	**65-70**	
Mrs M Hanson, Vice Chair	55-60	0	0	0	**55-60**		55-60	0	0	0	**55-60**	

	2016/17						2015/16					
Name and Role	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**	Salary (bands of £5,000) **£'000**	Benefit in kind (to nearest £100) **£**	Pension benefit (to nearest £1,000) **£**	Perfor-mance pay and bonuses (bands of £1,000) **£**	**Total (bands of £5,000) £'000**	*Full year equivalent salary (if part year)* **£'000**
Cllr C Carlisle, Independent Member	15-20	0	0	0	**15-20**							
Mr J Cunliffe, Independent Member	15-20	0	0	0	**15-20**							
Ms J Dean *(note 8)*, Independent Member												
Cllr B Feeley Independent Member	15-20	0	0	0	**15-20**		15-20	0	0	0	**15-20**	
Mrs M W Jones, Independent Member	15-20	0	0	0	**15-20**		15-20	0	0	0	**15-20**	
Mrs L Meadows, Independent Member	15-20	0	0	0	**15-20**		15-20	0	0	0	**15-20**	
Mrs B Russell Williams, Independent Member	15-20	0	0	0	**15-20**		15-20	0	0	0	**15-20**	
Prof J Rycroft-Malone *(note 9)*, Independent Member												
Mr C Stradling, Independent Member	15-20	0	0	0	**15-20**		15-20	0	0	0	**15-20**	

Notes

1. On 8 June 2015, the Health Board was placed into Special Measures by the Health and Social Services Minister, Mark Drakeford. On the following day the Board suspended its Chief Executive, Professor Trevor Purt, as a neutral act to enable due process to be followed.

   By mutual agreement, on 15 October 2015 Professor Purt stepped down from his role as Chief Executive of the Health Board and was seconded to an NHS Organisation in England. That secondment continued until 31st August 2016, at which point Professor Purt left the employment of the Health Board. During 2016/2017 Professor Purt received remuneration of £83,333.

2. Dr M Walker was the interim Medical Director for the period 1 March – 31 August 2016. Prior to this date Dr Walker was employed by the Health Board and also holds a position as an independent General Practitioner. It has not been possible to calculate the element of pension benefits that relate solely to his role as Interim Medical Director.

3. These employees are no longer active contributors to the NHS Pension Scheme and therefore do not accrue any additional in year benefits.

4. These employees commenced employment with the Health Board during 2016/2017 and previously held posts in NHS England. Prior year figures are not available to enable the in year pension benefit to be calculated.

5. Mr Adrian Thomas historically held the position of Assistant Director of Therapies and Health Sciences and was appointed as interim Executive Director on 1st August 2016. The post became substantive on 8th February 2017.

6. In addition to the disclosure above, during 2016/17 Mr JM Jones received an additional responsibility payment relating to work undertaken for the Health Board during 2015/16. This payment did not alter the previously disclosed salary banding for 2015/16, as the total salary (including the arrears payment) remained within the banding of £125 - £130k.

7. The Health Board undertook a consultation on proposed changes to the Corporate Services Department during March 2017. The consultation exercise concluded during May 2017 and the post of Director of Corporate Services has been removed from the structure with effect from 20 May 2017.

8. Ms J Dean is an employee of the Health Board and is an Independent Member drawn from a Trade Union background.

9. Professor J Rycroft-Malone is the University representative on the Board.

	Real Increase In Accrued Pension (bands of £2,500) **£'000**	Real Increase In Lump Sum (bands of £2,500) **£'000**	Total accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Cash Equivalent Transfer Value as at 31/03/16 **£'000**	Cash Equivalent Transfer Value as at 31/03/17 **£'000**	Real Increase in Cash Equivalent Transfer Value **£'000**
Prof. T Purt, 01/04/16 - 31/08/16	2.5-5.0	17.5-20.0	40-45	130-135	*(note 1)*	-	-
Mr G Doherty, Chief Executive	2.5-5.0	(2.5-5)	50-55	130-135	709	795	87
Dr M Walker *(note 2)*, Interim Executive Medical Director and Director of Clinical Services 01/04/16 - 31/08/16							
Dr E Moore *(note 3)*, Executive Medical Director 01/09/2016 - 31/03/17							
Prof A Hopkins, Executive Director of Nursing and Midwifery 01/04/16 - 11/04/16	0-2.5	0-2.5	40-45	125-130	986	*(note 1)*	

	Real Increase In Accrued Pension (bands of £2,500) **£'000**	Real Increase In Lump Sum (bands of £2,500) **£'000**	Total accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Cash Equivalent Transfer Value as at 31/03/16 **£'000**	Cash Equivalent Transfer Value as at 31/03/17 **£'000**	Real Increase in Cash Equivalent Transfer Value **£'000**
Mrs V Morris *(note 4)*, Interim Executive Director of Nursing and Midwifery 01/04/16 - 31/07/16	0-2.5	2.5-5.0	35-40	110-115	593	624	31
Mrs G Harris *(note 5)*, Executive Director of Nursing and Midwifery 01/08/16 - 31/03/17			65-70	200-205		1370	
Mr A Roach *(note 5)*, Director of Mental Health and Learning Disabilities 01/06/16 - 31/03/17			45-50	140-145		825	
Mr A Thomas, Executive Director, Therapies and Health Sciences 01/08/16 - 31/03/17	7.5-10.0	27.5-30.0	35-40	105-110	473	659	186
Mr A Jones *(note 4)*, Executive Director of Public Health 01/04/16 - 31/07/16	0-2.5	(0-2.5)	45-50	125-130	781	791	10

	Real Increase In Accrued Pension (bands of £2,500) **£'000**	Real Increase In Lump Sum (bands of £2,500) **£'000**	Total accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Cash Equivalent Transfer Value as at 31/03/16 **£'000**	Cash Equivalent Transfer Value as at 31/03/17 **£'000**	Real Increase in Cash Equivalent Transfer Value **£'000**
Ms T Owen, Executive Director of Public Health 01/01/17-31/03/17	0-2.5	35-37.5	30-35	90-95	553	568	15
Ms M Olsen, Chief Operating Officer	0-2.5	5.0-7.5	30-35	100-105	613	665	52
Mr R Favager, Executive Director of Finance	2.5-5.0	0	60-65	165-170	971	1030	58
Mr G Lang *(note 6)*, Director of Strategy	0	0	45-50	145-150	866	866	
Mr J M Jones *(note 6)*, Executive Director of Workforce and Organisational Development	0	0	50-55	155-160	1053	1053	
Ms B Cuthel, Interim Director of Primary, Community and Mental Health from 2nd August 2015	2.5-5.0	7.5-10	50-55	150-155	836	*(Note 1)*	
Mr C Wright, *(note 3)* Director of Corporate Services							

	Real Increase In Accrued Pension (bands of £2,500) **£'000**	Real Increase In Lump Sum (bands of £2,500) **£'000**	Total accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Lump sum related to accrued pension at 31 March 2017 (bands of £5,000) **£'000**	Cash Equivalent Transfer Value as at 31/03/16 **£'000**	Cash Equivalent Transfer Value as at 31/03/17 **£'000**	Real Increase in Cash Equivalent Transfer Value **£'000**
Mrs G Lewis-Parry, Board Secretary	0-2.5	2.5-5.0	30-35	95-100	634	676	42

Notes

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.

1. The Cash Equivalent Transfer value for these individuals is not disclosed as they are members of the 1995 Pension scheme aged 60 and above.

2. As Dr M Walker held a number of posts with the Health Board during 2016/17 it is not possible to calculate the element of pension benefits that relate solely to his role as Interim Medical Director.

3. During their period of employment with the Health Board these members of staff have not been members of the NHS Pension Scheme.

4. These staff were in post for part of the financial year and the disclosures of CETV only relates to the element attributed to their period of employment as a Senior Manager with the Health Board

5. Prior year figures are not available as these members of staff joined the Health Board during 2016/2017 from NHS England.

6. These members of staff are no longer actively participating in the NHS Pension Scheme and therefore the disclosures relate to historic accrued pension, lump sum and CETV.

Exit Packages and Severance Payments

During 2016/17 the Health Board agreed two exit packages; the details of the costs of these are reported in Note 5.5 to the Annual Accounts, on page 26A.

Staff Report

The average number of full time equivalent (FTE) staff employed by the Health Board during 2016/17 is reported below. This is calculated using the contracted hours recorded on the Health Board's electronic staff record.

Professional Group	Average FTE
Professional, Scientific and Technical	619
Additional Clinical Services	2,838
Administrative and Clerical	2,604
Allied Health Professionals	830
Estates and Ancillary	1,217
Healthcare Scientists	279
Medical and Dental	1,180
Nursing and Midwifery Registered	4,899
Students	22
Total	**14,488**

The actual number of staff in post during 2016/17 was 17,174 and the gender composition is provided in the table below.

Staff Composition	Female	Male	Total
Director	4	9	13
Manager (Band 8C and above)	52	36	88
Staff	13,779	3,294	17,073
Total	**13,835**	**3,339**	**17,174**

*For the purpose of this report manager is defined as a member of staff at Band 8c and above (or equivalent level for non-medical staff) based in a corporate function or operational Division with significant managerial and decision-making responsibilities affecting the whole organisation.

The sickness absence data for 2016/17 is provided below:

	2015-16	2016-17
Days lost (long term)	182,152	177,464
Days lost (short term)	71,896	77,639
Total days lost	**254,048**	**255,103**
Average working days lost	11	11
Total staff employed in period (headcount)*	16,621	16,977
Total staff employed in period with no absence (headcount)*	6,495	6,453
Percentage staff with no sick leave	**39.07%**	**37.7%**

*Average over 12 months

Sickness absence is measured using calendar days on the Electronic Staff Record system so the actual aggregate number of working days lost is lower. The sickness absence rate for 2016/17 was 4.81%.

Equalities and human rights

The Health Board has recently become a "Disability Confident Employer" which means that we guarantee to interview any applicant who declares a disability, providing they meet the essential criteria for the job. This is reinforced through a very robust approach to mandatory equality and human rights training for all staff, and specific, additional, recruitment and selection training for all those involved in the recruitment and selection process.

In common with all other Health Boards in Wales, our managers are trained and supported to implement the *All Wales Sickness Absence Policy* which includes explicit guidance on the application of the Equality Act 2010 in such circumstances, including the 'duty to make reasonable adjustments'.

Further guidance is provided through our *Guidelines on the Fair Treatment of Disabled People at Work* which was published and circulated to all managers in May 2015. This means that staff who become disabled whilst working for the organisation are treated fairly and offered support where appropriate. The latter document includes a commitment that disabled employees will be considered fairly and properly for opportunities within the Health Board. The document also includes examples of reasonable adjustments that managers may consider to promote a fair and consistent approach.

The majority of training undertaken by Health Board staff is regarded as Statutory and Mandatory and all staff are encouraged and enabled to attend this training regardless of their protected characteristics. Regular monitoring of attendance at mandatory training by protected characteristic is carried out and this demonstrates that attendance is in line with the underlying proportions within the overall staff community.

We are exploring the support for starting new employee networks including one for women and a disabled staff network to build upon the model that has proved so successful for Lesbian, Gay, Bisexual and Trans (LGBT) staff. This network has been instrumental in helping us achieve "Top 100 Employer" status within the Stonewall Workplace Equality Index, a national benchmarking survey of more than 400 employers' policy and practice with regard to the employment of LGBT people.

Our focus this year has been to further develop organisational understanding about the principles of Equality Impact Assessment (EqIA) to ensure, as far as possible, that when we make a decision, develop a strategy or policy, or do anything else that affects our service users or staff, then we do so in a fair, accountable and transparent way taking into account the needs and rights of all those who might be affected. We have strengthened our governance arrangements in this regard and established an external scrutiny group to provide advice and on Equality Impact Assessments relating to key Health Board strategies and service plans.

Off Payroll Engagements and Consultancy

The Health Board is required to disclose Off-payroll and Consultancy expenditure. The tables below outline the details of the Off Payroll Engagements that the Health Board has in place. It should be noted that HMRC introduced new rules in relation to compliance with tax regulations which took effect from 6 April 2017. These changes have widened the responsibilities of the Health Board in managing the Off Payroll engagements. As such the Off Payroll submission will change significantly going forward as most engagements will be subject tax and NI at source.

Number of existing engagements, for more than £220 per day and of over six months duration, as at 31 March 2017	**121**
Of which...	
Number that have existed for less than one year at time of reporting	44*
Number that have existed for between one and two years at time of reporting	57
Number that have existed for between two and three years at time of reporting	7
Number that have existed for between three and four years at time of reporting	11
Number that have existed for four or more years at time of reporting	2

* This figure includes new engagements for 2016/17 related to Medical Staff engaged via the Health Board's Managed Service arrangement.

Number of new off-payroll engagements for more than £220 per day and that will last for longer than six months, or that reached six months in duration between 1 April 2016 and 31 March 2017	**153**
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	153
Number for whom assurance has been requested	153
Of which...	
Number. for whom assurance has been received	153
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received.	0

Number of off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	**0**
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year, including both off-payroll and on-payroll engagements	29*

*The Board Members and Senior Officials who are deemed to be Senior Managers are those individuals whose salary details are disclosed on pages 49 to 53 of this report. During 2016/17 there are 29 individuals who have been included within the Senior Manager disclosures.

During the year the Health Board incurred expenditure of £2.342m on external consultancy services.

National Assembly for Wales Accountability and Audit Report

The Health Board is required to compile and publish an Accountability Report, the content of which is prescribed by the Welsh Government.

Regularity of expenditure

HM Treasury defines regularity as the requirement for all items of expenditure to be dealt with in accordance with the legislation authorising them, any applicable delegated authorities and rules of Government Accounting.

The Health Board is empowered to incur expenditure by the National Health Service (Wales) Act 2006 and receives revenue and capital resource allocations from the Welsh Government.

The Health Board's budget setting process aims to ensure that resources are allocated across the organisation for legitimate purposes. The Health Board has delegated arrangements with budget holders who must operate in accordance with their Accountability Agreements and the Standing Financial Instructions (SFIs) of the Health Board.

Arrangements are in place to monitor compliance with the SFIs and these are reported to each Audit Committee through the Conformance Report. In addition to a comprehensive Internal Audit programme the Health Board has a Local Counter Fraud Team.

The Health Board complies with recognised reporting standards to the extent that they are applicable to the Public Sector and the accounts are produced in accordance with the Manual for Accounts produced by the Welsh Government. Monthly financial monitoring returns are submitted to the Welsh Government with explanations for variances.

The Health board has incurred a deficit of £29.8m against its Revenue Resource Limit for the year. The Health Board has not met its statutory target to achieve breakeven over the three period 1 April 2014 – 31 March 2017 and has recorded a cumulative deficit of £75.9m.

No further issues have arisen during 2016/17 which impact on the regularity of expenditure.

Fees and charges

Fees and charges are not routinely charged to NHS patients unless the Health Board is permitted under the legislation to make a charge. Examples would include dental work and access to health records. It is confirmed that, to the best of our knowledge, the Health Board complies with Welsh Government directives in respect of charge rates.

Remote contingent liabilities

The Health Board is required to account for all remote contingencies in accordance with International Accounting Standard 37 (IAS37). These are fully disclosed in Note 18 in the Statement of Accounts.

Other remote contingencies not accounted for within IAS37 would include letters of comfort and third party guarantees given by management. To the best of our knowledge, the Health Board does not have any such liabilities that require disclosure.

Certificate of the Auditor General to the National Assembly for Wales

I certify that I have audited the financial statements of Betsi Cadwaladr University Local Health Board for the year ended 31 March 2017 under Section 61 of the Public Audit (Wales) Act 2004. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Tax Payers Equity and related notes. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs). I have also audited the information in the Remuneration Report that is described as having been audited.

Respective responsibilities of Directors, the Chief Executive and the Auditor

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for the preparation of financial statements which give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Financial Reporting Council's Ethical Standards for Auditors.

Scope of the audit of financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to Betsi Cadwaladr University Local Health Board circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors and Chief Executive; and the overall presentation of the financial statements.

I am also required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities which govern them.

In addition, I read all the financial and non-financial information in the Foreword and Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Betsi Cadwaladr University Local Health Board as at 31 March 2017 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Basis for Qualified Opinion on Regularity

Betsi Cadwaladr University Local Health Board has breached its resource limit by spending £75.9 million in excess of the £3,991 million that it was authorised to spend in the three-year period 2014-15 to 2016-17. This excess constitutes irregular expenditure.

Qualified Opinion on Regularity

In my opinion, except for the irregular expenditure of £75.9 million explained in the paragraph above, in all material respects the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In my opinion:

- the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers; and
- the information contained in the Foreword and Accountability Report is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- the Annual Governance Statement does not reflect compliance with HM Treasury's and Welsh Ministers' guidance;
- proper accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed; or
- I have not received all the information and explanations I require for my audit.

Please see my report attached.

Huw Vaughan Thomas
Auditor General for Wales
8 June 2017

24 Cathedral Road
Cardiff
CF11 9LJ

Report of the Auditor General to the National Assembly for Wales

Introduction

Local Health Boards (LHBs) are required to meet two statutory financial duties – known as the first and second financial duties.

For 2016-17 Betsi Cadwaladr University Local Health Board (the LHB) failed to meet both the first and the second financial duty and so I have decided to issue a narrative report to explain the position.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to LHBs by allowing them to balance their income with their expenditure over a three-year rolling period. The first three-year period under this duty is 2014-15 to 2016-17, and so it is measured this year for the first time.

As shown in Note 2.1 to the Financial Statements, the LHB did not manage its revenue expenditure within its resource allocation over this three year period. The cumulative revenue resource limit of £3,991million over the three years was exceeded by £75.9 million.

Where an LHB incurs expenditure above its resource allocation (i.e. spending limit) over a rolling three-year period, any expenditure over the resource allocation for those three years exceeds the LHB's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires LHBs to prepare, and have approved by the Welsh Ministers, a rolling three-year integrated medium term plan. This duty is an essential foundation to the delivery of sustainable quality health services. An LHB will be deemed to have met this duty for 2016-17 if it submitted a 2016-17 to 2018-19 plan approved by its Board to the Welsh Ministers who then approved it by 30 June 2016.

As shown in Note 2.3 to the Financial Statements, the LHB did not meet its second financial duty to have an approved three-year integrated medium term plan in place for the period 2016-17 to 2018-19.

Following the Health Board being placed in Special Measures in October 2015, the Welsh Government did not expect the Board to submit a three-year Integrated Medium Term Plan for 2016-19. Instead, the Health Board has operated, in agreement with Welsh Government, under annual planning arrangements.

Huw Vaughan Thomas
Auditor General for Wales
8 June 2017

PART THREE – Annual Accounts

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 H M Treasury, directed.

Statutory background

Betsi Cadwaladr University Local Health Board was established on 1st October 2009 following implementation of the Welsh Government's One Wales National Reform Programme for the NHS in Wales and the subsequent merger of two former NHS Trusts and six former Local Health Boards.

Performance Management and Financial Results

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the Local Health Board 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 has taken place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Expenditure on Primary Healthcare Services	3.1	**300,272**	297,128
Expenditure on healthcare from other providers	3.2	**323,673**	310,295
Expenditure on Hospital and Community Health Services	3.3	**915,124**	868,837
		1,539,069	1,476,260
Less: Miscellaneous Income	4	**131,027**	123,859
LHB net operating costs before interest and other gains and losses		**1,408,042**	1,352,401
Investment Income	8	**0**	0
Other (Gains) / Losses	9	**(370)**	(9)
Finance costs	10	**104**	101
Net operating costs for the financial year		**1,407,776**	1,352,493

See note 2 on page 20A for details of performance against Revenue and Capital allocations.

The notes on pages 8A to 61A form part of these accounts

Other Comprehensive Net Expenditure

	2016-17 £'000	2015-16 £'000
Net gain / (loss) on revaluation of property, plant and equipment	**2,426**	16,299
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	**(33)**	(401)
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Other comprehensive net expenditure for the year	**2,393**	15,898
Total comprehensive net expenditure for the year	**1,405,383**	1,336,595

Statement of Financial Position as at 31 March 2017

	Notes	31 March 2017 £'000	31 March 2016 £'000
Non-current assets			
Property, plant and equipment	11	**563,560**	532,739
Intangible assets	12	**1,238**	1,578
Trade and other receivables	15	**72,623**	52,176
Other financial assets	22	**0**	0
Total non-current assets		**637,421**	586,493
Current assets			
Inventories	14	**16,398**	15,574
Trade and other receivables	15	**48,250**	54,459
Other financial assets	22	**0**	0
Cash and cash equivalents	21	**3,510**	2,062
		68,158	72,095
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**68,158**	72,095
Total assets		**705,579**	658,588
Current liabilities			
Trade and other payables	16	**145,691**	136,559
Other financial liabilities	23	**0**	0
Provisions	17	**26,366**	31,246
Total current liabilities		**172,057**	167,805
Net current assets/ (liabilities)		**(103,899)**	(95,710)
Non-current liabilities			
Trade and other payables	16	**1,119**	1,168
Other financial liabilities	23	**0**	0
Provisions	17	**74,125**	53,697
Total non-current liabilities		**75,244**	54,865
Total assets employed		**458,278**	435,918
Financed by :			
Taxpayers' equity			
General Fund		**388,140**	367,579
Revaluation reserve		**70,138**	68,339
Total taxpayers' equity		**458,278**	435,918

The financial statements on pages 2 to 7 were approved by the Board on 30 May 2017 and signed on its behalf by:

Chief Executive  Date 30 May 2017

The notes on pages 8A to 61A form part of these accounts

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2016-17			
Balance at 1 April 2016	367,579	68,339	**435,918**
Net operating cost for the year	(1,407,776)		**(1,407,776)**
Net gain/(loss) on revaluation of property, plant and equipment	0	2,426	**2,426**
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	(33)	**(33)**
Movements in other reserves	0	0	**0**
Transfers between reserves	594	(594)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2016-17	(1,407,182)	1,799	**(1,405,383)**
Net Welsh Government funding	1,427,743		**1,427,743**
Balance at 31 March 2017	388,140	70,138	**458,278**

The notes on pages 8A to 61A form part of these accounts

Transfers between reserves respresents the balance held in the revaluation reserve for each non-current asset disposed during 2016-17.

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2016

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2015-16			
Balance at 1 April 2015	365,752	52,750	**418,502**
Net operating cost for the year	(1,352,493)		**(1,352,493)**
Net gain/(loss) on revaluation of property, plant and equipment	0	16,299	**16,299**
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	(401)	**(401)**
Movements in other reserves	0	0	**0**
Transfers between reserves	309	(309)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2015-16	(1,352,184)	15,589	**(1,336,595)**
Net Welsh Government funding	1,354,011		**1,354,011**
Balance at 31 March 2016	367,579	68,339	**435,918**

The notes on pages 8A to 61A form part of these accounts

Transfers between reserves respresents the balance held in the revaluation reserve for each non-current asset disposed during 2016-17.

Statement of Cash flows for year ended 31 March 2017

		2016-17	2015-16
		£'000	£'000
Cash Flows from operating activities	notes		
Net operating cost for the financial year		**(1,407,776)**	(1,352,493)
Movements in Working Capital	30	**(11,748)**	30,460
Other cash flow adjustments	31	**58,458**	30,856
Provisions utilised	17	**(11,190)**	(11,777)
Net cash outflow from operating activities		**(1,372,256)**	(1,302,954)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(60,164)**	(52,795)
Proceeds from disposal of property, plant and equipment		**917**	699
Purchase of intangible assets		**(181)**	(194)
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		**(59,428)**	(52,290)
Net cash inflow/(outflow) before financing		**(1,431,684)**	(1,355,244)
Cash flows from financing activities			
Welsh Government funding (including capital)		**1,427,743**	1,354,011
Capital receipts surrendered		**0**	0
Capital grants received		**5,389**	1,769
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		**1,433,132**	1,355,780
Net increase/(decrease) in cash and cash equivalents		**1,448**	536
Cash and cash equivalents (and bank overdrafts) at 1 April 2016		**2,062**	1,526
Cash and cash equivalents (and bank overdrafts) at 31 March 2017		**3,510**	2,062

The notes on pages 8A to 61A form part of these accounts

Notes to the Accounts

1. Accounting policies

The accounts have been prepared in accordance with the 2016-17 Local Health Board Manual for Accounts and 2016-17 Financial Reporting Manual (FReM) issued by HM Treasury. These reflect International Financial Reporting Standards (IFRS) with the particular accounting policies adopted by the Local Health Board being described below. These policies have been applied 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 Board (LHB) is an allocation (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund. 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.

Income is accounted for applying the accruals convention with income being 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 LHB does not ordinarily permit the carry forward of annual leave from one period to another unless the leave period differs from the accounting period. Where employees are permitted to carry forward leave into the following period the associated cost is fully recognised in the financial statements.

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 (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales 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 2012-13 a formal revaluation exercise was applied to land and properties. Land and buildings have been indexed with indices supplied by the District Valuation Office. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

From 2015-16, 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 sales 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 SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

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

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

1.11.1 The 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 on interest on the remaining balance of the liability. Finance charges are charged directly to the SoCNE.

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

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

1.11.2 The 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 first-in first-out/weighted average 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 twenty-four hours. Cash equivalents are investments that mature in three 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 Cashflows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

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

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

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

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

1.14.1 Clinical negligence and personal injury costs
The Welsh Risk Pool (WRP) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was not implemented in 2016-17 The WRP is hosted by Velindre NHS Trust.

1.15 Financial assets
Financial assets are recognised on the SoFP 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.

1.15.1 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.

1.15.2 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.

1.15.3 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.

1.15.4 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.

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

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

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

At the SoFP date, the 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 SoCNE and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

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

1.16 Financial liabilities
Financial liabilities are recognised on the SoFP 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.

1.16.1 Financial liabilities are initially recognised at fair value
Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

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

1.16.3 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.

1.17 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.

1.18 Foreign currencies
Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.19 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 25 to the accounts.

1.20 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.

1.21 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 28.

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.

1.22 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.

1.23 Key sources of estimation uncertainty
The preparation of the Health Board's financial statements requires the use of estimates and assumptions that affect the reported amounts of assets, liabilities, income and expenditure. These estimates are continually evaluated and are based on a range of factors which include notice of potential liabilities, historical experience and the professional judgement of external experts. Changes in accounting estimates may be necessary if there are changes in the circumstances on which an estimate was based or as a result of further information.

By their very nature estimates are uncertain in nature and carry the risk of adjustment to the carrying value in future periods. The following liabilities are based on a high degree of estimation and have been assessed as being at risk of material adjustment in future periods:

Clinical Negligence claims (Note 17 and 18)
Claims made against the Health Board are professionally managed by Legal and Risk Services (L&RS). Each claim is assessed by L&RS to determine the probability of liability and associated costs and accounted for in accordance with IAS37. The probability and cost are estimates based on all known facts as at the Balance Sheet date using the professional knowledge and experience of solicitors employed by L&RS. However, these estimates may change materially over the course of a claim as new information becomes available.

Continuing Healthcare Provision (Note 17)
The Health Board recognises a provision for potential liabilities arising from historic claims for continuing healthcare costs. The provision includes all known claims with an estimate of the likely settlement. The likely settlement is determined by using historical experience.

1.24 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 SoCNE.

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

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

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 SoFP.

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.

1.25 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 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.

1.26 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.

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
IFRS 9 Financial Instruments
IFRS14 Regulatory Deferral Accounts
IFRS15 Revenue from contracts with customers
IFRS 16 Leases

1.29 Accounting standards issued that have been adopted early
During 2016-17 there have been no accounting standards that have been adopted early.
All early adoption of accounting standards will be led by HM Treasury.

1.30 Charities
Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as corporate trustee of the linked NHS Charity "Betsi Cadwaladr University Health Board and Other Related Charities", it is considered for accounting standards compliance to have control of the Charity as a subsidiary. It is therefore required to consolidate the results off the Charity within the statutory accounts of the LHB. The determination of control is an accounting standards test of control and there has been no change to the operation of the Charity or its independence in its management of charitable funds.

The LHB has, however, with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will consolidate and 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) is at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2014-15	2015-16	2016-17	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	1,309,007	1,352,493	**1,407,776**	**4,069,276**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(929)	(966)	**(11)**	**(1,906)**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	**0**	**0**
Total operating expenses	1,308,078	1,351,527	**1,407,765**	**4,067,370**
Revenue Resource Allocation	1,281,462	1,332,002	**1,377,981**	**3,991,445**
Under /(over) spend against Allocation	(26,616)	(19,525)	(29,784)	**(75,925)**

Betsi Cadwaladr University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2014-15 to 2016-17.

2.2 Capital Resource Performance

	2014-15	2015-16	2016-17	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	51,859	48,044	**66,115**	**166,018**
Add: Losses on disposal of donated assets	0	0	**0**	**0**
Less NBV of property, plant and equipment and intangible assets disposed	(1,728)	(690)	**(548)**	**(2,966)**
Less capital grants received	(527)	(385)	**(1,639)**	**(2,551)**
Less donations received	(1,597)	(1,384)	**(3,751)**	**(6,732)**
Charge against Capital Resource Allocation	48,007	45,585	**60,177**	**153,769**
Capital Resource Allocation	48,039	45,588	**60,206**	**153,833**
(Over) / Underspend against Capital Resource Allocation	**32**	3	**29**	**64**

Betsi Cadwaladr University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2014-15 to 2016-17.

During 2016-17 Welsh Government provided the Health Board with £20.0m repayable cash assistance due to year-end pressures arising as a consequence of the overspend against Resource Allocation. The accumulated cash assistance provided to the Health Board on a repayable basis by Welsh Government is now £40.6m.The Health Board has not received any repayable resource brokerage.

Repayment of the cash assistance along with resource overspends will be informed through ongoing consideration of future Integrated Medium Term Plan submissions.

2.3 Duty to prepare a 3 year plan

The NHS Wales Planning Framework for the period 2016 -17 to 2018-19 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The Health Board was placed in Special Measures in June 2015 and in agreement with the Welsh Government did not submit a three year plan during 2016-17. Therefore the Health Board did not meet its statutory financial duty under section 175 (2A) of the National Health Service (Wales) Act 2006. The Annual Operating Plan for 2017-18 has been submitted to the Welsh Government for approval and the Integrated Medium Term Plan for the period 2017-18 to 2020-21 is in development.

	2016-17 to 2018-19
The Cabinet Secretary for Health and Social Services approval status	Not submitted

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2016-17 Total	2015-16
	£'000	£'000	£'000	£'000
General Medical Services	117,632		**117,632**	116,019
Pharmaceutical Services	31,098	(6,193)	**24,905**	25,819
General Dental Services	32,352		**32,352**	32,350
General Ophthalmic Services	1,386	6,204	**7,590**	6,330
Other Primary Health Care expenditure	10,833		**10,833**	10,714
Prescribed drugs and appliances	106,960		**106,960**	105,896
Total	**300,261**	**11**	**300,272**	297,128

3.2 Expenditure on healthcare from other providers

	2016-17	2015-16
	£'000	£'000
Goods and services from other NHS Wales Health Boards	**4,862**	4,722
Goods and services from other NHS Wales Trusts	**9,126**	8,668
Goods and services from other non Welsh NHS bodies	**61,465**	58,773
Goods and services from WHSSC / EASC	**151,366**	146,240
Local Authorities	**0**	0
Voluntary organisations	**7,566**	7,653
NHS Funded Nursing Care	**7,263**	7,996
Continuing Care	**76,848**	74,827
Private providers	**5,177**	1,416
Specific projects funded by the Welsh Government	**0**	0
Other	**0**	0
Total	**323,673**	310,295

Note 3.1 Expenditure on Primary Healthcare Services includes pay costs of £13,204,000 comprising:

	2016-17	2015-16
	£	£
General Medical Services - GP Out of Hours	6,719,000	6,740,000
General Medical Services - Including Managed Practices	5,309,000	775,000
General Dental Services	604,000	576,000
Other Primary Health Care Expenditure	38,000	60,000
	12,670,000	8,151,000

3.3 Expenditure on Hospital and Community Health Services

	2016-17 £'000	2015-16 £'000
Directors' costs	**2,203**	2,235
Staff costs	**667,340**	633,841
Supplies and services - clinical	**120,819**	116,062
Supplies and services - general	**25,870**	19,569
Consultancy Services	**2,342**	2,314
Establishment	**10,725**	10,263
Transport	**4,853**	4,216
Premises	**35,067**	36,546
External Contractors	**0**	0
Depreciation	**28,575**	28,083
Amortisation	**521**	517
Fixed asset impairments and reversals (Property, plant & equipment)	**8,383**	5,377
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	**453**	453
Other auditors' remuneration	**0**	0
Losses, special payments and irrecoverable debts	**2,575**	3,690
Research and Development	**455**	821
Other operating expenses	**4,943**	4,850
Total	**915,124**	868,837

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

Increase/(decrease) in provision for future payments:	2016-17 £'000	2015-16 £'000
Clinical negligence	**26,052**	1,358
Personal injury	**292**	489
All other losses and special payments	**271**	515
Defence legal fees and other administrative costs	**782**	1,288
Gross increase/(decrease) in provision for future payments	**27,397**	**3,650**
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	596
Irrecoverable debts	**175**	123
Less: income received/ due from Welsh Risk Pool	**(24,997)**	(656)
Total	**2,575**	**3,713**

Personal injury costs include £ 30,000 (2015-16 £687,000) in respect of permanent injury benefits. Charges to operating expenses include £435,000 (2015-16 £200,000) in respect of 127 cases arising from clinical redress (2015-16 89 cases), split between damages of £308,000 and defence costs of £127,000 (2015-16 damages of £151,000 and defence costs of £49,000).

4. Miscellaneous Income

	2016-17 £'000	2015-16 £'000
Local Health Boards	**5,556**	6,467
WHSSC /EASC	**38,262**	37,390
NHS trusts	**5,603**	5,037
Other NHS England bodies	**12,673**	13,847
Foundation Trusts	**1,278**	997
Local authorities	**11,020**	11,674
Welsh Government	**3,156**	796
Non NHS:		
Prescription charge income	**49**	50
Dental fee income	**9,961**	9,382
Private patient income	**1,269**	1,393
Overseas patients (non-reciprocal)	**495**	300
Injury Costs Recovery (ICR) Scheme	**1,635**	1,679
Other income from activities	**4,323**	3,286
Patient transport services	**0**	0
Education, training and research	**19,841**	19,875
Charitable and other contributions to expenditure	**1,279**	1,574
Receipt of donated assets	**3,750**	1,384
Receipt of Government granted assets	**1,639**	385
Non-patient care income generation schemes	**440**	378
NWSSP	**0**	3
Deferred income released to revenue	**79**	63
Contingent rental income from finance leases	**0**	0
Rental income from operating leases	**983**	505
Other income:		
Provision of laundry, pathology, payroll services	**175**	171
Accommodation and catering charges	**3,016**	2,916
Mortuary fees	**328**	405
Staff payments for use of cars	**970**	1,080
Business Unit	**0**	0
Other	**3,247**	2,822
Total	**131,027**	123,859

Injury Cost Recovery (ICR) Scheme income is generally subject to a provision for impairment of 22.94 % to reflect expected rates of collection as advised by the Compensation Recovery Unit. The Health Board has further increased the provision impairment rate on specific aged cases in order to reflect the additional risk of potential non-recovery.

The NHS Trusts miscellaneous income figure of £5,603,000 consists of £4,841,000 from Welsh NHS Trusts and £762,000 from English NHS Trusts

"Other Income: Other" includes recharges for staff costs of £1,289,000 not allocated to other categories.

5. Employee benefits and staff numbers

5.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Total	2015-16
	£000	£000	£000	£000	£000
Salaries and wages	524,331	2,655	45,004	**571,990**	547,026
Social security costs	49,037	0	0	**49,037**	36,929
Employer contributions to NHS Pension Scheme	62,610	0	0	**62,610**	61,332
Other pension costs	50	0	2	**52**	0
Other employment benefits	0	0	0	**0**	0
Termination benefits	53	0	0	**53**	180
Total	636,081	2,655	45,006	**683,742**	645,467
Charged to capital				**1,345**	1,057
Charged to revenue				**682,397**	644,410
				683,742	645,467
Net movement in accrued employee benefits (untaken staff leave accrual included above)				144	(148)

5.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Total	2015-16
	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,558	5	35	**2,598**	2,467
Medical and dental	1,216	24	180	**1,420**	1,347
Nursing, midwifery registered	4,783	1	148	**4,932**	4,936
Professional, Scientific, and technical staff	331	16	1	**348**	343
Additional Clinical Services	3,144	0	14	**3,158**	3,064
Allied Health Professions	784	0	25	**809**	791
Healthcare Scientists	227	0	10	**237**	228
Estates and Ancilliary	1,178	0	0	**1,178**	1,189
Students	21	2	0	**23**	14
Total	**14,242**	**48**	**413**	**14,703**	14,379

5.3. Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who are Scheme members and who retired early on ill-health grounds during the year. NHS Pensions has advised that during 2016-17 there were 17 early retirements at an additional cost of £766,088 (2015-16 20 early retirements at a cost of £894,224). This cost has been calculated by multiplying the average value of ill-health pension by the number of years from payment to age 60. Any pensions increase has been ignored.

5.4 Employee benefits

Employee benefits refer to non-pay benefits which are not attributable to individual employees, for example group membership of a club.

The Health Board does not currently operate any employee benefit schemes.

5.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2016-17 Number of compulsory redundancies Whole numbers only	2016-17 Number of other departures Whole numbers only	2016-17 Total number of exit packages Whole numbers only	2016-17 Number of departures where special payments have been made Whole numbers only	2015-16 Total number of exit packages Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	1	0	1	0	1
£25,000 to £50,000	0	1	1	0	2
£50,000 to £100,000	0	0	0	0	1
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	**1**	**1**	**2**	**0**	**4**

Exit packages cost band (including any special payment element)	2016-17 Cost of compulsory redundancies £'s	2016-17 Cost of other departures £'s	2016-17 Total cost of exit packages £'s	2016-17 Cost of special element included in exit packages £'s	2015-16 Total cost of exit packages £'s
less than £10,000	0	0	0	0	0
£10,000 to £25,000	17,533	0	17,533	0	19,461
£25,000 to £50,000	0	35,869	35,869	0	99,479
£50,000 to £100,000	0	0	0	0	60,643
£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	**17,533**	**35,869**	**53,402**	**0**	**179,583**

This disclosure reports the number and value of exit packages taken by staff leaving the Health Board during the year. Whilst the exit costs in this note are accounted for in full in the year of departure the expenses associated with these departures may have been recognised in part or full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Additional costs relating to early retirements are met by the Health Board and not by the NHS Pension Scheme.

Ill-health retirement costs are not included in these tables as they are met by the NHS Pension Scheme. Further details are provided in Note 5.3 Retirements due to ill-health.

5.6 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 2016-17 was £200,000 -£205,000 (2015-16, £200,000 - £205,000). This was 7.11 times (2015-16, 7.29) the median remuneration of the workforce, which was £28,462 (2015-16, £27,760).

In 2016-17, seventeen (2015-16, eight) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £200,000 - £205,000 to £270,000 - £275,000 (2015-16 £200,000-£205,000 to £275,000-£280,000).

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.

The Remuneration Relationship decreased during 2016-17 reflecting that, with the exception of Senior Managers, all staff received an inflationary pay award. In addition, 18.15% of staff receive incremental pay progressions within their pay scales.

5.7 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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 2% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 1% of this. The legal minimum level of contribution level is increasing to 8% over the next three years.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £5,824 and £43,000 for the 2016-17 tax year (2015-16 £5,824 and £42,385).

NEST has an annual contribution limit of £4,900 for the 2016-17 tax year (£4,700 for 2015-16). This means the most that can be contributed to a single pot in the current tax year is £4,900. This figure will be adjusted annually in line with average earnings. The annual contribution limit includes member contributions, money from their employer and any tax relief.

Alternatively under certification, employers may choose to calculate contributions in a way that meets the requirements of one of three sets of tiers described in the legislation. The three tiers have minimum contribution rates as detailed on the NEST website.

6. Operating leases

LHB as lessee

The following types of lease are included within operating leases:

- Lease of various medical and administrative equipment
- Lease of cars over periods of three and four years, and
- Lease of various properties over differing periods.

Payments recognised as an expense	**2016-17**	2015-16
	£000	£000
Minimum lease payments	**3,320**	3,671
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**3,320**	3,671

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**2,630**	2,685
Between one and five years	**4,628**	4,206
After 5 years	**12,964**	12,449
Total	**20,222**	19,340

There are no future sublease payments expected to be received

LHB as lessor

Operating leases include the lease of various properties over differing periods. The rent reeivable for each lease is negotiated at the time that the contract is entered into.

Rental revenue	**£000**	£000
Rent	**374**	475
Contingent rents	**0**	0
Total revenue rental	**374**	475

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**374**	475
Between one and five years	**18**	18
After 5 years	**23**	27
Total	**415**	520

7. Public Sector Payment Policy - Measure of Compliance

7.1 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.

	2016-17	**2016-17**	2015-16	2015-16
NHS	**Number**	**£000**	Number	£000
Total bills paid	**6,386**	**260,440**	7,945	244,979
Total bills paid within target	**6,025**	**257,565**	7,518	242,659
Percentage of bills paid within target	**94.3%**	**98.9%**	94.6%	99.1%
Non-NHS				
Total bills paid	**307,791**	**561,808**	272,642	366,139
Total bills paid within target	**296,956**	**551,760**	254,484	344,086
Percentage of bills paid within target	**96.5%**	**98.2%**	93.3%	94.0%
Total				
Total bills paid	**314,177**	**822,248**	280,587	611,118
Total bills paid within target	**302,981**	**809,325**	262,002	586,745
Percentage of bills paid within target	**96.4%**	**98.4%**	93.4%	96.0%

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

	2016-17	2015-16
	£	£
Amounts included within finance costs (note 10) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

Welsh Government has set a requirement for the Health Board to pay 95% of non-NHS creditors, by number, within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. During 2016-17 the Health Board paid 96.5% of invoices within 30 days and therefore achieved this performance measure.

8. Investment Income

	2016-17	2015-16
	£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

9. Other gains and losses

	2016-17	2015-16
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**370**	9
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	**370**	9

10. Finance costs

	2016-17	2015-16
	£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	**42**	44
contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**42**	44
Provisions unwinding of discount	**62**	57
Other finance costs	**0**	0
Total	**104**	101

11 Property, plant and equipment

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 2016	48,685	457,757	17,623	66,233	95,186	1,340	19,205	5,111	**711,140**
Indexation	1,874	0	0	0	0	0	0	0	**1,874**
Additions									
- purchased	0	0	0	52,686	3,566	0	3,239	1,083	**60,574**
- donated	0	684	0	(684)	2,962	0	187	571	**3,720**
- government granted	0	1,639	0	0	0	0	0	0	**1,639**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	29,019	(4)	(32,711)	3,696	0	0	0	**0**
Revaluations	0	1,289	0	0	0	0	0	0	**1,289**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	(7)	(26)	0	0	0	0	0	0	**(33)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	(763)	(1,296)	0	0	(5,429)	(213)	(6,380)	(484)	**(14,565)**
At 31 March 2017	49,789	489,066	17,619	85,524	99,981	1,127	16,251	6,281	**765,638**
Depreciation at 1 April 2016	515	99,857	2,103	0	59,254	1,242	12,738	2,692	**178,401**
Indexation	527	0	0	0	0	0	0	0	**527**
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	210	0	0	0	0	0	0	**210**
Reversal of impairments	(507)	0	0	0	0	0	0	0	**(507)**
Impairments	140	8,746	0	0	4	0	0	0	**8,890**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	(467)	(1,045)	0	0	(5,429)	(213)	(6,380)	(484)	**(14,018)**
Provided during the year	0	16,855	520	0	8,503	43	2,171	483	**28,575**
At 31 March 2017	208	124,623	2,623	0	62,332	1,072	8,529	2,691	**202,078**
Net book value at 1 April 2016	48,170	357,900	15,520	66,233	35,932	98	6,467	2,419	**532,739**
Net book value at 31 March 2017	49,581	364,443	14,996	85,524	37,649	55	7,722	3,590	**563,560**
Net book value at 31 March 2017 comprises :									
Purchased	49,581	354,969	14,996	85,524	31,110	55	7,502	2,944	**546,681**
Donated	0	6,940	0	0	6,539	0	220	631	**14,330**
Government Granted	0	2,534	0	0	0	0	0	15	**2,549**
At 31 March 2017	49,581	364,443	14,996	85,524	37,649	55	7,722	3,590	**563,560**
Asset financing :									
Owned	49,581	363,496	14,996	85,524	37,649	55	7,722	3,590	**562,613**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	947	0	0	0	0	0	0	**947**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2017	49,581	364,443	14,996	85,524	37,649	55	7,722	3,590	**563,560**

The net book value of land, buildings and dwellings at 31 March 2017 comprises :

	£000
Freehold	**425,068**
Long Leasehold	**3,952**
Short Leasehold	**0**
	429,020

11.1 Property, plant and equipment (continued)

	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 2015	47,430	402,178	17,006	64,719	95,246	1,427	17,424	4,730	**650,160**
Indexation	930	22,965	971	0	0	0	0	0	**24,866**
Additions									
- purchased	450	0	0	38,049	3,253	0	3,136	1,248	**46,136**
- donated	0	334	0	0	975	0	20	0	**1,329**
- government granted	0	0	0	385	0	0	0	0	**385**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	32,533	19	(36,920)	4,368	0	0	0	**0**
Revaluations	5	148	5	0	0	0	0	0	**158**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	(401)	0	0	0	0	0	0	**(401)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	(130)	0	(378)	0	(8,656)	(87)	(1,375)	(867)	**(11,493)**
At 31 March 2016	48,685	457,757	17,623	66,233	95,186	1,340	19,205	5,111	**711,140**
Depreciation at 1 April 2015	155	69,781	1,516	0	59,735	1,274	11,796	2,979	**147,236**
Indexation	372	8,219	117	0	0	0	0	0	**8,708**
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	16	1	0	0	0	0	0	**17**
Reversal of impairments	(369)	(4,234)	(30)	0	0	0	0	0	**(4,633)**
Impairments	357	9,653	0	0	0	0	0	0	**10,010**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	(35)	0	(8,656)	(87)	(1,375)	(867)	**(11,020)**
Provided during the year	0	16,422	534	0	8,175	55	2,317	580	**28,083**
At 31 March 2016	515	99,857	2,103	0	59,254	1,242	12,738	2,692	**178,401**
Net book value at 1 April 2015	47,275	332,397	15,490	64,719	35,511	153	5,628	1,751	**502,924**
Net book value at 31 March 2016	48,170	357,900	15,520	66,233	35,932	98	6,467	2,419	**532,739**
Net book value at 31 March 2016 comprises :									
Purchased	48,170	350,471	15,520	66,233	31,300	98	6,412	2,318	**520,522**
Donated	0	6,512	0	0	4,632	0	54	82	**11,280**
Government Granted	0	917	0	0	0	0	1	19	**937**
At 31 March 2016	48,170	357,900	15,520	66,233	35,932	98	6,467	2,419	**532,739**
Asset financing :									
Owned	48,170	356,871	15,520	66,233	35,932	98	6,467	2,419	**531,710**
Held on finance lease	0	13	0	0	0	0	0	0	**13**
On-SoFP PFI contracts	0	1,016	0	0	0	0	0	0	**1,016**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2016	48,170	357,900	15,520	66,233	35,932	98	6,467	2,419	**532,739**

The net book value of land, buildings and dwellings at 31 March 2016 comprises :

	£000
Freehold	417,478
Long Leasehold	4,112
Short Leasehold	0
	421,590

11.1 Property, plant and equipment (continued)

(i) Donated and Government Granted asset additions include schemes funded by:
- Betsi Cadwaladr University Health Board and Other Related Charities - £3.398m
- Other hospital based voluntary bodies - £0.352m
- Grants from the Ministry of Justice in relation to HMP Berwyn - £1.639m

(ii) Impairments relate to the revaluation of:
- Glan Clwyd Hospital - Wards 4, 8,12, Fracture/Orthopaedics, Head and Neck, Main Entrance, Offices
- Glan Clwyd Hospital - Day Surgery
- Revaluation of Flint Health Care Centre to current market value
- Revaluation of Buckley Health Care Centre to current market value

The revaluation of wards and departments at Glan Clwyd Hospital was undertaken prior to building assets becoming fully operational.

(iii) Asset lives for buildings and dwellings are provided by the District Valuer with lives for equipment assets being assessed and reviewed on a regular basis by users of the equipment.

(iv) There has been no compensation from third parties for assets impaired, lost or given up during the year.

(v) There have been no write-downs to recoverable amounts or reversals of such write-downs during the year.

(vi) The Health Board does not have any temporary idle assets.

(vii) The gross carrying amount of fully depreciated tangible asset still in use as at 31 March 2017 was £35.07m (31 March 2016 £38.77m).

(viii) IFRS13 Fair Value Measurement has not been applied in the preparation of these accounts as the Health Board does not hold any non-operational assets.

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 2016	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 2017	0	0	0	0	0	**0**
Balance brought forward 1 April 2015	179	38	0	0	0	**217**
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	(179)	(38)	0	0	0	**(217)**
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 2016	0	0	0	0	0	**0**

The Health Board will be seeking Ministerial approval for the disposal of the following properties during 2017/18. As these properties were in operational use at the balance sheet date their values are included within Note 11.1 property, plant and equipment.

Bishops Court, Broughton
Agricultural Land - Bryn Y Neuadd, Llanfairfechan
Argyll Road Clinic, Llandudno
Caergwrle Clinic
Tywyn Health Centre

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 2016	4,235	0	0	0	0	0	**4,235**
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	**151**	**0**	**0**	**0**	**0**	**0**	**151**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**30**	**0**	**0**	**0**	**0**	**0**	**30**
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	**(725)**	**0**	**0**	**0**	**0**	**0**	**(725)**
Gross cost at 31 March 2017	**3,691**	**0**	**0**	**0**	**0**	**0**	**3,691**
Amortisation at 1 April 2016	2,657	0	0	0	0	0	**2,657**
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	**521**	**0**	**0**	**0**	**0**	**0**	**521**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(725)**	**0**	**0**	**0**	**0**	**0**	**(725)**
Amortisation at 31 March 2017	**2,453**	**0**	**0**	**0**	**0**	**0**	**2,453**
Net book value at 1 April 2016	**1,578**	**0**	**0**	**0**	**0**	**0**	**1,578**
Net book value at 31 March 2017	**1,238**	**0**	**0**	**0**	**0**	**0**	**1,238**
At 31 March 2017							
Purchased	**1,026**	**0**	**0**	**0**	**0**	**0**	**1,026**
Donated	**212**	**0**	**0**	**0**	**0**	**0**	**212**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2017	**1,238**	**0**	**0**	**0**	**0**	**0**	**1,238**

12 Intangible non-current assets (continued)

	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 2015	4,041	0	0	0	0	0	**4,041**
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	139	0	0	0	0	0	**139**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	55	0	0	0	0	0	**55**
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 2016	**4,235**	**0**	**0**	**0**	**0**	**0**	**4,235**
Amortisation at 1 April 2015	2,140	0	0	0	0	0	**2,140**
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	517	0	0	0	0	0	**517**
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 2016	**2,657**	**0**	**0**	**0**	**0**	**0**	**2,657**
Net book value at 1 April 2015	**1,901**	**0**	**0**	**0**	**0**	**0**	**1,901**
Net book value at 31 March 2016	**1,578**	**0**	**0**	**0**	**0**	**0**	**1,578**
At 31 March 2016							
Purchased	1,327	0	0	0	0	0	**1,327**
Donated	0	0	0	0	0	0	**0**
Government Granted	251	0	0	0	0	0	**251**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2016	**1,578**	**0**	**0**	**0**	**0**	**0**	**1,578**

Explanatory Notes: Note 12 Intangible non-current assets

(i) Software intangible assets are amortised over a standard life of five years, subject to an annual review by the relevant department. The Health Board does not hold any intangible non-current assets where the useful lives are considered to be indefinite.

(ii) The gross carrying amount of fully depreciated intangible assets still in use as at 31 March 2017 was £0.502m (31 March 2016 £1.066 million)

13. Impairments

	2016-17 Property, plant & equipment £000	2016-17 Intangible assets £000	2015-16 Property, plant & equipment £000	2015-16 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	**(203)**	0	**0**	0
Others (specify)	**8,619**	0	**5,778**	0
Total of all impairments	**8,416**	0	**5,778**	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	**8,383**	0	**5,377**	0
Charged to Revaluation Reserve	**33**	0	**401**	0
	8,416	0	**5,778**	0

Impairments charged to the Statement of Comprehensive Net Expenditure during 2016-17 were conducted by the District Valuer in accordance with the requirements of IFRS.

Analysis of Impairments

Changes in market price	**£'000**
Revaluation of Flint Health Care Centre	216
Revaluation Buckley Health Care Centre	82
Reversal of prior year impairments	(501)
	(203)

Other Impairments	**£'000**
Glan Clwyd Hospital - Wards 4, 8,12, Fracture/Orthopaedics, Head and Neck, Main Entrance, Offices	6,298
Glan Clwyd Hospital - Day Surgery	1,863
Tywyn Health Centre	454
Flint Health Care Centre - impairment of equipment	4
	8,619
Total of all impairments	**8,416**

14 Inventories

14.1 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	7,044	6,552
Consumables	9,079	8,798
Energy	227	177
Work in progress	0	0
Other	48	47
Total	**16,398**	15,574
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2017 £000	31 March 2016 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	134	131
Reversal of write-downs that reduced the expense	0	0
Total	**134**	**131**

Write-down of inventories relates to the disposal of obsolete, out-of-date or damaged pharmacy stock. The write-down figure represents 0.2% of drugs purchases during the year (2015-16 0.3%)

15. Trade and other Receivables

Current	**31 March 2017 £000**	31 March 2016 £000
Welsh Government	**688**	204
WHSSC / EASC	**674**	1,984
Welsh Health Boards	**1,560**	985
Welsh NHS Trusts	**641**	1,001
Non - Welsh Trusts	**576**	2,428
Other NHS	**1,559**	0
Welsh Risk Pool	**27,577**	32,648
Local Authorities	**2,243**	3,278
Capital debtors	**0**	0
Other debtors	**8,492**	7,328
Provision for irrecoverable debts	**(2,298)**	(2,468)
Pension Prepayments	**0**	0
Other prepayments	**4,347**	4,588
Other accrued income	**2,191**	2,483
Sub total	**48,250**	54,459
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
Welsh Risk Pool	**69,543**	49,106
Local Authorities	**0**	0
Capital debtors	**0**	0
Other debtors	**0**	0
Provision for irrecoverable debts	**(400)**	(391)
Pension Prepayments	**0**	0
Other prepayments	**1,107**	1,125
Other accrued income	**2,373**	2,336
Sub total	**72,623**	52,176
Total	**120,873**	106,635
Receivables past their due date but not impaired		
By up to three months	**2,771**	2,297
By three to six months	**674**	508
By more than six months	**328**	456
	3,773	3,261
Provision for impairment of receivables		
Balance at 1 April	**(2,860)**	(2,222)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**237**	106
Amount recovered during the year	**0**	0
(Increase) / decrease in receivables impaired	**(75)**	(744)
Bad debts recovered during year	**0**	0
Balance at 31 March	**(2,698)**	(2,860)

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	**1,035**	430
Other	**0**	0
Total	**1,035**	430

16. Trade and other payables

Current	31 March 2017 £000	31 March 2016 £000
Welsh Government	0	76
WHSSC / EASC	763	5,641
Welsh Health Boards	668	330
Welsh NHS Trusts	1,531	1,305
Other NHS	14,149	16,807
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	5,820	1,696
NI contributions payable to HMRC	7,630	4,104
Non-NHS creditors	36,313	30,122
Local Authorities	11,229	9,993
Capital Creditors	11,681	5,912
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	50	48
Pensions: staff	0	0
Accruals	61,033	65,283
Deferred Income:		
Deferred Income brought forward	1,554	204
Deferred Income Additions	(236)	1,413
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	(79)	(63)
Other creditors	4,040	4,962
PFI assets –deferred credits	0	0
Payments on account	(10,455)	(11,274)
Total	**145,691**	136,559

Non-current		
Welsh Government	0	0
WHSSC / EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	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	1,119	1,168
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	**1,119**	1,168

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

"Other taxes payable to HMRC" consists of PAYE, Student Loan Repayments and Construction Industry Scheme liabiities less sums reoverable in respect of Statutory Maternity Pay, Statutory Paternity Pay and Statutory Adoption Pay.

17. Provisions

	At 1 April 2016	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 2017
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	**24,446**	(4,156)	(2,174)	(20,395)	36,657	(7,659)	(6,449)	0	**20,270**
Personal injury	**928**	0	0	196	1,045	(735)	(753)	51	**732**
All other losses and special payments	**185**	0	0	0	312	(312)	(41)	0	**144**
Defence legal fees and other administration	**1,141**	0	0	(197)	1,302	(732)	(520)		**994**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**163**			(32)	175	(159)	0	11	**158**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**4,383**		0	0	1,921	(1,593)	(643)		**4,068**
Total	**31,246**	**(4,156)**	**(2,174)**	(20,428)	41,412	(11,190)	(8,406)	**62**	**26,366**
Non Current									
Clinical negligence	**48,810**	0	0	20,395	0	0	0	0	**69,205**
Personal injury	**3,663**	0	0	(196)	0	0	0	0	**3,467**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**594**	0	0	197	0	0	0		**791**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**630**			32	0	0	0	0	**662**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**0**		0	0	0	0	0		**0**
Total	**53,697**	**0**	**0**	**20,428**	**0**	**0**	**0**	**0**	**74,125**
TOTAL									
Clinical negligence	**73,256**	**(4,156)**	**(2,174)**	**0**	**36,657**	**(7,659)**	**(6,449)**	**0**	**89,475**
Personal injury	**4,591**	**0**	**0**	**0**	**1,045**	**(735)**	**(753)**	**51**	**4,199**
All other losses and special payments	**185**	**0**	**0**	**0**	**312**	**(312)**	**(41)**	**0**	**144**
Defence legal fees and other administration	**1,735**	**0**	**0**	**0**	**1,302**	**(732)**	**(520)**		**1,785**
Pensions relating to former directors	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Pensions relating to other staff	**793**			**0**	**175**	**(159)**	**0**	**11**	**820**
Restructuring	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Other	**4,383**		**0**	**0**	**1,921**	**(1,593)**	**(643)**		**4,068**
Total	**84,943**	**(4,156)**	**(2,174)**	**0**	**41,412**	**(11,190)**	**(8,406)**	**62**	**100,491**

Expected timing of cash flows:

	In year to 31 March 2018	Between 1 April 2018 31 March 2022	Thereafter	Total
				£000
Clinical negligence	20,270	69,205	0	**89,475**
Personal injury	731	1,096	2,372	**4,199**
All other losses and special payments	144	0	0	**144**
Defence legal fees and other administration	994	791	0	**1,785**
Pensions relating to former directors	0	0	0	**0**
Pensions relating to other staff	158	428	234	**820**
Restructuring	0	0	0	**0**
Other	4,068	0	0	**4,068**
Total	**26,365**	**71,520**	**2,606**	**100,491**

"Other Provisions" included above are as follows:	**£'000**
Continuing Health Care claims subject to further review	2,115
Staff grading reviews and appeals	1,220
Mental Health and Learning Disabilities Division Special Measures costs	619
Relocation expenses	82
Claims for on-call payment arrears	32
Total	4,068

The provision for Continuing Health Care claims is based on estimates from the claims which have been processed up to the balance sheet date. This is subject to a significant degree of sensitivity and is dependent on the percentage of claims which are deemed eligible along with the average settlement rate.

The expected timing of cashflows is based on best available information for each individual provision as at 31 March 2017 and may be subject to changes in future periods.

17 Provisions (continued)

	At 1 April 2015	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 2016
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	20,397	(2,396)	(5,075)	15,966	24,577	(8,200)	(20,823)	0	**24,446**
Personal injury	1,610	0	0	(420)	1,426	(796)	(937)	45	**928**
All other losses and special payments	107	0	0	0	515	(437)	0	0	**185**
Defence legal fees and other administration	795	0	0	52	1,742	(994)	(454)		**1,141**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	166			143	0	(163)	5	12	**163**
Restructuring	0			0	0	0	0	0	**0**
Other	5,550		0	0	743	(1,187)	(723)		**4,383**
Total	**28,625**	**(2,396)**	**(5,075)**	**15,741**	**29,003**	**(11,777)**	**(22,932)**	**57**	**31,246**
Non Current									
Clinical negligence	64,776	0	0	(15,966)	0	0	0	0	**48,810**
Personal injury	3,243	0	0	420	0	0	0	0	**3,663**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	646	0	0	(52)	0	0	0		**594**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	773			(143)	0	0	0	0	**630**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**69,438**	**0**	**0**	**(15,741)**	**0**	**0**	**0**	**0**	**53,697**
TOTAL									
Clinical negligence	85,173	(2,396)	(5,075)	0	24,577	(8,200)	(20,823)	0	**73,256**
Personal injury	4,853	0	0	0	1,426	(796)	(937)	45	**4,591**
All other losses and special payments	107	0	0	0	515	(437)	0	0	**185**
Defence legal fees and other administration	1,441	0	0	0	1,742	(994)	(454)		**1,735**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	939			0	0	(163)	5	12	**793**
Restructuring	0			0	0	0	0	0	**0**
Other	5,550		0	0	743	(1,187)	(723)		**4,383**
Total	**98,063**	**(2,396)**	**(5,075)**	**0**	**29,003**	**(11,777)**	**(22,932)**	**57**	**84,943**

18. Contingencies

18.1 Contingent liabilities

	2016-17	2015-16
Provisions have not been made in these accounts for the following amounts :	£'000	£'000
Legal claims for alleged medical or employer negligence	178,843	176,346
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	4,117	3,863
Continuing Health Care costs	3,254	5,090
Other	0	0
Total value of disputed claims	186,214	185,299
Amounts recovered in the event of claims being successful	174,477	173,228
Net contingent liability	11,737	12,071

18.2 Remote Contingent liabilities

	2016-17	2015-16
	£'000	£'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

18.3 Contingent assets

	2016-17	2015-16
	£'000	£'000
The Health Boards does not hold any contingent assets	0	0
	0	0
	0	0
Total	0	0

19. Capital commitments

Contracted capital commitments at 31 March	**2016-17**	2015-16
	£'000	£'000
Property, plant and equipment	**54,978**	70,899
Intangible assets	**0**	0
Total	**54,978**	70,899

Capital commitments as at 31 March 2017 related to the following schemes:

- Glan Clwyd Hospital Redevelopment
- Flint Primary Care Resource Centre
- Blaenau Ffestiniog Primary Care Resource Centre
- Sub Regional Neonatal Intensive Care Centre (SuRNICC)
- Patient Administration Systems
- Emergency Department Informations Systems (EDCIMS)
- Prestatyn Primary Care Centre
- Bala Primary Care Centre

20. 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. This note is, therefore, 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 2017		Approved to write-off to 31 March 2017	
	Number	£	Number	£
Clinical negligence	164	11,475,968	112	8,569,587
Personal injury	44	735,131	15	211,524
All other losses and special payments	277	311,713	272	311,417
Total	485	12,522,812	399	9,092,528

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 £
00RT7MN0002	Clinical Negligence	0	5,357,460	0
03RT7MN0021	Clinical Negligence	0	711,390	711,390
03RT7MN0025	Clinical Negligence	145,000	1,614,999	1,614,999
04RT9MN0023	Clinical Negligence	1,047,073	1,917,073	0
05RT9MN0011	Clinical Negligence	2,179,255	3,374,800	0
06RT9MN0022	Clinical Negligence	0	450,000	0
08RT7MN0008	Clinical Negligence	160,000	1,726,804	0
10RT8MN0021	Clinical Negligence	48,000	535,884	535,884
10RT8MN0035	Clinical Negligence	0	443,900	443,900
10RT9MN0016	Clinical Negligence	44,158	659,900	659,900
10RT9MN0033	Clinical Negligence	310,000	310,000	0
117A1MN0067	Clinical Negligence	523,231	523,231	0
11RT9MN0022	Clinical Negligence	914,000	915,500	0
127A1MN0004	Clinical Negligence	383,000	390,142	0
147A1MN0122	Clinical Negligence	65,000	305,000	305,000
98RT8MN0011	Clinical Negligence	0	560,000	560,000
Sub-total		**5,818,717**	**19,796,083**	**4,831,073**
All other cases		6,704,095	13,409,292	4,261,453
Total cases		**12,522,812**	**33,205,375**	**9,092,526**

21. Cash and cash equivalents

	2016-17	2015-16
	£000	£000
Balance at 1 April	2,062	1,526
Net change in cash and cash equivalent balances	1,448	536
Balance at 31 March	3,510	2,062
Made up of:		
Cash held at GBS	3,427	1,801
Commercial banks	0	0
Cash in hand	83	261
Current Investments	0	0
Cash and cash equivalents as in Statement of Financial Position	3,510	2,062
Bank overdraft - GBS	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in Statement of Cash Flows	3,510	2,062

22. Other Financial Assets

	Current		Non-current	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£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

23. Other financial liabilities

Financial liabilities	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000	£000	**£000**	£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

24. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

Health Bodies	Expenditure with related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Abertawe Bro Morgannwg University LHB	521	1,257	38	1,056
Aneurin Bevan LHB	118	160	31	130
Cardiff & Vale University LHB	662	734	18	233
Cwm Taf LHB	64	50	26	6
Hywel Dda LHB	4,301	572	156	3
Powys LHB	854	2,868	405	132
WHSSC / EASC	151,363	38,214	763	674
Public Health Wales NHS Trust	4,318	3,535	98	170
Velindre NHS Trust	17,979	4,408	1,433	340
Welsh Ambulance Services NHS Trust	4,698	480	0	131
Welsh Risk Pool	0	0	0	97,120
Welsh Government	268	1,444,305	0	688
Total	**185,146**	**1,496,583**	**2,968**	**100,683**

Other Organisations	Expenditure with related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Conwy County Borough Council	3,491	1,174	3,353	344
Denbighshire County Council	4,532	1,664	1,023	258
Flintshire County Council	6,762	1,913	2,648	526
Gwynedd County Council	6,607	1,107	1,394	128
Isle of Anglesey Council	3,447	1,066	773	67
Wrexham County Borough Council	5,774	4,041	1,997	910
Other Welsh Local Authorities (Including Police & Crime Commissioners and Fire Authorities)	552	196	41	10
Total	**31,165**	**11,161**	**11,229**	**2,243**

Charitable Funds

The Health Board is corporate trustee of the Betsi Cadwaladr University Health Board Charity and Other Related Charities (registered charity number 1138976). All voting members of the Health Board can act as corporate trustees of the charity. Operational responsibility for the administration of the charity is delegated to a Charitable Funds Committee.

The Health Board received revenue and capital grants totalling £4.68 million from the charitable fund during the year (2015-16 £2.24 million)

24. Related Party Transactions (continued)

A number of the Health Board's members have declared interests in related parties as follows:

Name	Details	Interests
Dr R M Walker	Interim Executive Medical Director and Director of Clinical Services 1 April - 31 August 2016	Employed as a salaried GP in Llanfairfechan. Works as a specialty doctor within the Health Board Wife is a GP partner in Bron Derw Surgery, Bangor Undertakes ad-hoc work for Cardiff University as an examiner for the Diploma of Practical Dermatology Has run courses on minor surgery for the Royal College of Surgeons and has received payment for this work Receives honorarium from AWMSG
Dr E Moore	Executive Medical Director and Director of Clinical Services From 1 September 2016	Wife is the Clinical Director of Breast and Endocrine Surgery at the Royal Liverpool and Broadgreen University Hospitals NHS Trust
Prof A Hopkins	Executive Director of Nursing and Midwifery 1 April - 11 April 2016	Engages in professional engagement and development of policy as an Executive Nurse Director in Wales with the Royal College of Nursing. No remuneration received. Member of the National Cultural Alignment Group, sponsored by the Royal College of Nursing Awarded an honorary chair at Bangor University School of Healthcare Sciences, October 2015
Mr A Thomas	Executive Director of Therapies & Health Sciences substantive from 11th February 2017	Employed by the Health Care Professions as a Panel Member
Mr A Roach	Director of Mental Health and Learning Disabilities From 5 May 2016	Director of Thatchers Green (Treales) Residents Association Limited
Mr G M Lang	Executive Director of Strategy	Member of the Board of Governors of Coleg Cambria
Mrs B Cuthel	Interim Director of Primary, Community and Mental Health Services 1 April - 31 August 2016	Governing Body Member of Nugent Care Family member is an employee of the Health Board
Mr A P Jones	Executive Director of Public Health 1 April - 31 July 2016	Trustee of Dolen Cymru Spouse is an employee of the Health Board
Mr C Wright	Director of Corporate Services	Partner is a Director of University of South Manchester NHS Foundation Trust
Dr P Higson OBE	Chair	Trustee of Cartrefi Cymru Cyf Member of Bangor University Council
Mrs M W Jones	Independent Member	Member of Snowdonia National Park Authority Member of S4C Authority Trustee of Canolfan Gerdd William Matthias Member of the Arts Council for Wales
Cllr B Feeley	Independent Member	County Councillor - Denbighshire County Council Lead Cabinet Member for Social Care and Older People Champion, Denbighshire County Council Chair of Cefndy Healthcare (run by Denbighshire County Council)
Ms J Dean	Independent Member and Trades Union Representative	Partner is a part-time employee of Bangor University
Prof J Rycroft-Malone	Independent Member and University Representative	Husband is an employee of the Health Board Chair of the NICE Implementation Strategy Group Professor of Health Services and Implementation Research - Bangor University Head of School for Healthcare Sciences and academic lead for impact - Bangor University Sits on a number of national and international strategy, funding and think tank groups Sits on the editorial Board of BioMed Central Implementation Science
Mr C Stradling	Independent Member	Deputy Chair of Democracy and Boundary Commission for Wales Chairs the audit and risk committee of the Democracy and Boundary Commission for Wales Member of Snowdonia National Park Authority
Mrs L Meadows	Independent Member	Employed at Bangor University until 30th September 2016
Mrs B Russell-Williams	Independent Member	Chief Executive Office of Gwynedd County Voluntary Council which may contract with the Health Board Husband is Chair of the Gwynedd Community Health Council
Mr J Cunliffe	Independent Member	Director of Abernet Limited Wife is an employee of the Health Board
Cllr C Carlisle	Independent Member	County Councillor - Conwy County Borough Council Carers Champion - Conwy County Borough Council Member of Conwy and Denbighshire Joint Adoption Panel Governor at Ysgol Bryn Elian
Cllr P Edwards	Associate Member and Stakeholder Reference Group Chair	Member of Conwy County Borough Council
Mrs N Stubbins	Associate Member and Representative of Directors of Social Services	Statutory Director of Social Services, Denbighshire County Council

No other Health Board members provided declarations of interest in related parties during the period.

Material transactions between the Health Board and related parties disclosed above during 2016-17 were as follows (unless already reported on page 49A):	Expenditure with related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Bangor University	1,334	1,523	137	934
Bron Derw Surgery, Bangor	1,090	0	0	0
Cardiff University	124	658	1	80
Cartrefi Cymru Cyf	91	0	0	0
Coleg Cambria	16	4	4	1
Dolen Cymru	41	0	0	0
Plas Menai Surgery, Llanfairfechan	902	0	0	0
Royal College of General Practitioners	10	0	10	0
Royal Liverpool and Broadgreen University Hospitals NHS Trust	5,790	3	301	1
University Hospital of South Manchester NHS Foundation Trust	696	0	14	0

25. Third Party assets

As at 31 March 2017, the Health Board held £241,836 cash at bank and in hand on behalf of third parties (31 March 2016 £234,552) comprising:

	2016-17	2015-16
	£	£
Monies held on behalf of patients	197,252	200,927
Deposits for staff residential accommodation	44,584	33,575
Other refundable deposits	0	50
	241,836	234,552

These balances have been excluded from the Cash and Cash Equivalents figure reported in Note 21 of these Accounts.

26. Finance leases

26.1 Finance leases obligations (as lessee)

The Health Board does not have any finance lease obligations as a lessee.

Amounts payable under finance leases:

Land	**31 March 2017 £000**	31 March 2016 £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

26.1 Finance leases obligations (as lessee) (continued)

Amounts payable under finance leases:

Buildings	**31 March 2017**	31 March 2016
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 2017**	31 March 2016
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

26.2 Finance leases obligations (as lessor)

The Local Health Board does not have any finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2017	31 March 2016
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

27. Private Finance Initiative contracts

27.1 PFI schemes off-Statement of Financial Position

The Health Board does not have any PFI scheme off-statement of financial position.

Commitments under off-SoFP PFI contracts	Off-SoFP PFI contracts 31 March 2017 £000	Off-SoFP PFI contracts 31 March 2016 £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

27.2 PFI schemes on-Statement of Financial Position

The Conwy & Denbigshire NHS Trust (a legacy organisation of the Health Board) contracted with Fresenius Medical Care to build and equip a Renal Diabetic Unit at Glan Clwyd Hospital under PFI contract arrangements.

Whilst Fresenius continue to have defined responsibilities for the maintenance of the Unit, including the provision of consumables, the Health Board is responsible for the delivery of all clinical care and other support costs. The Unit is treated as an asset of the Health Board and is included in Note 11. Property, Plant and Equipment.

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

	On SoFP PFI Capital element 31 March 2017 £000	On SoFP PFI Imputed interest 31 March 2017 £000	On SoFP PFI Service charges 31 March 2017 £000
Total payments due within one year	50	40	315
Total payments due between 1 and 5 years	218	143	1,383
Total payments due thereafter	901	222	6,207
Total future payments in relation to PFI contracts	1,169	405	7,905

	On SoFP PFI Capital element 31 March 2016 £000	On SoFP PFI Imputed interest 31 March 2016 £000	On SoFP PFI Service charges 31 March 2016 £000
Total payments due within one year	48	42	308
Total payments due between 1 and 5 years	211	151	1,355
Total payments due thereafter	957	255	6,680
Total future payments in relation to PFI contracts	1,216	448	8,343
Total present value of obligations for on-SoFP PFI contracts	7,183		

27.3 Charges to expenditure

	2016-17	2015-16
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	303	296
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	303	296

The LHB is committed to the following annual charges

	31 March 2017	31 March 2016
PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	303	296
Total	303	296

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

27.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	1	0
Number of PFI contracts which individually have a total commitment > £500m	1	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	1

PFI Contract	
Renal Diabetic Unit at Glan Clwyd Hospital	On SOFP

27.5 The LHB does not have any Public Private Partnerships

28. Pooled budgets

The Health Board has entered into three pooled budgets; one jointly with Flintshire County Council and Wrexham County Borough Council and two with Denbighshire County Council.

Under these arrangements, which are governed by the NHS (Wales) Act 2006, funds are pooled for the following activities:
- North East Wales Community Equipment Service
- Denbighshire Community Equipment Service
- Denbighshire Health and Social Care Support Workers Service

Management boards representing the partner organisations oversee the operational management of each of the pooled budgets.

A memorandum note to the accounts provides details of the joint income and expenditure of each of the pooled budget arrangements. The information within this memorandum note is subject to audit as part of the local authorities accounts.

Intermediate Care Fund

The Intermediate Care Fund (ICF) was established in 2014 to support initiatives which prevent unnecessary hospital admission, inappropriate admission to residential care, and delayed discharges from hospital. From 1 April 2017 this will be rebranded as the Integrated Care Fund to better reflect an expanded scope.

Regional Partnership Boards (RPBs) lead on the planning and use of the fund alongside health services, social services, housing and third independent sector to ensure delivery which maximises outcomes for the use of this resource. This delivery mechanism provides assurance that the objectives for the use of this fund are met as outlined in the Welsh Government guidance. The RPBs have further established Programme Boards to monitor measurable performance outcomes and financial returns using results based accountability (outcome) methodologies. The Health Board Area Directors has also established ICF/ISB Lead Groups at a local Health Economy level tied into this RPB structure, to ensure that the decisions, interventions and investments are delivered at a local level. These ISB's include representation from Health, Local Authority, Ambulance, Fire, Third Sector to name but a few.

The Health Board's expenditure for the year was £11.4m which was in line with allocated funding from Welsh Government.

29. 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 Health Board 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 Health Board 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 Health Board in undertaking its activities.

Currency risk
The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Health Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

Interest rate risk
Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk
The Health Board 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 Health Board is not, therefore, exposed to significant liquidity risks.

30. Movements in working capital

	2016-17	2015-16
	£000	£000
(Increase)/decrease in inventories	(824)	(675)
(Increase)/decrease in trade and other receivables - non - current	(20,447)	15,735
(Increase)/decrease in trade and other receivables - current	6,209	(12,100)
Increase/(decrease) in trade and other payables - non - current	(49)	(49)
Increase/(decrease) in trade and other payables - current	9,132	22,604
Total	(5,979)	25,515
Adjustment for accrual movements in fixed assets -creditors	(5,769)	4,945
Adjustment for accrual movements in fixed assets -debtors	0	0
Other adjustments	0	0
	(11,748)	30,460

31. Other cash flow adjustments

	2016-17	2015-16
	£000	£000
Depreciation	28,575	28,083
Amortisation	521	517
(Gains)/Loss on Disposal	(370)	(9)
Impairments and reversals	8,383	5,377
Release of PFI deferred credits	0	0
Donated assets received credited to revenue but non-cash	(3,750)	(1,384)
Government Grant assets received credited to revenue but non-cash	(1,639)	(385)
Non-cash movements in provisions	26,738	(1,343)
Total	58,458	30,856

32. Events after the Reporting Period

The Health Board does not consider that there are any additional disclosure requirements relating to events following the end of the reporting period.

33. Operating segments

Accounting standard IFRS 8 defines an operating segment as a component of an entity:

1. That engages in activities from which it may earn revenue and incur expenses (including internally);
2. Whose operating results are regularly reviewed by the Chief Operating Decision Maker to make decisions about resource allocation to the segment and assesses its performance;
3. For which discrete information is available.

The Health Board's Operational Management Structure reports on an Area-based and Site-based divisional approach with each of the individual functions being responsible for their own services and performance within devolved management structures. Five of the Health Board's functions are considered to represent operating segments under the accounting standard with their performance being reported at monthly Board meetings.

Information on divisions which do not exceed reporting thresholds has also been disclosed in the following table in order to provide additional details of the Health Board's activities during the year.

Prior year figures have been restated to reflect changes to budget responsibility and reporting during the year and to assist with year-on-year comparisons. Provider Income reported for the first time in 2016-17 relates to income streams which were previously included in specific Health Board divisions.

Area Teams - Operating Costs less Miscellaneous Income	**2016-17**	**2015-16 Restated**
	£'000	**£'000**
Area Teams	561,498	541,679
Commissioner Contracts	175,524	167,644
Total Area Teams	**737,022**	**709,323**
Secondary Care - Operating Costs less Miscellaneous Income		
Secondary Care - District Hospital Services	299,554	276,992
North Wales Hospital Services	92,292	90,363
Womens Services	32,954	32,209
Provider Income	(8,171)	0
Total Secondary Care	**416,629**	**399,564**
Mental Health & Learning Disabilities	**112,350**	**100,272**
Corporate Functions and Other Expenditure	**110,003**	**110,125**
Depreciation, Impairments and Finance Costs	**37,520**	**34,020**
Donated/Granted Capital Income	**(5,389)**	(1,769)
(Profit)/Loss on disposal of capital assets	**(370)**	**(9)**
Operating Costs sub-total	**1,407,765**	**1,351,526**
Revenue Resource Limit	**1,377,981**	**1,332,001**
Under/(over) spend against Revenue Resource Limit	**(29,784)**	**(19,525)**

34. Other Information

Special Measures

Welsh Government Minister for Heath and Social Services took the decision to place the Health Board into Special Measures on 8 June 2015. As part of Special Measures the Minister has appointed a team to provide support for improvement in the following key areas:

Governance and Leadership
Mental Health Services
Maternity Services at Ysbyty Glan Clwyd
GP and Primary Care Services

On 21 October 2015, Welsh Government confirmed that the Health Board would remain in Special Measures with progress and milestones being reviewed every six months. Welsh Government has issued a framework to support improvement in these long standing areas of concern and to assist with the development of a Integrated Medium Term Plan.

Continuing Healthcare Cost uncertainties

Liabilities for continuing healthcare costs continue to be a significant financial issue for the Health Board. The 31 July 2014 deadline for the submission of any claims for continuing healthcare costs dating back to 1 April 2003 resulted in a large increase in the number of claims registered last financial year.

Betsi Cadwaladr University LHB is responsible for post 1 April 2003 costs and the financial statements include the following amounts relating to those uncertain continuing healthcare costs:

Note 17 sets out the £2.115 million provision made for probable continuing care costs relating to 84 claims received;

Note 18.1 sets out the £3.254 million contingent liability for possible continuing care costs relating to 129 claims received;

However, in addition the LHB has a further 171 claims, which were received by the 31 July 2014 deadline, for which the assessment process remains incomplete. The assessment process is highly complex, involves multi-disciplinary teams and for those reasons can take many months. At this stage, the LHB does not have the information to make a judgement on the likely success or otherwise of these claims, however they may result in significant additional costs to the LHB, which cannot be quantified at this time.

Claims received after 31 July 2014 total 100 and at this stage the LHB does not have the information to make a judgement on the likely success or otherwise of these claims. However they may also result in significant additional costs to the LHB, which cannot be quantified at this time.

Powys Teaching Health Board is aiming to complete all claims received by 31 July 2014 by the end of June 2018.

Supreme Court Ruling

Health Boards in Wales (and equivalent bodies accross the UK) are currently waiting for the Supreme Court to deliver its ruling over the responsibility for the costs of nurses delivering care in care homes. The Health Board currently pays for what it considers to be appropriate "nursing care" costs in accordance with legislation, however, the Supreme Court case focuses on the local authorities claim that "nursing care" should be more widely defined than at present. We are not currently in a position to determine the likely outcome of this ruling nor any potential financial impact.

Memorandum Note - Note 28 - Pooled Budgets

North East Wales Community Equipment Service Memorandum Accounts 2016/17
The North East Wales Pool is hosted by Flintshire County Council and the formal partnership agreement commenced on 8 July 2009. A memorandum of account has been produced by Flintshire County Council, as shown below:

	2016/17	2015/16
Pooled Budget contributions	**£ 000**	**£ 000**
Flintshire County Council	(288)	(319)
Wrexham County Borough Council	(275)	(269)
Betsi Cadwaladr University Local Health Board	(397)	(393)
Other	(140)	(204)
Total Pooled Budget contributions for the year	**(1,100)**	**(1,185)**
Expenditure		
Equipment Purchases	539	626
Operating Expenditure	495	504
Non Operating Expenditure	0	0
Total Expenditure for the year	**1,034**	**1,130**
Net (Surplus)/Deficit on the Pooled Budget for the Year	**(66)**	**(55)**

Denbighshire Community Equipment Services Memorandum Accounts 2016/17
The Denbighshire Pool is hosted by Denbighshire County Council. The initial three year partnership agreement commenced on 1 April 2009 and ended on 31st March 2012. The second partnership agreement commenced on 1 April 2012 and ran until 31 March 2015. For 2015-16 onwards it was decided to revert to one year agreements. A memorandum of account has been produced by Denbighshire County Council which is shown below:

	2016/17	2015/16
Pooled budget contributions	**£ 000**	**£ 000**
Denbighshire County Council	(220)	(211)
Betsi Cadwaladr University Local Health Board	(138)	(130)
Other - HEC / CHC / Intermediate Care	(136)	(199)
Total Pooled Budget contributions for the year	**(494)**	**(540)**
Expenditure		
Equipment purchases	149	173
Operating Expenditure	352	338
Total Expenditure for the year	**501**	**511**
Net (Surplus)/Deficit on the Pooled Budget for the Year	**7**	**(29)**
Cumulative net (Surplus)/Deficit on the Pooled Budget	**(38)**	**(45)**

Memorandum Note - Note 28 - Pooled Budgets

Denbighshire Health and Social Care Support Workers Service - Memorandum Accounts 2016/17
The Denbighshire pool is hosted by Denbighshire County Council. The initial and current five year partnership agreement commenced on April 1 2013 and runs until 1 March 2018. A memorandum of account has been produced by Denbighshire County Council which is shown below:

	2016/17	2015/16
Pooled Budget contributions	**£ 000**	**£ 000**
Denbighshire County Council	(50)	(50)
Betsi Cadwaladr University Local Health Board	(92)	(50)
ICF Grant Allocation	(33)	(64)
ICF Grant Allocation - from slippage	0	(7)
Total Pooled Budget contributions for the year	**(175)**	**(171)**
Expenditure		
Employee Expenses	163	151
Other Operating Expenditure	10	19
Total Expenditure for the year	**173**	**170**
Net (Surplus)/Deficit on the Pooled Budget for the Year	**(2)**	**(1)**
Cumulative net (Surplus)/Deficit on the Pooled Budget	**(47)**	**(45)**

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

APPENDIX – Annual Governance Statement

1. Introduction

1.1 This Annual Governance Statement covers a period of both great challenge and also some improvement for the Betsi Cadwaladr University Health Board ('the Health Board'). The Health Board remains in Special Measures following the Minister's acceptance of the advice of Welsh Government officials, Wales Audit Office and Healthcare Inspectorate Wales in June 2015, and the then Deputy Minister's announcement in October 2015 that Special Measures would continue for a further two years. The National Assembly for Wales' Public Accounts Committee published a report in February 2016, stating that the Health Board had more work to do to make its governance and management arrangements fully fit for purpose.

1.2 In 2016/17 the Health Board breached its statutory duty to produce an Integrated Medium Term Plan (IMTP) and since March 2016 has been working to a deficit Interim Financial Plan, and has breached its statutory duty to achieve financial balance over the 3 year period ending 31.3.17.

1.3 By the end of this Annual Governance Statement's 2016/17 reporting period, the Health Board was beginning to demonstrate progress in addressing the expectations of the Special Measures Improvement Framework issued in January 2016 – making improvements in the areas of concern and working towards greater stability through appointments to key leadership roles. However, in my view it remains clear that there is yet more to be done.

1.4 In April 2016, the Well-being of Future Generations (Wales) Act 2015 and Social Services and Well-being (Wales) Act came into force, with major implications for the Health Board and the way in which it conducts its business. As part of the Health Board's implementation of the requirements of the Acts, the Board's strategic goals have been aligned to the 7 well-being goals, and these have been adopted as our organisation's well-being objectives. Four well-being assessments have been carried out via collaborative working on the Public Service Boards, and the emerging findings from these assessments will help to refine the well-being objectives. The development of well-being plans is underway, and will run in tandem with the development of the IMTP. This programme of work and the culture shift it demands will be a significant task which will bring its own set of challenges. Further information is available via http://www.wales.nhs.uk/sitesplus/documents/861/16_92%20External%20Partnership%20Governance.pdf , on page 2, item 17.44 via http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Health%20Board%2016.2.17%20Public.pdf and on page 1, item 17.62 via http://www.wales.nhs.uk/sitesplus/documents/861/Agenda_bundle%5B1%5D%20Board%2016.3.17.pdf

1.5 Further detail on the challenges faced by the Health Board during 2016/17 is included later in this Statement.

2. Scope of Responsibility

2.1 The Board is accountable, via the Chairman, to the Cabinet Secretary for Health, Well-being and Sport for its Governance, Risk Management and Internal Control. As Accountable Officer and Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out

in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales. Welsh Government issued confirmation of my Accountable Officer status in March 2016.

2.2 In discharging this responsibility I, together with the Board, am responsible for putting in place arrangements for the effective governance of the Health Board, facilitating the effective implementation of the functions of the Board and the management of risk.

3. Background Information

3.1 The Health Board had a revenue income of £1.3 billion for 2016/17 and a workforce of approximately 16,800 (14,400 whole time equivalents).

3.2 The Health Board is responsible for improving the health and wellbeing of the population of North Wales. This encompasses prevention of ill health as well as treating illness and providing excellent healthcare services.

3.3 The Health Board is responsible for the provision of primary, community and mental health as well as acute hospital services for a population of about 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham).

3.4 The Health Board operates three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases.

3.5 The Health Board also coordinates the work of 109 GP practices and NHS services provided by dentists, opticians and pharmacists in North Wales.

3.6 The clinical management of services is delivered by 3 Area Teams, a Mental Health and Learning Disabilities Division, and a single Secondary Care Division comprising 3 hospital site teams, all supported by the corporate departments.
3.7 Recruitment to senior Executive posts is now complete. All Board Member positions are now filled. Further information is available via
http://www.wales.nhs.uk/sitesplus/861/page/40834

4. Special Measures

4.1 The then Deputy Minister for Health issued a Special Measures Improvement Framework to the Health Board on 29.1.16, setting out expected improvement milestones up to November 2017, divided into three phases, in the following areas, which are still in the process of being further strengthened:

- Leadership
- Governance
- Strategic & service planning
- Engagement
- Mental health
- Maternity services
- Primary care.

4.2 The Framework also set out the criteria that the Health Board must meet in order to be considered for de-escalation (return to routine arrangements) in the future. In response to the Improvement Framework the Health Board established the Special Measures Improvement Framework Task & Finish Group to oversee improvements, and drafted an action and progress log. This log, which also incorporates Public Accounts Committee recommendations, describes the actions taken to date and future actions to achieve the expectations set out in the framework.

4.3 The Board receives monthly updates on Special Measures http://www.wales.nhs.uk/sitesplus/documents/861/16_70.1%20Special%20Measures%20improvement%20framework.pdf and, phase 1 (November 2015 to April 2016) http://www.wales.nhs.uk/sitesplus/documents/861/16_91%20Special%20Measures%20Improvement%20Framework%20End%20Phase%201%20Report%20v1.0.pdf and phase 2 (May 2016 to November 2016) http://www.wales.nhs.uk/sitesplus/documents/861/Agenda_bundle%20Health%20Board%2017.11.16%20v2.0%20REVISED%20reduced%20file%20size.pdf are complete, with the end of phase reports submitted to the Board and Welsh Government. The Task & Finish Group held a 'Deep Dive' day, which involved requiring Executives and Senior Managers to submit additional information on progress against Special Measures expectations, and to attend to give a presentation and to be held to account as appropriate. The Task & Finish Group scrutinised the evidence presented in detail, and this fed into the End of Phase 2 report. Over the past year, the Board has also undertaken a comprehensive Board Development Programme as part of Special Measures (see section 12 later in this document).

4.4 I report on progress against the Improvement Framework expectations at each monthly Board meeting. The Health Board is committed to achieving the necessary transformation.

4.5 To assist me in my role as Accountable Officer, and to contribute to improvements under Special Measures, a programme of work to strengthen governance arrangements is ongoing. For example, a fundamental review of Executive Team (ET) and Executive Management Group (EMG) terms of reference took place during the year to strengthen the overall governance processes and structures.
Further information on strengthening governance is available via *http://www.wales.nhs.uk/sitesplus/documents/861/16_40.2%20Strengthening%20Governance.pdf*

4.6 Actions relating to phase 3 (December 2016 to November 2017) are being driven forward and in addition, completed actions from previous phases continue to be monitored in order to ensure sustainable improvement. The outcome of the Third HIW/WAO Joint Review was awaited at the time of writing, however I received correspondence from Welsh Government on 12.4.17, noting that progress had been made in respect of governance arrangements, Board effectiveness, staff & public engagement, maternity services and GP out of hours services. It was also stated that further work is required on the challenges in Mental Health, concerns handling & lessons learnt, service planning and developing stronger working relationships with key partners.

5. Financial Position

5.1 The Board approved a 2016/17 budget which included a deficit of £30m as a planning assumption on 30.3.16. During the year, the Health Board overspent against its Revenue Resource Limit by £29.8m, resulting in a cumulative overspend of £75.9m over the three-year statutory breakeven period ending 31.3.17.

5.2 As a result of Welsh Government Special Measures, the Health Board received additional financial support of £4.8m to support the process of addressing the underlying causes of Special Measures and the financial implications of the Improvement Framework.

5.3 The issues facing the Health Board have built over the long term; and the necessary improvement will likewise take time. Implementing a disciplined approach to planning and delivering sustained improvements in the longer term will be important, while remaining focused on patient experience through delivering safe services of a high quality.

5.4 The continuation of the Programme Management Office (PMO) approach (introduced in late 2014/15 to support service change schemes designed to improve productivity and make savings where appropriate, whilst ensuring good quality patient care) supported the Board to deliver savings of £33.5m in 2016/17. Of these savings, £19.178m were recurring and £14.364m were non-recurring.

5.5 This PMO approach will be developed further during 2017/18 to provide a disciplined approach to change management, supported by new software. The recruitment process for a substantive Turnaround Director will be concluded and this Director will be responsible for ensuring the effective development and implementation of the Health Board's transformation programme, managing the PMO and service improvement resources.

5.6 In March 2017, the Health Board approved an Interim Financial Plan for 2017/18 which identified a deficit of £26m, after delivering savings of £35.4m. Addressing the structural deficit will require a focus on stabilising the financial position, and delivering an improvement trajectory over a longer period as part of developing the Annual Operating Plan and ultimately an Integrated Medium Term Plan.

6. Integrated Medium Term Plan (IMTP)

6.1 In breach of its statutory duty, the Health Board does not as yet have an approved IMTP, but is working to develop one for approval by Welsh Government by March 2018. For 2016/17, an Annual Operational Plan (AOP) has been agreed, and this approach has been endorsed by Welsh Government. The AOP sets out the 11 key deliverables for improvement from the national priorities of staying healthy, timely care, individual care, safe care, effective care, dignified care and staff & resources. The aim was to ensure that the Health Board could deliver safe and sustainable services to the population of North Wales and address and improve health and healthcare services.

6.2 In respect of a general assessment of progress against the Annual Operating Plan, although a challenging year, positive progress has however been made in relation to the requirements of the Special Measures Improvement Framework, focusing on mental health services, maternity, engagement with communities and staff and Board responsibilities for governance. Clear improvements have been made in each of these areas whilst managing our resources in line with the budget set for the year. We have responded positively to challenges in primary care, implementing new models such as healthy Prestatyn whilst supporting existing GP Practices through new clinical roles and enhanced community teams. Within planned care we are on track to deliver the waiting times targets agreed with Welsh Government with notable success in delivering an 8 week maximum wait for diagnostic tests. We have made some progress in unscheduled care, but this remains an area of challenge for the Board and further improvement is required against key performance and quality measures.

6.3 Alongside the Annual Operating Plan there is a clear timeline for the development of the Health Board's overall strategy which will provide the strategic context for the IMTP. As part of the development of this overall strategic direction and plan, the Health Board has developed three Strategic Framework documents to meet the requirements of Phase 2 of Special Measures. These cover Primary care and Community Services, Mental Health Services and Maternity, Neonatal and Paediatric services and were considered and approved by the Health Board at its meeting in November 2016. An extensive programme of engagement with a wide range of stakeholders has taken place to underpin the development of the strategy and IMTP. Progress on the Plan and Strategy is monitored by the Strategy, Partnerships and Population Health Committee and Board on a regular basis. Further detail is available via *http://www.wales.nhs.uk/sitesplus/documents/861/16_90%20Annual%20Operating%20plan%20key%20deliverables.pdf*

and item 16/209 via
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda_bundle%20Health%20Board%2017.11.16%20v2.0%20REVISED%20reduced%20file%20size.pdf
and item SPPH16/208
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20SPPH%2024.11.16%20Public%20V1.0.pdf

7. Emergency Preparedness

The Health Board is categorised as a Category 1 responder within the Civil Contingencies Act (2004) and as result required to have certain arrangements in place. The Health Board has in place: -

- a Major Emergency Plan and underpinning site specific or incident specific plans which describe the response of the organisation to an emergency defined as a major incident.
- a governance structure which provides oversight and coordination of our emergency preparedness arrangements. This structure links into the non statutory Local Resilience Forum which provides the coordinated planning and preparedness across all agencies involved in civil protection activity.
- a programme of exercises and training to support our staff who have specified roles within our major emergency arrangements which delivers command and control competencies in line with National Occupational Standards, bespoke training relating to pre-hospital medical response and generic induction awareness.
- a major programme of work focused on developing a Business Continuity Management System for critical services, to enable recovery within tolerable timescales following a business disruption.

Further information is available here:
http://howis.wales.nhs.uk/sitesplus/861/page/44943

8. Partnership Working

8.1 The Health Board has ensured during the course of the year that it works closely with partner organisations such as local authorities and the voluntary sector, to discuss and address health inequalities, promote community engagement and exploit joint working opportunities. The partner organisations include:

- Welsh Ambulance Services Trust;
- Public Health Wales;
- BCU Community Health Council;
- Local Authorities (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham);
- Neighbouring NHS bodies in England and Wales;
- The Community Voluntary Councils;
- Public Service Boards / Regional Leadership Boards;
- Mid Wales Healthcare Collaborative

The Health Board is currently reviewing emerging partnership governance risks, with a view to incorporating the detail into the Corporate Risk & Assurance Framework.

9. The Role of the Board

9.1 The role of the Board is to:

- Formulate strategy for the organisation within the overall policies and priorities of the Welsh Government, responsive to the health needs of the local population;

- Ensure accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that the systems of control are robust and reliable;
- Shape a positive culture for the Board and the organisation;
- Maintain high standards of corporate governance;
- Ensure effective financial stewardship.

9.2 The Board functions as a corporate decision making body. Executive Directors and Independent Members are full and equal members sharing corporate responsibility for all decisions of the Board. The Board is supported by the Board Secretary who acts as principal advisor on all aspects of governance within the Health Board.

9.3 The Health Board's stated purpose, vision, strategic goals, well-being objectives and values are shown below. These are reflected within the planning framework and work is ongoing to embed them across the organisation at all levels:-

Our Purpose:

- To improve health and provide excellent care.

Our Vision

- We will improve the health of the population, with a particular focus upon the most vulnerable in our society.
- We will do this by developing an integrated health service, which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.
- We will develop our workforce so that it has the right skills and operates in a research-rich, learning culture.

Our Strategic Goals and Well-being Objectives

- Improve health and wellbeing for all and reduce health inequalities.
- Work in partnership to design and deliver more care closer to home.
- Improve the safety and outcomes of care to match the NHS' best.
- Respect individuals and maintain dignity in care.
- Listen to and learn from the experiences of individuals.
- Support, train and develop our staff to excel.
- Use resources wisely, transforming services through innovation and research.

9.4 Our purpose, vision and strategic goals set out the long terms aims of the Board. We have further work to do to translate these into specific objectives for improvement in population health and health services which we will include in our plans going forward.

Our Values:

- Put citizens first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate openly and honestly.

9.5 Our values guide the way the Board conducts its business and the way in which our staff engage with those who use our services and each other to deliver our strategic goals.

10. Board Composition

10.1 The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, which are reflected in its Standing

Orders:
http://www.wales.nhs.uk/sitesplus/documents/861/standing%20orders%20v14.00%20approved%20by%20audit%20committee%20july%2015%20and%20board%20aug%2015%20%20excl%20schedule%202.1%20and%204.1%20no%20trac.pdf

10.2 The Board meets on a monthly basis and consists of the Chair, ten Independent Members (IMs), four Associate Members (the Director of Mental Health & Learning Disabilities became an Associate Member in June 2016), the Chief Executive and eight Executive Directors. The Board Secretary and Director of Corporate Services are in attendance.

10.3 During the reporting period of this Annual Governance Statement, the Board has achieved greater stability following a number of key appointments including a substantive Executive Medical Director, Executive Director of Nursing & Midwifery and Executive Director of Therapies & Health Science. Board membership is documented at Appendix 1, together with related information including Board Members' Champion roles.

10.4 Public appointments to the Board have also been made in-year, as detailed in Appendix 1.

11. Board Effectiveness and Standards

11.1 In order to improve its effectiveness and meet aspirations for openness and accountability, the Board aims to be transparent about the decisions it makes and the way in which it operates. The majority of Board and Committee meetings are routinely held in public.

11.2 All Board Members have a responsibility to abide by the Nolan principles of public life and Executive Directors must adhere to the NHS Code of Conduct (Disciplinary Rules and Standards of Behaviour).

11.3 Board Members are required to declare any interests at the beginning of Board meetings and complete a return annually. Board Members are also required to declare gifts and hospitality received or offered, in line with the set guidance. Declarations are recorded on the corporate register, which is available for public inspection via the Office of the Board Secretary. In November 2016, a new Standards of Business Conduct Policy and electronic declaration system were introduced. https://bcu-ghi.cymru.nhs.uk/

11.4 In the interests of good governance, scrutiny and challenge, all Health Board Committees are chaired by an Independent Member.

11.5 The Board's annual cycle of business/ work plan was reviewed and updated in February 2017
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Health%20Board%2016.2.17%20Public.pdf

11.6 As stated earlier in section 4, I have received correspondence from Welsh Government, and this noted that progress has been made in respect of Board effectiveness. The Wales Audit Office Structured Assessment 2016 also noted that Board effectiveness had improved during the past year, with the Board beginning to behave like a team, with self-reflection, learning and improvement actions taking place:
https://www.wao.gov.uk/publication/betsi-cadwaladr-university-health-board-structured-assessment-2016

12. Board Development

12.1 The Health Board has committed a minimum of a day per month over the last year to Board Development, as part of a special measures programme led by Mrs Ann Lloyd. A bi-monthly half day was also devoted to Board briefings to update members on key strategic, service and mandatory training issues. Topics covered as part of the Board Development Programme included Board effectiveness and maturity, strategic planning, service sustainability, organisational culture, risk management, service issues and workforce matters.

12.2 Building upon this, an external consultant has been commissioned to provide a 12 month Board Development programme. This commenced in March 2017 and will cover topics such as transformational change, partnership working and strategic & service planning.

13. Board and Committee Arrangements

13.1 The Board's committee structure comprises seven committees and two sub-committees, namely the

- Audit Committee
- Remuneration & Terms of Service Committee
- Mental Health Act Committee with its Mental Health Act Power of Discharge Sub-Committee
- Finance & Performance (F&P) Committee
- Quality, Safety & Experience (QSE) Committee
- Strategy, Partnerships and Population Health (SPPH) Committee.
- Charitable Funds Committee, with its Charitable Funds Advisory Group Sub-Committee.

13.2 These committees and sub committees were in addition to the Health Board's three Advisory Groups and three Joint Committees, as illustrated in the structure diagram in Figure 1 below.

13.3 The Health Board has established a Committee Business Management Group (CBMG) to oversee effective communication between its Committees. This avoids duplication and ensures that all appropriate business is managed effectively and efficiently through the governance framework, meeting statutory requirements and taking account of emerging best practice.

13.4 Health & Safety (H&S) reporting has been strengthened in year, with the maturing Strategic H&S Committee now reporting to the Quality, Safety & Experience Committee. See item QS16.123.1 via:
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20QSE%2013.9.16%20V1.0%20PUBLIC.pdf

13.5 The Wales Audit Office (WAO) Structured Assessment found that committee effectiveness improved during 2016, with evidence of better scrutiny and challenge. As the new committee structure introduced in March 2016 has matured, WAO noted improved flows and assurances to the Board from its committees and commented that this, along with revised standards, etiquette, assurance reports, the Board Development work, new Board members, and improved behaviours, was beginning to be reflected in the quality of Board and committee scrutiny.

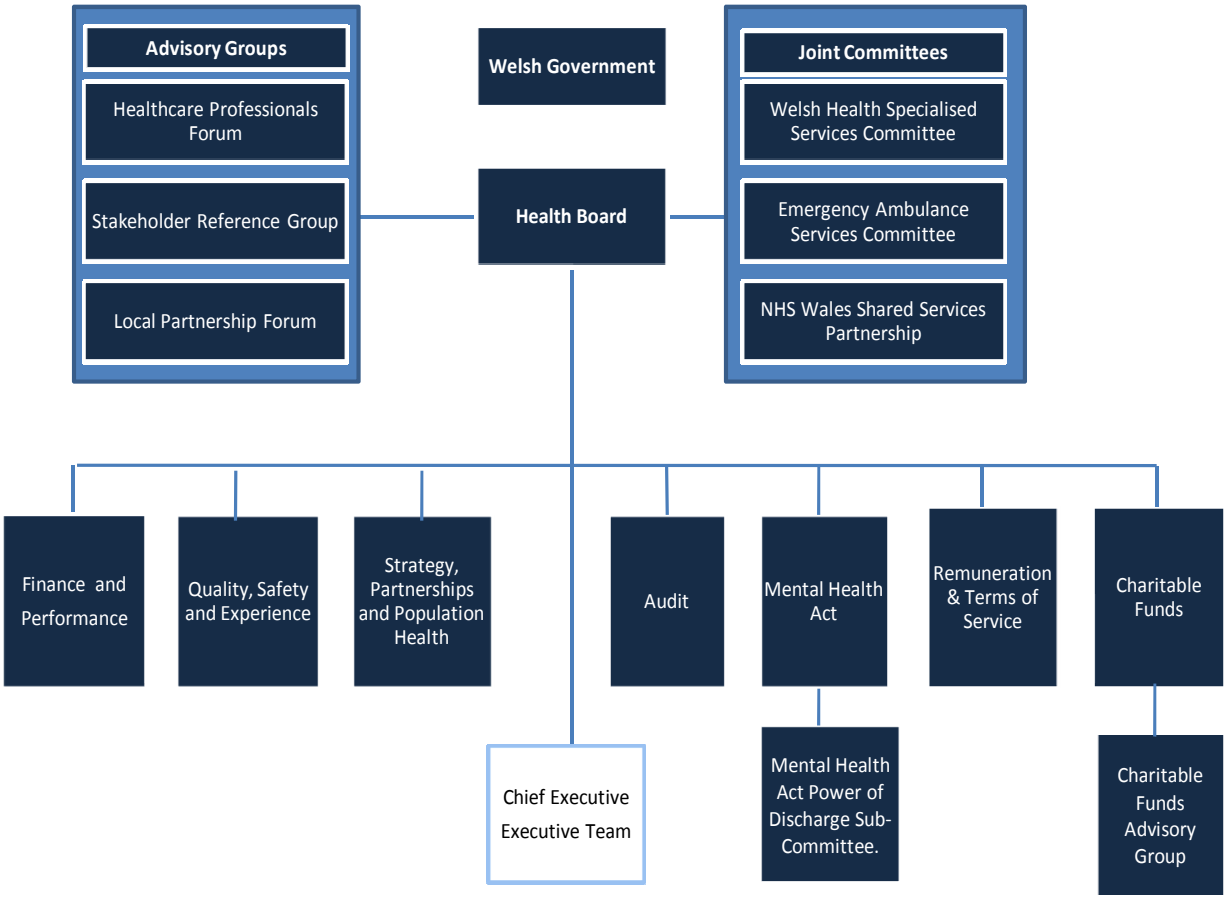
13.6 The Health Board has three Advisory Groups to assist it in performing its statutory duty to take account of representations from the community it serves and other key stakeholders. The three groups are: the Stakeholder Reference Group (SRG), Healthcare Professionals Forum

(HPF) and the Local Partnership Forum (LPF). Two of the Advisory Group Chairs attend and contribute to committee meetings as follows:

- Quality, Safety & Experience Committee – HPF Chair
- Strategy, Partnerships and Population Health Committee – SRG Chair.

13.7 The Health Board's Committee and Advisory Group structure is illustrated below in Figure1.

Fig.1 The Health Board's Committee and Advisory Group Structure



13.8 Committee / Sub-Committee Membership is detailed in Appendix 1.
Health Board members' attendance at Board meetings is detailed in Appendix 2.
Board and Committee meetings held throughout the year are detailed below.

13.9 Meetings of the Health Board and Committees held in 2016/17:

Meeting	Date													
Health Board	21.4.16	9.5.16	23.6.16	21.7.16	18.8.16	22.9.16	20.10.16	17.11.16	15.12.16	19.1.17	16.2.17	16.3.17	6.9.16 AGM only	
Quality, Safety & Experience (QSE) Committee	12.4.16	10.5.16	14.6.16 *	12.7.16	9.8.16	13.9.16	11.10.16	8.11.16	6.12.16	101.17	7.2.17	7.3.17		
Finance & Performance (F&P) Committee	26.4.16	24.5.16	5.7.16	26.7.16	23.8.16	27.9.16	25.10.16	22.11.16	20.12.16	24.1.17	21.2.17	21.3.17		
Strategy, Partnerships & Population Health (SPPH) Committee	26.5.16	28.7.16	10.10.16	24.11.16	26.1.17	30.3.17								
Remuneration and Terms of Service Committee	16.5.16	18.7.16	17.10.16	16.1.17	23.3.17									
Mental Health Act Committee	27.5.16	22.7.16	4.11.16	3.2.17										
Charitable Funds Committee	24.6.16	12.9.16	12.12.16	13.3.17										
Audit Committee **	31.5.16	14.7.16	15.9.16	8.12.16	9.3.17									

* The latter part of the meeting was not quorate – no decisions were taken whilst inquorate

** The Audit Committee met in private from April – September 2016. In line with Welsh Health Circular (WHC/2016/033) the committee met in public session from 8.12.16

13.10 Each Board Committee produces an annual report. A new, more detailed format and an earlier submission timeline for these reports was agreed in 2016/17. The revised arrangements for the cycle of committee annual reporting originated from a request by the Chair of the Audit Committee for reports to be submitted to the Board earlier in the year. It was subsequently agreed that in future, the Audit Committee would receive all the committee annual reports in advance (May meeting) and would then submit an overarching assurance report to the Board. Further information on the new arrangements is available from item AC16/92 via http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle2.pdf
The 2015/16 annual reports were received by the Board in September 2016 – see item 16/174 via http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20Bundle%20Health%20Board%2022.9.16%20Public%20V1.0.pdf . They detailed the business, activities and main issues and risks dealt with by the Committees or escalated to the Board during the previous year.

13.11 Committee Chairs provide written assurance reports to the Board after each committee meeting, highlighting issues of significance and any key risks. These Chairs' reports are published with Health Board papers.

13.12 The significant matters considered by the Committees, and examples of actions taken during 2016/17 were as follows. These key issues feature as highlights in Committee Chairs' Assurance Reports, an example of which, item 17/60.2, can be accessed via http://www.wales.nhs.uk/sitesplus/documents/861/Agenda_bundle%5B1%5D%20Board%2016.3.17.pdf

13.13 **Audit Committee**

- Financial Conformance Reports
- Internal Audit Progress Reports/Charter and Annual Plan/Report and Options
- Wales Audit Office update and Performance reports including Structured Assessment and Annual Audit Report.
- Updates against internal and external audit recommendations (tracker tool)
- Clinical audit progress reports/plan.
- Post payment verification reports.
- Counter fraud progress reports/annual plan/annual report.
- Various national reports and publications for Information.
- Review of Committee terms of reference and cycle of business; self-assessment and annual report.
- Corporate Risk and Assurance framework review including reviewing Corporate Risk Register and Risk Management Strategy review.
- Adopting of Standards of Business Conduct Policy and Annual Review of Declarations of Interest.
- Annual Governance Statement/Annual Quality Statement/ Annual Accounts/ Accountability Reports.
- Standing Orders/Standing Financial Instructions, financial statements and Annual Report review and amendments.
- Review Performance Management Strategy and Operational Framework.
- Reviewed and proposed new arrangements for Committee annual reporting.

Examples of how the Committee has acted upon significant issues that have arisen include:

- In order to address the issue of better assurance required for the Board, the Committee reviewed the Board Assurance Framework and is developing an Assurance Map on behalf of the Board.

- In response to previous concerns regarding the need for timely implementation of audit report recommendations, the Committee has employed more rigorous review of the Audit Tracker Tool. The Committee has also held Executives to account by requiring them to attend meetings to present evidence of progress on key issues, for assurance purposes.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/51690

13.14 **Charitable Funds Committee**

- Investment Manager's Report
- Charitable Funds Annual Accounts & Annual Report and Wales Audit Office ISA 260 Report and opinion
- Fundraising and finance strategy and reports
- Charitable funds budget
- Minutes of Charitable Funds Advisory Group
- Presentations and requests for expenditure approvals
- Briefings and governance papers.

An example of how the Committee has acted upon significant issues that have arisen include:
- The Committee discussed concerns raised regarding governance arrangements relating to an external charitable fundraising campaign which had received financial support from the Health Board. As a result, Wales Audit Office was requested to carry out a review, the findings of which were used to learn lessons. This resulted in the Committee agreeing a Collaborative Working Protocol to strengthen future governance and decision-making.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/44875

13.15 **Mental Health Act Committee (MHAC)**

- Regular reporting and scrutiny of Mental Health Act and Mental Health Measure performance data including a fundamental review of the data and format of presentation of the reports.
- Oversight and detailed discussion of the reports prepared in respect of the Hospital Manager's Update and provision of support provided to Associate Hospital Managers' to assist them in carrying out their role.
- Deprivation of Liberty Safeguards (DoLS) reports including Authorisation Applications and risks in meeting legislative timeframe
- Children & Adolescent Mental Health Services (CAMHS) reports including performance updates, challenges and service developments
- Update reports received on the progress of the Street Triage project, including the Section 136 Progress Report
- Oversight on the arrangements and service developments for the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales, including additions and removals made to the register
- Review of the Independent Mental Health Advocacy (IMHA) Monitoring Report
- Updates on Healthcare Inspectorate Wales visits/report
- Updates on training issues (including the arrangement of training workshop for members of the Committee and its Sub-Committee)
- Minutes of the previous meetings and summary action plan, including review of issues of significance to inform the Chair's report

- MHAC terms of reference and Power of Discharge Sub-Committee's terms of reference review including a review of the frequency and timing of meetings.
- MHAC Annual Report 2015/16
- MHAC cycle of business and work plan 2016/17.
- Oversight of the work of the Power of Discharge Sub-Committee.

Examples of how the Committee has acted upon significant issues that have arisen include:

- In respect of Section 136 relating to under 18s, the Committee has continued to express concern about the increasing numbers of under 18s being detained under a Section 136 order. The Committee continues to monitor the position and actions being undertaken to address the situation and has commended the steps being taken by the Director of Mental Health and Learning Disabilities in his ongoing dialogue with North Wales Police.

- In respect of Deprivation of Liberty Safeguards (DoLS) the Committee has reviewed DoLS data for the last two financial years, the Independent Mental Capacity Advocate (IMCA) role and supporting data, Best Interest Assessor appointments and training, risk review and next steps in terms of the Service realignment. The safeguarding risk register has been reviewed within the Safeguarding Group chaired by the Executive Nurse and the risk relating to DoLS has been discussed at length. The risk level remains unchanged at this moment in time pending completion of the training and full recruitment of the Best Interest Assessors. This has been fully discussed at the Quality and Safety Group.

- In respect of Healthcare Inspectorate Wales (HIW) Reports, HIW issued their Annual Report for 2015/16 in August 2016. Within it there were references to reviews undertaken which specifically relate to the Mental Health Act. Whilst monitoring of the report and the actions has been addressed by the Quality, Safety and Experience Committee, it was recognised that the specific elements relating to the Mental Health Act should have been presented to MHAC and therefore a change to future reporting arrangements was agreed.

- In respect of performance monitoring, the Mental Health & Learning Disabilities Division continues to improve the Mental Health Act/Mental Capacity Act and Mental Health Measure performance report and the Committee has commended the work undertaken to date.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/48736

13.16 **Finance & Performance Committee**

- Financial Management eg Monthly Finance reports; Quarterly External Contracts update reports; Continuing Healthcare Fees 2016/17;
- Performance Management and accountability eg Monthly Integrated Quality and Performance reports; Performance Management Strategy 2016 update;
- Capital Expenditure and Working Capital eg Monthly Capital Programme reports; Discretionary Capital Programme 2016/17;
- Informatics and Information Governance eg Informatics Operational Plan; Welsh Patient Administrative System (WPAS) implementation update.
- Workforce e.g staff seasonal flu vaccination summary report 2015/16; Workforce information system update report;
- Governance eg Committee annual report; Shared Services Partnership Committee assurance reports; review of corporate risks assigned to the Committee.

Examples of how the Committee has acted upon significant issues that have arisen include:

- The Committee discussed concerns regarding the financial position, which were picked up by the Executive Team, as a result of which efforts were redoubled to make savings and I required project initiation documents for all savings schemes. The outcome of this was that the planned deficit of £30m was achieved, with a £29.8m overspend.
- The Committee discussed referral to treatment time (RTT) performance and waiting times, particularly in relation to Orthopaedics. Subsequent to this, an Orthopaedics Plan has been drafted.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/77166

13.17 **Quality, Safety & Experience Committee**

- Regular reports from the Director of Quality Assurance (incorporating Healthcare Inspectorate Wales and other external reports, Trusted to Care, volunteering, quality improvement priorities, matters raised at the Quality Assurance Executive, safety dashboards)
- Health & Care Standards monitoring reports
- Endorsement of Service User Experience Strategy 2016-19
- Listening and Learning reports including a specific patient story
- Progress report into standards for accessible communication
- Putting Things Right annual report
- Public Sector Ombudsman for Wales annual letter and reports
- Coroner reports
- Welsh Risk Pool report into concerns and claims management
- Regular infection prevention and control reports including report of further review by Prof B Duerden
- Monthly integrated quality & performance reports providing key performance data and exception reports across all relevant domains
- Specific “deep dive” presentations
- Approval of cycle of business and review of terms of reference
- Review of the Health Board’s university status
- Health and safety annual report and mid year update
- Consideration of relevant internal audit reports (eg; Quality Improvement Strategy, GP Out of Hours)
- Endorsement of new and/or updated policies or procedures eg; Being Open Policy,
- Safeguarding reports (including specific report on adult safeguarding)
- Mental health assurance and service development reports including Tawel Fan mortality review (in committee)
- Quarterly reports on continuing health care
- Annual Quality Statement
- Assurance reports into monitoring of women’s services
- Review of corporate risks allocated to the Committee
- Annual reports eg Health Protection Team

Examples of how the Committee has acted upon significant issues that have arisen include:

- It was determined by the Committee that the pace of reduction in the prevalence of C.Diff and MRSA/MSSA infections was inadequate and the topic was therefore re-escalated back to monthly reporting to drive improvement. Additional work was carried out on antimicrobial stewardship, learning from root cause analysis, and the “Asepsis – Act Now” campaign to rapidly improve clinical practice.

- Concerns were raised about the instability of the nursing home market place in North Wales and the reduction in nursing care beds which impacted negatively on delayed transfers of care performance. The matter was passed on to the Executive Team, who identified an Executive Sponsor, tasked senior leads with a range of actions relating to liaison with providers, and I offered to meet with key individuals from the nursing home sector in order to seek solutions to the pressures.
- The Committee was concerned by risks highlighted by a Safeguarding report, resulting in revision of the corporate risk register and the establishment of new interim management arrangements for the Safeguarding team.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/77166

13.18 **Strategy, Partnerships and Population Health Committee**

- Developing whole systems strategy for health and healthcare in North Wales
- Volunteer Strategy
- Draft strategies eg Staff Engagement Strategy
- Welsh Language Strategic Plan
- Living Healthier : Staying Well (including report on survey findings; strategy development;
- Workforce themes from Annual Operational Plan
- Wylfa B Development
- Planning Principles 2017-18
- Provision of healthcare to HMP Berwyn
- Strategic Frameworks (primary/community, maternity/paediatrics/neonatal and mental health)
- Seasonal Plan 2016-17
- Business Continuity Policy
- Well-Being of Future Generations (Wales) Act 2015
- North Wales Population Assessment
- Annual Reports eg Carer's Measure
- Monitoring Reports eg Welsh Language (including new Standards)
- Partnership Working eg Well North Wales
- Review of allocated corporate risks

Examples of how the Committee has acted upon significant issues that have arisen include:

- The reporting mechanisms from local Public Service Boards (PSBs), including the timeliness of reporting, were discussed and as a result the partnership governance arrangements of PSBs and other Health Boards in Wales were reviewed, for comparison and lessons learned purposes.

- Concerns were discussed regarding the recruitment of prison officers for safe staffing of the designated rehabilitation prison HMP Berwyn and also the potential impact on health services. As a result, individual Executives and the Board met with the Prison Governor to secure assurances on the issues raised.
- The Committee discussed the potential impacts on health services from the Wylfa B development. As a result, work took place involving GPs, to explore primary care model solutions, and I also sought a meeting with Horizon representatives to seek assurances.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/77166

13.19 **Remuneration & Terms of Service Committee**

- Consideration of Voluntary Early Release Scheme applications
- Evaluation of very senior manager and Director posts outside of JESP range – in year this had included the interim Executive Director of Therapies & Health Sciences and Director of Turnaround; and substantive arrangements for the Executive Medical Director and Executive Director of Nursing & Midwifery;
- Approval of Committee Annual Report for 2015-16
- Approval of Remuneration Report 2015-16
- Employment position of former Chief Executive
- Job Planning for Medical Staff
- Waiting List Initiatives
- Relocation expense allowances of overseas recruitment
- Internal locum hourly remuneration rates
- NHS Contract and leavers including data on displaced staff
- Pay Flexibility in terms of Significant Additional Responsibilities for Executives and Directors.

Examples of how the Committee has acted upon significant issues that have arisen include:

- Committee members queried the extent to which the Committee had fulfilled its obligation to comment specifically upon objectives for Executive Directors and other Very Senior Managers. It was felt that this had not been fully achieved over the past year and therefore this was self-assessed as an 'amber' rating and in order to improve this position it was agreed to introduce an Objectives Assurance Report for the Committee.
- In early 2016, the Committee considered the fact that two key Executive posts – the Medical Director and Director of Nursing & Midwifery – had become vacant. Matters of principle, fairness, equality and allocation of duties were resolved in order to secure satisfactory interim post holders, thus providing stability to the Board pending substantive appointments.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/77170

13.20 Advisory Groups:

Items of business considered by the Board's Advisory Groups are detailed below. The Chair of each Group provides an Assurance Report to the Board after each meeting to highlight significant issues or advice, an example of which can be found here 16/115.3:
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20_public_revised.pdf

13.20.1 **Stakeholder Reference Group**

- Primary Care Strategy; Strategic Equality Plans; Deloittes Report 2013/4
- BCUHB Engagement Strategy; BCUHB Mental Health Strategy; BCUHB Integrated Quality & Performance
- BCUHB Financial Position; HMP Berwyn; Medicines Management; BCU Special Measures Improvement Plan
- BCUHB Whole Systems Strategy; Public Health Wales – Well North Wales; BCUHB Welsh Language Standards
- Welsh Ambulance Trust Annual Report (WAST); BCUHB Communications & Engagement; Bevan Advocates
- BCUHB Living Healthier, Staying Well – Strategy Development Update
- BCUHB Mid-Year Finance Position; Unscheduled Care/Winter Plan; Delayed Transfers of Care

- BCUHB Primary & Communities Services Development; BCUHB Corporate Planning including Operational Plan 2017/18 & Living Healthier, Staying Well; Adverse Childhood Experiences (ACEs) in Wales
- Corporate Planning including Engagement; BCUHB Mental Health Strategy; HMP Berwyn; Public Health Wales Population Assessment

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/51648

13.20.2 **Local Partnership Forum**

- Workshops
    - Special Measures
    - Management structure
    - Corporate Planning including Annual Operating Plan, Living Healthier , Staying Well
    - Job Evaluation
    - Finance
    - Draft Annual Quality Statement 2015/16 and 2016/17
    - Primary Care Strategy
    - Mental Health Strategy
    - Workforce Engagement Strategy
    - Recruitment Attraction Strategy
    - Private Patients Policy
    - Standards of Business Conduct Framework Policy
    - North Wales prison healthcare project update.

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/52988

13.20.3 **Healthcare Professionals Forum**

- The role of HPF and its members
- How the HPF could enable contribution to the Health Board's thinking at an earlier stage
- Escalation of HPF concerns
- Updates on the Annual Operating Plan (AOP) and Whole Systems Strategy
- Primary Care Strategy
- North Wales Recruitment and Retention Strategy
- Well North Wales
- Corporate Planning
- Infection Prevention and Control
- Prevention of Inpatient and Community Falls
- Development of Quality Dashboards
- Research & Development

Minutes are available via:
http://www.wales.nhs.uk/sitesplus/861/page/51649

13.21 **Joint Committees**

The Board also receives and considers regular summaries, copies of minutes or reports from the Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services

Committee (EASC) and the NHS Wales Shared Services (NWSSP) Partnership Committee. These can be accessed via:
http://www.wales.nhs.uk/sitesplus/861/page/75045

14. The Purpose of the System of Internal Control

14.1 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.

14.2 The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Health Board's strategic goals and corporate objectives. This includes evaluating the likelihood of those risks being realised and the impact should they be realised, and the arrangements in place to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

15. Capacity to Handle Risk

15.1 The Health Board has a challenging risk profile due to the diversity of services provided, ranging from primary and community services through to acute hospital wards as well as mental health services and a medium secure unit. In addition, the Health Board has a wide geographical spread, cultural diversity and significant provision of services from England. It also has to be capable of dealing with peaks in demand as a result of North Wales being a holiday destination of choice for many.

15.2 The Health Board has in place a structure to identify, assess and control its risks. I have delegated responsibility for ensuring that the Health Board is provided with competent advice and support in the development of effective systems and arrangements to help facilitate the Board's approach to risk management and strategy to the Director of Corporate Services. The Board Secretary has specific delegated authority for the Board Assurance Framework and Corporate Risk Register which for reporting purposes and in the absence of an Integrated Medium Term Plan have been amalgamated this year and described in more detail below.

16. Corporate Risk and Assurance Framework

16.1 During Summer 2016 work was undertaken to examine the various levels of reporting within the Risk Register database (Datix), with the Executive Team revising the structure relating to the different levels at which risks across the organisation will be managed. This replaced the former three tiers of Corporate, Strategic and Operational. The organisation is now working to a 5 tier approach, details of which are included within the Risk Management Strategy, guidance and procedures which have been updated during the year, with the revised Strategy being agreed by the Audit Committee on behalf of the Board in September 2016.

16.2 All Executive Directors are required to ensure the management of risk within their particular area of responsibility and this is explicit within the revised Risk Management Strategy. In addition, all staff are encouraged and empowered to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they are encouraged to follow guidance on whistle blowing and raising concerns.

16.3 At the September 2016 meeting of the Audit Committee, members proposed a move to an integrated Corporate Risk & Assurance Framework (CRAF) approach which essentially combines the former Board Assurance Framework (BAF) document and Corporate Risk Register

(CRR). It was felt this would remove duplication of effort and ensure that a single document could provide detail on assurances and gaps, and actions to address these gaps. This approach was approved by the Board in September 2016.

16.4 In January 2017 the Board received the first iteration of the new CRAF. The information contained within the CRAF has been drawn directly from Datix (to ensure Datix is used as the definitive source across the organisation) using the latest risks as documented on the former CRR. The CRAF is intended to be a succinct document providing a brief narrative update, with the detail being provided in the respective assurance reports to the various committees.

16.5 Each risk on the CRAF shows the links to the Principal Risk and has been informed by the work of the Board at a development session conducted in October 2016. Assurances within the CRAF have been populated from information contained within the former BAF where appropriate and then reviewed and updated by the relevant lead.

16.6 The Health Board has adopted a risk appetite statement which describes the risks it is prepared to accept or tolerate in the pursuit of its strategic goals. The Board recognises this is not a fixed concept and may change over time - see section 4 of the Board Assurance Framework in Appendix 4 of the following document:
http://www.wales.nhs.uk/sitesplus/documents/861/16_40.2%20Strengthening%20Governance.pdf

16.7 In defining the risk appetite, the Board adopted a maturity matrix for risk scoring which includes elements relating to quality, reputation, finance and regulation. The Board continues to keep the CRAF under review. Each risk generated has a number of actions identified to manage and mitigate the risk.

Risks have been assigned to an identified Executive Director and Board level Committee to ensure they are scrutinised on a regular basis. Controls are in place to address all these risks, which are reported to, and monitored by, the Board and its Committees. In addition a further level of scrutiny has been introduced this year with the Directorate registers now being reviewed by the Executive Management Group on a cyclical basis.

16.8 The Health Board involves its public stakeholders in managing risks that impact on them. For example, there is ongoing public engagement as an integral part of the development process of the Living Healthier, Staying Well strategy, focusing on reducing risks to the most vulnerable in society and also addressing risks arising from e.g long waiting lists. Item 16/209 via the link below also demonstrates the extensive engagement in respect of the development of strategic services e.g the mental health strategy (identified as a significant special measures risk):
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda_bundle%20Health%20Board%2017.11.16%20v2.0%20REVISED%20reduced%20file%20size.pdf
In addition, the population assessment carried out in 2016 involved input from the public on how best to meet social care and health needs in future plans.

17. Principal Risks

17.1 The Health Board has determined nine principal risks to achieving its strategic goals:

1: Failure to maintain the quality of patient services
2: Failure to maintain financial sustainability
3: Failure to manage operational performance
4: Failure to sustain an engaged and effective workforce
5: Failure to develop coherent strategic plans
6: Failure to deliver the benefits of strategic partnerships

7: Failure to engage with patients and reconnect with the wider public
8: Failure to reduce inequalities in health outcomes
9: Failure to embed effective leadership and governance arrangements.

17.2 In addition, one new risk has been identified and escalated during 2016/17 (entered on the Register in May 2016) in relation to Safeguarding. This was previously a risk on the Corporate Risk Register, entered in November 2013 but de-escalated in November 2015 as a result of increasing confidence that the Safeguarding risk as originally identified on the CRR was being managed and mitigated and that the actions being taken were demonstrating some improvement.

17.3 The decision to re-instate the Safeguarding risk on the CRAF was taken when it became apparent that the planned actions were not mitigating the former risks as anticipated. Furthermore, during the year the Board requested that the risk in relation to the IMTP be divided into two elements reflecting strategy development and development of the IMTP. The details of the current controls and the further actions being taken for each of the risks identified is detailed within the Health Board's CRAF which is publicly available via http://www.wales.nhs.uk/sitesplus/861/document/301428

17.4 As previously explained, each risk identified within the CRAF is categorised under one of the nine principal risks (PR) lists; for example, PR1 'failure to maintain the quality of patient services' covers the organisation's top clinical risks of Infection Prevention and Control, Continuing Health Care, Maternity Services and Mental Health Services. Key clinical services risks were identified as follows under Special Measures:

18. Key Special Measures Risk: Maternity Services at Ysbyty Glan Clwyd

18.1 Following judicial review proceedings regarding a proposed temporary change to maternity services and the subsequent full public consultation during Summer 2015, it was determined that the risks originally identified had been sufficiently mitigated through the recruitment of additional medical and midwifery staff, underpinned by a robust shift by shift monitoring of quality and safety risks.

Significant progress has continued to be made against the expectations set out in the Special Measures Improvement Framework. The service has been further stabilised through successful recruitment to the position of Consultant Midwife and an experienced Senior Medical Consultant, making it more robust and sustainable.

18.2 The Health Board is working with an external provider to drive and deliver sustained improvements in consultant behaviour in Ysbyty Glan Clwyd, to enhance multidisciplinary working and minimise clinical risk to mothers and babies. Clarity about the future strategy and service plan for redesigning maternity, neonatal and paediatric services has been achieved through the production of the Strategic Framework. A key element of this is the role of the Sub-Regional Neonatal Intensive Care Centre (SURNICC). The full business case for this development was approved by Welsh Government and the main development works have now commenced in line with the project timeline.

19. Key Special Measures Risk: Mental Health Services

19.1 One of the Board's key areas of focus throughout the year has been Mental Health services and the associated risks in relation to leadership, governance and the quality and safety of services. To mitigate these risks, actions to date include the formation of a Mental Health and Learning Disabilities Division with the appointment of a substantive director with effect from 5.5.16. This post reports directly to the Chief Executive and the Cabinet Secretary

has granted approval for it to become an Associate Board Member position, signalling the Health Board's clear commitment to Mental Health Services and increasing visibility and accountability at Board level. Other senior appointments have also been made to the leadership team.

19.2 The Board recognises the significant scale of the challenge in sustainably improving mental health services across North Wales. Ongoing progress is being made within the Mental Health and Learning Disabilities Division. Particular emphasis is being placed on addressing the key risks through the development of effective leadership and governance structures, supported by systems and processes to underpin operational delivery, service development and the delivery of high quality, safe care. Compliance with the Mental Health Act and Mental Health (Wales) Measure has improved. Improvements have also been made to internal governance arrangements within the Division. A new strategy for mental health services is under development, with expert external input. A formal patient engagement strategy for Older Adults' Mental Health has also been developed. A mental health experience sub-group has been established, to utilise service user and carer experience of services to shape and inform future service development and improvement. A new involvement project was commissioned by the Health Board and the Area Planning Board from the 1st April 2016, with the aim of improving equity of service provision across mental health and substance misuse services within North Wales.

19.3 All recommendations identified by HIW following inspections of mental health and learning disability sites have either been progressed or fully completed. A Director of External Investigations, reporting to the Chief Executive, has been appointed to coordinate the Health Board's input to the wider governance review of older people's mental health services led by Donna Ockenden, and the Health & Social Care Advisory Service (HASCAS) investigation into the concerns and complaints raised by members of the families of patients treated on Tawel Fan ward. This work is ongoing and remains a significant undertaking.

20. Key Special Measures Risk: GP Out of Hours / Primary Care Services

20.1 Good progress has been maintained with regard to all special measures expectations relating to Primary Care. Work is underway to mitigate the key risks, through the development of an integrated primary and community care strategy, active management of GP recruitment, innovative models of primary care, implementation of the General medical Services (GMS) Sustainability Framework, implementation of the 5 domain Practice Risk Assessment and Area Cluster Risk assessments. The Area Teams review the risk assessments on a regular basis and prioritise actions to mitigate levels of risks. Where practices are highlighted as facing significant risks the primary care teams in the area will enter into discussions with the practice to seek to further understand the issues they are facing and seek to assist them in the short and medium term if possible. This work will provide a strong foundation upon which to build cluster plans for sustainable GMS services for the future as cluster planning processes mature and strengthen to take account of all the risk assessment information available on which to base their action plans.

20.2 There is increasing evidence of effective cluster working, with each cluster having agreed priorities which are now being implemented. Funding is being used to improve access and to support any struggling practices so that patients can be seen nearer/in their own homes and spend less time on waiting lists.

The Health Board is working towards full compliance with the new Wales Quality and Monitoring Standards for the delivery of GP out of hours services, which are reported on a monthly basis to Welsh Government. The Special Measures Improvement Framework Task & Finish Group received detailed assurance on the progress being made to improve access and response

times, internal governance arrangements and the fill rates for rotas. In addition, work has progressed to engage with partner agencies using all available skills and resources to support patients close to home in the out of hours period.

21. The Control Framework

21.1 As Accountable Officer, I have personal responsibility for the overall organisation, management and staffing of the Health Board. I am required to assure myself, and the Board, that the Health Board's Executive and Clinical Management arrangements and overarching control framework are fit for purpose.

21.2 The control framework is designed to manage risk at a reasonable level rather than to eliminate all risk of failure to achieve our strategic goals and corporate objectives (see also section 14). Governance and internal control of the organisation is an ongoing process designed to

- Identify and prioritise risks to the achievement of our purpose, vision, strategic goals and values;
- Evaluate the likelihood of these risks being realised and the impact, should they be realised
- Managing these risks efficiently, effectively and economically.

The Board has agreed a risk appetite statement referred to earlier in this document in section 16.

22. Standing Orders

22.1 The Health Board has agreed Standing Orders for the regulation of proceedings and business. The Standing Orders can be accessed from the link below:
http://howis.wales.nhs.uk/sitesplus/861/page/41916

22.2 The Standing Orders are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice. 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 Health Board and define - its 'ways of working'. These documents, together with the Board Assurance Framework, the corporate risk register and a range of policies and business standards agreed by the Board make up the control framework within which the Board operates.

22.3 The Audit Committee has undertaken an annual review of the Standing Orders. The Committee approved amendments that have been reported to the Health Board for ratification.

22.4 A Conformance Report is provided at every Audit Committee meeting. The report highlights conformance with the Standing Financial Instructions, in relation to

- Procurement Procedures
  (Reporting of waivers of tenders and breaches of procurement requirements).
- Payroll Procedures
  (Reporting of overpayments of salaries and wages).
- Receivable and Payable Procedures
  (Reporting of aged balances over £10,000 and over 6 months old).
- Losses and Special Payments requirements
  (Reporting of losses, special payments, and write-off of balances owed to the Health Board).

22.5 During 2016/17 key issues identified in the conformance report in addition to the above included assurance on the Financial Assurance Framework, Carbon Reduction Credits, Department for Work and Pensions issues, taxation issues and updates on outstanding debts.

23. External Audit

23.1 Wales Audit Office published the following reports and documents relating to the Health Board (either directly or as part of an All Wales review) during 2016/17. The Health Board has formally responded to each of these and actions arising from recommendations are tracked using actions plans and the Audit Tracker Tool database, with progress formally monitored by the Audit Committee:

- Structured Assessment 2016 – Issued December 2016
- Annual Audit Report 2016 – Issued February 2017
- Medical Equipment Management – Issued October 2016
- NHS Consultant Contract – Follow up of previous audit recommendations – Issued November 2016
- Financial Contribution to the 'Lap of Wales' – BCUHB – Issued December 2016
- Hospital Catering and Patient Nutrition – A review of progress (All Wales) – Issued September 2016
- Meeting demand for Orthopaedic Services: Key questions for NHS Board Members (All Wales) – Issued August 2016
- All Health Boards and NHS Trusts in Wales – Structured Assessment 2015: Comparison of Performance Reporting to Boards (All Wales) – June 2016
- Managing Medicines in Primary and Secondary Care (All Wales) – Issued December 2016

These publications are available at the following website:
https://www.wao.gov.uk/publications

24. Corporate Governance Code

24.1 For the NHS in Wales, governance is defined as "a system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives." In simple terms this means the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

24.2 The Health Board follows and is compliant with the principles and relevant aspects as described in 'Corporate Governance in Central Government Departments: Code of Good Practice 2011' which are consistent with the 'Good Governance Guide' for NHS Wales Boards issued by Welsh Government in January 2014. In particular, the Board complies with the principles set out in relation to the role of the Board, Board composition, Board effectiveness and risk management.

24.3 The Code of Good Practice can be accessed via the following link:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220645/corporate_governance_good_practice_july2011.pdf

25. Quality and Governance Arrangements

25.1 In September 2016 the Health Board published its Annual Quality Statement 2015/16 which brought together a summary of how the organisation had been working over the past year to improve the quality of all the services it plans and provides. The report can be found here: http://www.wales.nhs.uk/sitesplus/861/page/40903

25.2 The Executive lead for Quality & Safety within the organisation is the Executive Director of Nursing and Midwifery, which complements the role of the Executive Medical Director and Executive Director of Therapies & Health Science.

25.3 The Quality & Safety Group (QSG) replaced the Quality Assurance Executive (QAE) Group in February 2017. The QSG was established to oversee the implementation of the Quality Improvement Strategy and associated delivery plans. It impacts positively on overall governance and controls by routinely monitoring clinical risk, escalating and de-escalating as necessary. The group seeks assurance from its established sub-groups, ensuring the triangulation of assurances and evidence of learning from patient experience.

25.4 During 2016/17 the Director of Corporate Services had responsibility for Putting Things Right (PTR) regulations. The most recent Annual Report on PTR was presented to the Board in September 2016 and can be accessed via the following link (16/175):
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20Bundle%20Health%20Board%2022.9.16%20Public%20V1.0.pdf
Over the next year, the PTR reporting timescale will be brought into line with the new (earlier) annual report and accounts timescale.
The Board also received regular update reports on PTR through the Integrated Quality & Performance Report, which reflects the Health Board's performance against key Government and local targets and continues to be developed and refined (16/177):
http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20Bundle%20Health%20Board%2022.9.16%20Public%20V1.0.pdf
and through other specific PTR papers to the Quality, Safety & Experience Committee, covering topics such as policy, themes, trends and learning:
http://www.wales.nhs.uk/sitesplus/documents/861/QS16_81%20Concerns%20Procedure.pdf
Principles for remedy are covered in the PTR disclosures made in the AQS, accessible via the link provided above.

25.5 Work has progressed in year to improve clinical leadership and ownership of the PTR process which has included work to establish a Patient Advocacy & Liaison Service. In addition, the Health Board has been working to systematically improve lessons learnt with the development of a Learning Framework. The Concerns function is also to transfer under the leadership of the Executive Nurse Director in order to strengthen the triangulation of themes and the ability of the Health Board to learn from concerns, complaints and incidents.

26. Engaging With Stakeholders

26.1 Improving visibility and engagement has been a key priority and a very active programme of public engagement took place during 2016. In addition, more than 25 '3D' staff engagement sessions have been held in order to strengthen the links between the Board and staff working throughout North Wales. The 3D approach to employee engagement seeks to bridge the gap between employee aspirations and employer expectations.The intention is to develop an organisation in which engagement is a continuous feature, in order to rebuild relationships and regain trust:
http://www.wales.nhs.uk/sitesplus/documents/861/15_284%20Engagement%20Review%20and%20Plan%20-%20BCUHB%20Nov%2015%20_final_.pdf

The Health Board has been seeking the views of stakeholders on its engagement strategy. As a result of this work, a Public Engagement Strategy has been approved and this provides the framework moving forward. The Strategy can be found at: *http://www.wales.nhs.uk/sitesplus/documents/861/16_70.2%20Special%20Measures_Engagement%20Strategy.pdf*

26.2 In addition, the Health Board continues to engage with, consult and involve a wide range of stakeholders in a variety of ways, most notably:

- The Board's Stakeholder Reference Group includes representation from the third and independent sectors and from community groups. Regular meetings enable this Group to keep abreast of developments and advise the Board of the views of the wider community;
- Formal Board-to-Board meetings take place with the Community Health Council (CHC) - 3 such meetings took place during the past year, in addition to 2 Chair-to-Chair meetings of the Health Board and CHC Chairmen;
- Meetings with the 6 Local Authority Council Leaders and Chief Executives take place on a quarterly basis;
- The Board engages on an ongoing basis with staff and trade unions across all professional groups. This includes regular communications issued to staff, consultations and meetings of the Local Partnership Forum, Healthcare Professionals Forum, Local Medical Committee, Local Negotiating Committee as well as other primary care contractor committees;
- Health Board meetings are held in public on a monthly basis; members of the public and other observers are welcome to attend;
- A system is in place for engaging with AMs and MPs and responding to queries or concerns they raise on behalf of their constituents.

26.3 The Board approved a Staff Engagement Strategy in August 2016 and an implementation plan. This has been developed with the direction of the Staff Engagement Working Group, a tri-partite body comprising Board Members, Trade Union representatives and senior managers. An update report on progress was submitted to the Board at its January 2017 meeting. The staff engagement work programme will be further developed in response to the 2016 NHS Wales Staff Survey Results.

Key highlights of the Staff Engagement work programme include

- Proud of Campaign at the main hospital sites
- Launch of the Proud to Lead Leadership Behaviours Framework
- Launch of the Gwobr Seren Betsi Star Award
- Identification of Listening Leads
- Appointment of Staff Engagement Ambassadors
- Launch of Discover, Debate, Deliver the Health Board's listening and engagement methodology
- the Generation 2015 Ward Managers Leadership Development programme is now on its sixth cohort
- Launch of revised Performance Appraisal & Development Review process with a strong focus on the Health Board's values and behaviours.

27. Health and Care Standards for Wales: Governance, Leadership & Accountability

27.1 The Health and Care Standards launched in April 2015 confirmed that effective governance, leadership and accountability was essential for the sustainable delivery of safe, effective person centred care and as such was an integral part of all the Health and Care Standards.

27.2 On 22.3.16 Welsh Government issued a technical update note with regards to the governance leadership and accountability standard. Previous advice had been that 2014/15 was

to be the final iteration of the module and that Health Boards were to make local arrangements to assess this standard in the interim. As the Health Board was placed in Special Measures in June 2015, evidence of progress against this standard has been focussed and monitored as an integral part of the Special Measures Improvement Framework.

27.3 As part of this process the Board, with advice from Ann Lloyd as Independent Adviser, has as mentioned earlier engaged in an ongoing Board Development Programme focussed on improving Governance, Leadership and Accountability. This has included self-assessment questionnaires, individual interviews with Board Members, and workshops to discuss the results and assessment of individual and collective performance. The Board Development Programme which reflects the expectations within the Special Measures Improvement Framework is tailored to achieve the developments necessary.

27.4 As stated earlier in this Statement, the Board receives regular updates on the progress being made against the Special Measures Improvement Framework and these are available on the website. Progress is also monitored at a national level through tripartite meetings between Welsh Government, Wales Audit Office and Healthcare Inspectorate Wales.

27.5 In broad terms the Health Board is still developing plans and processes but can demonstrate progress albeit there remain some key areas for improvement, such as completion of all senior appointments below Board level and finalisation of structures confirming how corporate functions work with operational teams. As such an indicative assessment against the historic Governance and Accountability Module Scoring Matrix would be determined as a 'Level 3'.

28. The Health & Care Standards (HCS): Revised Framework

28.1 Following the launch of the revised HCS Framework, together with the twelve key Quality Indicators issued by the Older People's Commissioner, the Health Board continues to incorporate the recommendations into its current monitoring arrangements of the monthly ward to Board audits.

28.2 The Health & Care Standards Quality Themes are mapped to the Integrated Quality & Performance Report, and progress, monitored (including results of the ward to board audits) via this report on a monthly basis by the Board. :
http://www.wales.nhs.uk/sitesplus/documents/861/Item%2016_58%20IQPR.pdf

28.3 A Ward to Board HARM Dashboard (utilising information from the Quality Data Hub) has been developed in 2016/17. This Dashboard will be launched across all Wards from Spring 2017. The development of Quality Dashboards for the Health Board will support the implementation of the Quality Improvement Strategy and help develop a culture where the aim of zero harm is considered the norm. The Dashboards are being developed in close collaboration with staff who will be using them on a daily basis (Ward Managers, Matrons etc). Consultation events / sessions are ongoing regarding content and format at each phase of development ensuring a bottom up approach to development that will lead to full commitment and sustainable change.

28.4 The development of a HCS Dashboard has commenced, with the aim of providing real time assurance across BCUHB against each of the HCS standards utilising information from the Quality Data Hub.

28.5 The HCS and Older People's Commissioner (OPC) recommendations are now mapped to each of the HIW recommendations and reported to the Quality, Safety & Experience Committee on a quarterly basis and Quality and Safety Group on a monthly basis. Work is also ongoing with

the Community Health Council to map the questions asked during inspections to both the HCS standards and OPC recommendations. See QS17/80 via: http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20QSE%209.5.17%20Public%20V2.01.pdf

29. Quality Improvement Strategy

29.1 The BCUHB Quality Improvement Strategy (2014 to 2017) focuses on three domains including the patient experience, the safety of our services to improve health outcomes and the quality of outcomes delivered through clinical excellence. A review, refresh and refocus is now taking place across the organisation to engage staff in discussions about the second phase of our Quality Improvement Strategy which will be for the period 2017-2020.

29.2 The Service User Experience Team has implemented the revised All Wales Framework for Assuring Service User Experience during 2016/17. To ensure a balanced approach, the Health Board has refined the methods used to capture patient feedback, to include real time feedback, implementation of All Wales inpatient and outpatient survey, generic comment cards and patient stories. Regular reports on themes, trends and lessons learned from feedback (including complaints) are discussed and disseminated via the Listening and Learning from Experience Group. Going forward a real time feedback system is being procured, to enable the collection of real time data across the Health Board. The Patient Advice and Support Service (PALS) to be implemented in Summer 2017 will further enhance the gathering of feedback and a more customer focused approach. Work is ongoing to incorporate the patient experience feedback into the dashboard.

29.3 Significant work has been undertaken during 2016/17 to further develop the triangulation of information from leadership and safety walkabouts and a number of different sources. The evidence from all of these sources provides opportunities to prospectively evidence our compliance with health and care standards, the Older People's Commissioner's standards and priority objectives. To support this triangulation, the Quality team have been working with Informatics to develop a dashboard which will enable the Board, Divisions and wards to look at their data to support areas of improvement. This is being finalised for going live in Summer 2017.

29.4 Further work across secondary care and Area teams through Governance arrangements will be needed to evidence local triangulation and implementation of improvement to demonstrate lessons learned.

30. Other Control Framework Elements

30.1 **Equality Diversity & Human Rights**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with, by:

- The values of fairness, respect, equality, dignity and autonomy (commonly known as FREDA), set out within the equality duties and the principles of human rights which underpin our strategic direction; they also featured prominently in the development of a set of organisational Values;
- The approval of the Equality, Diversity and Human Rights Policy and Procedure for Equality Impact Assessment;
- The review and revision of an Equality and Human Rights Strategic Plan for the Health Board 2016-2020; including Equality Objectives developed following extensive public engagement and in collaboration with public sector partners across North Wales;
- Regular meetings of the Equalities and Human Rights Strategic Forum which monitors compliance against the equality outcomes and objectives of the action plan, which are

underpinned by the public sector equality duties. Issues of Significance and compliance weaknesses are communicated to Chairs of Board Sub-Committees, the Executive Team, Area Directors, Directors of Secondary Care and Mental Health Services for action.

- Progress is also presented to the external Equality Stakeholder Reference Group four times each year. This group includes representation from members of the public with an interest in equality issues;
  Progress is also reported annually to the Community Health Council;
- The provision of Equality Impact Assessment Training including targeted support and guidance, for example, for service review projects;
- Strengthened EqIA scrutiny and governance arrangements by the establishment of a group to provide advice and scrutiny on Equality Impact Assessments relating to key BCUHB Strategies and Service Plans. Membership of this group includes external stakeholders as well as representatives from key BCUHB functions (Planning, Engagement, Communications, Public Health, Equalities) and nominated members of our Equality and Human Rights Operational Group.
- The implementation of the Fairness, Rights & Responsibilities e-learning package. This has been mandated for all staff to raise awareness of equality and human rights and the equality duties, and to encourage staff to better understand how these issues can impact upon their roles in the organisation;
- The submission of an Equality, Diversity and Human Rights Annual Report to the Board.

30.2 **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 and regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

30.3 **Post Payment Verification**

30.3.1 The aim of the Post Payment Verification (PPV) process is to ensure propriety of payments of public monies by the Health Board; this requires the Post Payment Verification team to undertake probity checks on a continuous basis. This gives the necessary assurance to the Health Board that public monies have been expended appropriately and also provides assurance to contractors regarding their arrangements.

30.3.2 An adjusted 3 year rolling programme of Post Payment Verification visits for General Medical Services and General Optical Services has been agreed, in accordance with NHS Wales agreed protocols.

30.3.3 The NHS Wales Shared Services Partnership (NWSSP) applies risk analysis techniques and liaises with relevant Health Board colleagues, and depending on error rates found, undertakes re-visits or other appropriate action with the Health Board.

30.3.4 Regular updates against the agreed work plan and an Annual Report are received by the Audit Committee detailing the analysis of recoveries by Contractor, which is anonymised.

30.4 Carbon Reduction Delivery Plans

30.4.1 The organisation has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements

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. Partnership arrangements and information sharing with other public bodies are also being pursued as part of continuous development of the Health Board Carbon Reduction Strategy.

30.4.2 The Health Board has a number of environmental aspects, which if not carefully managed would have significant financial and environmental impacts. As part of its corporate commitment towards reducing these impacts, the Health Board has successfully implemented and maintains a formal Environmental Management System (EMS), which is designed to achieve the following key principles :-

- Sustainable development.
- Compliance with relevant legal and government requirements.
- Prevention of pollution.
- Mitigation against the impact of climate change.
- A culture of continuous improvement.

30.4.3 Effective environmental management is achieved through the following processes:-

- Promotion of the environmental policy to all relevant stakeholders.
- Identification of all significant environmental aspects and associated legal requirements, including those resulting from service change and new legislation.
- Establishing and monitoring objectives and targets aimed at reducing environmental and financial impacts, in line with those issued by the Welsh Government.
- Provision of appropriate training to all relevant personnel.
- Regular internal and external audits.
- Regular review of the effectiveness of the EMS by the Environmental Steering Group.
- Working with local, regional and national partners to achieve a consistent public sector approach to environmental management and ensure best practice procedures are identified and implemented.

30.4.4 The Health Board has met each phase of the three year Welsh Government target to achieve certification to the BS EN ISO14001:2004 Environmental Management System (EMS). The final target was to roll out the EMS to community health centres by December 2014. This was achieved following a successful audit by UKAS accredited external auditors in November 2014. BCU is now in its second year of continual assessment audits. BS EN ISO14001:2004 Standard has now been superseded by BS EN ISO14001:2015, external audits at all sites covered in the scope of the EMS will ensure a smooth 3 year transition.

30.4.5 An implementation strategy to manage the Carbon Reduction Commitment (CRC) has been developed and implemented and is now awaiting an internal audit review to test the robustness of the regime.

30.4.6 A Corporate Carbon Action Plan has been developed in Welsh Government standard format. Implementation will be monitored and reported annually. Most items on the plan are dependent upon resource allocation from Major Capital Development and Annual Discretionary Capital Allocations, which will vary year on year. The action plan progress will therefore be dependent upon corporate resource availability.

30.5 Local Counter Fraud Service

30.5.1 The Audit Committee receives regular Local Counter Fraud Progress Reports, on a quarterly basis and an Annual Report of Local Counter Fraud work which has been undertaken during the financial year. This collectively provides a summary briefing of the work which has been undertaken by Local Counter Fraud Services Team, during the year and details the main

outcomes in-year, including both the number of Criminal and Disciplinary sanctions, as well as the financial recoveries which have been secured.

30.5.2 The Chair of the Audit Committee holds quarterly bilateral private meetings with the Head of Local Counter Fraud Services, to ensure that there is a clear understanding of current issues and risks, as recommended in the NHS Wales Audit Committee Handbook. The change in frequency to quarterly meetings from an annual meeting was recommended by the Executive Director of Finance. This represents an improvement in assurance for the Health Board and results in more efficient performance of the Audit Committee when dealing with Counter Fraud matters.

30.5.3 During 2016/17 the Local Counter Fraud team has undertaken a range of activities, leading to the outcomes and benefits realised as set out below:

- 56 Fraud Awareness Events have been undertaken across the Health Board.
- 16 Fraud Deterrence Activities have been undertaken across the Health Board.
- 191 Fraud Prevention Activities have been undertaken across the Health Board.
- £6,040.21 criminal compensation costs have been awarded by the Court.
- £5,315.00 investigation costs have been awarded by the Court.
- £42,090.87 civil recovery or voluntary repayments have been secured by the Local Counter Fraud team.
- The Home Office Immigration Service has informed the Local Counter Fraud team that Welsh Government has informed the Home Office that they would like the system which is in place at the Health Board for overseas visitor patients, to be replicated at other Health Boards across Wales. The work with the Home Office Immigration Service continues on an ongoing basis to ensure that the resources of NHS Wales are accessed by NHS patients who are eligible, in line with Welsh Government guidance.

30.6 Ministerial Directions

30.6.1 From October 2014, Ministerial Letters were replaced by Welsh Health Circulars (WHCs) and can be accessed by the following link:
http://gov.wales/topics/health/nhswales/circulars/?lang=en

30.6.2 A range of WHCs were published by Welsh Government during 2016-17 and are centrally logged within the Health Board with a lead Executive Director being assigned to oversee implementation of any required action e.g WHC2016/033 was acted upon and this led to the Audit Committee changing its practice of meeting in private, to meeting in public. All Independent Members are provided with a copy of WHCs upon receipt, and also alerted through a weekly Forward Look via the Communications Team. This allows Committee Chairs to ensure that the Board or one of its Committees is also sighted on the content as appropriate.

30.6.3 In addition, Ministerial Directions continue to be received and actioned by the Health Board. A logging and tracking system is in place, and was enhanced during 2016 to include more detail on the adoption of requirements as set out in the Directions. The Health Board was not impeded by any significant issues in implementing the actions required over the past year. Directions can be accessed by the following link:
http://gov.wales/legislation/subordinate/nonsi/nhswales/2015/directions-7/?lang=en

31.7 Data

31.7.1 Data Security

31.7.1.1 Responsibility for information governance in the Health Board rests with the Director of Corporate Services who acts as the Senior Information Risk Owner (SIRO) with the Assistant Director of Information Governance and Assurance acting as the Data Protection Officer. The Deputy Medical Director is the Caldicott Guardian.

31.7.1.2 The Health Board's information governance status was regularly reviewed by the Finance and Performance Committee with specific note to mandatory training compliance. The Health Board has undertaken a Caldicott self-assessment using a recognised tool, maintaining a Class 4 star rating and 88% compliance against the tool, which is the same score as that achieved in 2015/16.

31.7.1.3 The Health Board self-reported 4 data security breaches that triggered referral to the Information Commissioner's Office and Welsh Government, however the Board did not incur any financial penalties during the year. These related to two incidents involving non secure transportation of confidential information, 1 in respect of incorrect advice provided regarding information sharing arrangements and one in relation to a national data security breach involving a radiation monitoring provider.

31.7.1.4 As part of the process to ensure lessons are learnt following incident investigation, the Information Governance Team has taken a number of steps, including:

- quarterly information governance bulletins are disseminated across the organisation and available on the staff intranet site.
- alerts are issued to all staff to remind them of their responsibilities under safe transportation of patient & personal information requirements
- local team processes have been strengthened to ensure that papers are gathered up at the end of meetings
- a review of databases has been undertaken and access restrictions strengthened as a result

31.7.2 Data Quality

31.7.2.1 The Health Board makes every attempt to ensure the quality and robustness of its data, and has regular checks in place to assure the accuracy of information relied upon. However, the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement.

31.7.2.2 During 2016/17 the Patient Administration System (PAS) was replaced at Ysbyty Glan Clwyd. This was a positive move towards the standardisation of information sources and data collection processes across the Health Board. However, it represented a major exercise requiring the technical management of data migration and the re-training of staff on the use of new business processes, and as such has resulted in some initial data quality issues since implementation in November 2016. For example, waiting list data required detailed analysis before reporting could be re-established and other data were reported together with a cautionary warning. These issues have been discussed by committees of the Board and Internal Audit has been engaged to review the implementation and support the lessons learnt process ahead of a similar replacement programme planned for Wrexham Maelor Hospital in 2017.

31.7.2.3 The monthly Integrated Quality & Performance Report presented to the Board includes data on both performance against plan for the year as well as demonstrating the reported performance in the current and previous period. This assists the Board in scrutinising area where

variance is greater than would be expected and also enables contributors to the report to highlight any data quality issues in their exception reports. Overall, the Board is satisfied that data quality is sufficiently accurate to be able to identify patterns or trends in performance. Continuous improvement as regards data quality remains an ongoing process.

32. Review of Effectiveness

32.1 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 Directors 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.

32.2 My review has also been informed by

- Feedback from Welsh Government
- External inspections by Healthcare Inspectorate Wales
- Independent reviews
- Delivery of audit plans and reports by external and internal auditors
- Feedback from the Community Health Council
- Feedback from statutory Commissioners
- Feedback from staff, patients, service users and members of the public.
- Being relatively new to the organisation, reviewing systems in operation here in the Health Board when compared to other Health Organisations where I have worked at a senior level.

32.3 My review of the effectiveness of the system of internal control has been guided by the governance arrangements of the Health Board. We are working to continuously improve the effectiveness of the Health Board's systems of governance in a number of ways, for example:

- Board Development Sessions on Risk and Assurance

- The Audit Committee: The Chair of the Audit Committee participates in the All Wales Audit Committee Chairs Group to identify issues and share good practice. The Audit Committee Members have previously received specific training facilitated by Wales Audit Office to improve knowledge and effectiveness. As previously mentioned, revised arrangements were also agreed for the cycle of committee annual reporting to enable the Audit Committee to review all Committee reports and in turn include assurance to the Board by way of its Annual Report.

- Internal Audit: The Audit Committee has approved an Internal Audit Charter with NHS Wales Shared Services Partnership, a Strategy and a risk based audit plan for 2015 to 2018. The plan is kept under review by the Head of Internal Audit and the Board Secretary and any proposed changes are reported to the Audit Committee. At each of the Audit Committee meetings a progress report is presented and scrutinised. (See the Head of Internal Audit's Opinion in section 33).

32.4 Following on from discussions at the Board, Directors were asked to map out the internal governance structures operating within their respective areas (i.e. those bodies established by the directorate as opposed to groups/bodies which members from the directorate attend). These were reviewed and revised to ensure a level of consistency across the organisation and include Executive Lead responsibilities for assurance reporting from Health Board-wide Strategic Management Groups.

32.5 Each Directorate is expected to have in place Senior Leadership Team meetings. These meetings should work within broad terms of reference whereby it is explicit that such matters as listed below are considered and triangulated:

- quality, safety & experience – including concerns and incidents, continuing healthcare, learning from experience, feedback from leadership walkabouts
- finance & performance – including performance and accountability reviews, estates and capital
- workforce and organisational development – including team brief, relationships with Staff side, workforce planning, training & development, appraisals and revalidation
- risk management

32.6 In addition, the Chief Operating Officer has established and chairs an Operational Management Group to oversee operational delivery.

32.7 The information above is not intended as an exhaustive list; rather, it represents a framework to drive consistency and good governance. We recognise that the way in which these duties will be discharged will vary dependent on the scope and size of each directorate. These arrangements were routinely reviewed by Internal Audit in 2016/17.

32.8 A review of the terms of reference for the Quality Assurance Executive was undertaken and this Group was formally disbanded and replaced by the new Quality & Safety Group (QSG), reporting directly to the Executive Team.

33. Internal Audit

33.1 Internal Audit provided me as Accountable Officer, and the Board through the Audit Committee, with a flow of assurance on the system of internal control. A programme of audit work was commissioned and 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 focused on significant risk areas and local improvement priorities.

33.2 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 Health Board in reviewing effectiveness and supporting our drive for continuous improvement.

33.3 The Head of Internal Audit has concluded:
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 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.

33.4 Basis for Forming the Opinion
33.4.1 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.
33.4.2 The Head of Internal Audit has concluded *substantial assurance* can be reported for the Financial Governance & Management and Strategic Planning, Performance Management & Reporting domains; *reasonable assurance* can be reported for the Corporate Governance, Risk Management and Regulatory Compliance, Quality & Safety, Operational Service and Functional Management and Workforce Management domains; but only *limited assurance* can be reported across the Information Governance & Security and Capital & Estates Management domains.
33.4.3 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; and
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations.

33.4.4 As stated above these detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed. Where there is insufficient evidence to draw a firm conclusion the assurance domain is not rated.
33.4.5 In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported (none received 'no assurance' during the reporting period). Further, a number of audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. Where changes were made to the audit plan then the reasons were presented to the Audit 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.
33.4.6 The following 9 internal audits received limited assurance:

- East Area governance arrangements
- Medical equipment & devices- compliance with manufacturers' maintenance requirements
- Asset management life cycle- procurement through to disposal
- Informatics service desk
- Health records security (in partnership with Informatics and Health & Safety)
- General Medical Services- Health Board managed General Practitioner practices (draft)
- Staff personal appraisal and development reviews (PADRs) (draft)
- Estates and Facilities management- backlog maintenance (draft)
- Welsh Patient Administration System (WPAS) (draft).

33.4.7 All internal audits have an agreed management action plan with identified timescales for the actions to be completed. Progress is driven via the maintenance of an electronic tracking tool and is reported to and monitored by the Audit Committee. In respect of the limited assurance audits, management action has been taken to strengthen governance arrangements.

34. Structured Assessment 2016

34.1 On behalf of the Auditor General for Wales, staff of the Wales Audit Office conducted a Structured Assessment, as referred to earlier in this Statement. This was presented to the Audit Committee in December 2016 and key messages shared with the Board in January 2017 and subsequently discussed as part of the Annual Audit Report, presented in February 2017. The

External Audit Annual Report summary conclusions are detailed below (details of the full report can be accessed via the Wales Audit office website):-

- The Auditor General for Wales issued an unqualified opinion on the 2015/16 financial statements of the Health Board, although in doing so, brought several issues to the attention of officers and the Audit Committee and placed a substantive report alongside his audit opinion.
- In reviewing the Health Board's financial planning arrangements, the Auditor General found that the Health Board continued to monitor and report performance against its budgets and savings plans effectively, although it was highly unlikely to achieve financial balance at the end of 2016/17.
- The Health Board was laying some sound foundations to secure its future and the pace of change was increasing, although it was considerable further work to do in important areas.
- Performance audit work had identified opportunities to secure better use of resources in key areas.

34.2 Overall WAO's structured assessment work found that the Health Board had laid some foundations to secure its future and that the pace of change was increasing, although it remained in a challenging financial position and had considerable further work to do across a range of important areas. The Health Board received the formal recommendations from the 2016 Structured Assessment work in January 2017 which are summarised as follows:-

- Recommendation (R1) – Financial reporting – Review the timing of Board meetings, with a view to improve the timeline for financial reporting to the Board.
- R2 – Board assurance – The Health Board should build upon its assurance mapping work and work towards a board assurance map to complement the corporate risk register, and ultimately the IMTP.
- R3 – Board effectiveness – The Health Board should review its Board development programme and consider how it can be used to improve the balance and quality of support and challenge provided by independent members to drive improvement.
- R4a – Learning lessons – The Health Board should look at further steps to improve clinical leadership and ownership of Putting Things Right processes, to support the improvement needed in response times and learning from complaints, incidents and claims.
- R4b – Learning lessons – The Health Board should strengthen its processes for systematically reporting, cascading and implementing lessons learnt.
- R5 – Culture – Work to support a positive and open culture from ward to board needs to expand beyond the most challenged teams to help the wider organisation understand and apply positive values and behaviours.
- R6 – Strategy and Planning – The Health Board must maintain focus on developing its strategy and plans to ensure it meets its own challenging timescales.

34.3 By mid May 2017 the Health Board had completed and implemented the requirements of R1 and R3, and completed actions in line with recommendations and timeframe in respect of R2, but it is recognised that this work will continue. Work is continuing at pace to address the remaining recommendations R4a, R4b, R5 and R6. The full detail of those recommendations, together with the initial management response is included in the Structured Assessment report available via:

http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Board%20public%2019.1.17%20V1.0.pdf

35. Conclusion

As Accountable Officer, based on the review process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control (see section 32). Taking into account the evidence detailed in this Statement, together with feedback from Welsh Government and Ann Lloyd as part of special measures, from Wales Audit Office via their Structured Assessment and Joint Review with Healthcare Inspectorate Wales and from Internal Audit's improved assurance assessment (sections 11, 12 and 33), I have concluded that, in terms of effectiveness, the key mechanisms within the Health Board's system of internal control are satisfactory.

The last twelve months have been difficult and challenging for the organisation and whilst there is evidence of progress being made there remain several areas, as outlined in this Statement, that partially account for the Health Board remaining in Special Measures and these need to continue to be actively addressed.

The key areas for improvement and focus in the year ahead will be those set out in the Special Measures Improvement Framework as described earlier in section 4 and I am confident of the willingness and commitment of all staff within the organisation to deliver success that translates into better performance and outcomes for patients.

A step change is also required in our willingness to look to the long-term, to collaborate with partners and involve citizens in the development of services. In the context of the requirements on the Health Board relating to the Social Services & Well-Being (Wales) Act and the Well-Being of Future Generations (Wales) Act, effective partnership governance and culture shift will become more challenging. The Health Board will focus on best practice in good governance in the public sector and work with others to develop and test new audit approaches to assess progress and provide evidence of intended outcomes.

The Annual Governance Statement has been developed in accordance with the Health Board's governance arrangements and was approved by the Audit Committee on 30.5.17. As the Accountable Officer, I am taking assurances on the accuracy of the Annual Governance Statement from the arrangements established by the Health Board.

Signed:

Gary Doherty
Chief Executive and Accountable Officer

Date: 1st June 2017

Appendix 1 – Board and Committee Membership 2016/17

A number of changes to Board membership, including interim and acting up arrangements, have occurred during 2016/17 and are reflected in the table below.

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Dr Peter Higson	Chairman		• Chair of the Board • Chair, Remuneration and Terms of Service Committee	• Veterans
Mrs Margaret Hanson	Vice-Chair	Primary Care & Mental Health	• Vice Chair of the Board • Chair, Mental Health Committee • Chair to May 2016, Member wef June 2016, Strategy, Partnerships and Population Health Committee to May 2016 • Vice Chair, Remuneration and Terms of Service Committee • In attendance, Stakeholder Reference Group to May 2016 • Chair, Quality, Safety & Experience Committee wef June 2016	• Cleaning, Hygiene and Infection Management • Older People • Safeguarding
Mr John Cunliffe	Independent Member	Information Communication Technology	• Board Member • Member Audit Committee • Vice Chair, Finance and Performance Committee	
Ms Jenie Dean	Independent Member	Trade Union	• Board Member • Vice Chair Audit Committee wef June 2016 • Member, Mental Health Act Committee wef June 2016 • Vice Chair, Quality, Safety and Experience Committee • Vice Chair, Finance and Performance Committee to May 2016 • Member, Remuneration and Terms of Service Committee • Ex-Officio Local Partnership Forum	• Violence and Aggression • Equality
Mrs Marian W Jones	Independent Member	Community	• Board Member • Vice Chair, Audit Committee to May 2016 • Acting Chair, Quality, Safety and Experience Committee to May 2016 • Member to May 2016, Chair wef June 2016 Finance and Performance Committee • Chair, Charitable Funds Committee	• Public and Patient Involvement
Cllr Bobby	Independent	Local Authority	• Board Member	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Feeley	Member		• Member, Quality, Safety and Experience Committee to May 2016 • Member, Strategy, Partnerships and Population Health Committee wef June 2016 • Member, Audit Committee • Member, Mental Health Act Committee wef June 2016	
Mr Ceri Stradling	Independent Member	Community	• Board Member • Chair, Audit Committee • Member, Remuneration and Terms of Service Committee • Member to May 2016, Vice Chair wef June 2016, Charitable Funds Committee	
Mrs Bethan Russell-Williams	Independent Member	Third Sector	• Board Member • Vice-Chair Mental Health Act Committee • Member to May 2015, Vice Chair wef June 2016, Strategy, Partnerships and Population Health Committee • Member, Finance & Performance Committee wef June 2016	• Welsh language
Mrs Lyn Meadows	Independent Member	Community	• Board Member • Member, Finance and Performance Committee to May 2016 • Member to May 2015, Chair wef June 2016, Strategy, Partnerships and Population Health Committee • Member Quality, Safety and Experience Committee wef June 2016 • In attendance, Stakeholder Reference Group wef June 2016	• Concerns
Mrs Cheryl Carlisle	Independent Member	Community	• Board member • Member Charitable Funds Committee • Member Finance and Performance Committee • Member Quality, Safety and Experience Committee	• Carers • Children and Young People
Prof Jo Rycroft - Malone	Independent Member	University	• Board Member	
Mrs Nicola Stubbins	Associate Member	Director of Social Services, Flintshire	• Associate Board Member	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Mr Gary Doherty	Chief Executive		• Board Member • In attendance, Remuneration and Terms of Service Committee • In attendance, Audit Committee • Joint Chair, Local Partnership Forum • Member, Charitable Funds Committee	
Mr Russ Favager	Executive Director of Finance		• Board Member • In attendance, Audit Committee • Lead Director/Member, Charitable Funds Committee • Lead Director/In attendance, Finance and Performance Committee	
Mr Andrew Jones	Executive Director of Public Health to July 2016		• Board Member • In attendance, Quality, Safety and Experience Committee • In attendance, Strategy, Partnerships and Population Health Committee • In attendance, Stakeholder Reference Group • In attendance, Healthcare Professionals Forum to July 2016	
Miss Teresa Owen	Executive Director of Public Health wef January 2017		• Board Member • In attendance, Quality, Safety and Experience Committee • In attendance, Strategy, Partnerships and Population Health Committee • In attendance, Stakeholder Reference Group	
Mr Martin Jones	Executive Director of Workforce & Organisation-al Development (OD)		• Board Member • Lead Director/In attendance, Remuneration and Terms of Service Committee • In attendance, Finance and Performance Committee • In attendance, Strategy, Partnerships and Population Health Committee • Lead Director / Member, Local Partnership Forum	
Mr Geoff Lang	Executive Director of Strategy		• Board Member • Lead Director / In attendance, Strategy, Partnerships and Population Health Committee • Member, Charitable Funds Committee • In attendance, Finance and	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
			Performance Committee	
Dr Evan Moore	Executive Medical Director / Deputy Chief Executive wef September 2016		• Board member • In attendance, Quality, Safety and Experience Committee	
Dr Mark Walker	Interim Executive Medical Director to August 2016		• Board Member • In attendance, Quality, Safety and Experience Committee • Lead Director / In attendance Healthcare Professionals Forum to September 2016	
Ms Morag Olsen	Chief Operating Officer		• Board Member • Lead Director, in attendance, Mental Health Act Committee to May 2016 • In attendance, Finance and Performance Committee • In attendance, Quality, Safety and Experience Committee • Member, Local Partnership Forum	
Mrs Vicky Morris	Interim Executive Director Nursing & Midwifery and Therapies and Health Sciences to July 2016		• Board member • Lead Director / In attendance, Quality, Safety and Experience Committee • In attendance, Strategy, Partnerships and Population Health Committee • Member, Local Partnership Forum • In attendance, Healthcare Professionals Forum	
Mrs Gill Harris	Executive Director Nursing and Midwifery wef August 2016		• Board member • Lead Director / In attendance Quality, Safety and Experience Committee • In attendance Strategy, Partnerships and Population Health Committee • Member Local Partnership Forum In attendance Healthcare Professionals Forum	
Mr Adrian Thomas	Executive Director Therapies & Health		• Board member • Lead Director / In attendance Healthcare Professionals Forum wef January 2017	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
	Sciences Interim wef Sept 2016 Substantive wef Feb 2017		• In attendance Quality, Safety and Experience Committee	
Mr Andy Roach	Associate Board Member / Director of Mental Health and Learning Disabilities wef June 2016		• In attendance at Board • Lead Director / In attendance Mental Health Act Committee wef June 2016 • Member, Local Partnership Forum wef June 2016	
Mr Chris Wright	Director of Corporate Services		• In attendance at Board • In attendance, Quality, Safety and Experience Committee • Lead Director, Stakeholder Reference Group	
Mrs Grace Lewis-Parry	Board Secretary		• In attendance at Board • Lead Director/In attendance, Audit Committee	
Advisory Group Associate Members				
Cllr Phil Edwards	Associate Member	Chair of the Stakeholder Reference Group	• Associate Board Member • In attendance Strategy, Partnerships and Population Health Committee	
Prof Michael Rees	Associate Member	Chair of the Healthcare Professionals Forum	• Associate Board Member • In attendance Quality, Safety & Experience Committee	

Appendix 2 - BCUHB Health Board member attendance at Board Meetings held in public 2016/17

Y = Present A = Apologies P = Part attendance

		21.4.16	19.5.16	23.6.16	21.7.16	18.8.16	22.9.16	20.10.16	17.11.16	15.12.16	19.1.17	16.2.17	16.3.17		AGM 6.9.16
Dr Peter Higson Chairman	Member	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y		Y
Mrs Margaret Hanson Vice Chair	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		A
Ms Jenie Dean Independent Member	Member	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y		Y
Cllr Bobby Feeley Independent Member	Member	Y	Y	A	Y	Y	Y	Y	Y	Y	P	Y	Y		Y
Mrs Marian W Jones Independent Member	Member	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Prof Jo Rycroft-Malone Independent Member	Member	Y	A	Y	A	A	A	A	A	A	Y	A	Y		A
Mr Ceri Stradling Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Mrs Bethan Russell-Williams Independent Member	Member	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Mrs Lyn Meadows Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y		Y
Mr John Cunliffe Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Mrs Cheryl Carlisle Independent Member	Member	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	A		Y
Mr G Doherty Chief Executive	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Dr Evan Moore Executive Medical Director / Deputy Chief Executive	Member from Sept 2016						Y	Y	Y	Y	Y	A	Y		Y
Dr M Walker Interim Executive Medical Director	Member to August 2016	Y	Y	A	Y	A									
Mr Russell Favager Executive Director of Finance	Member	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y		A
Mr Andrew Jones Executive Director of	Member to July 2016	A	A	Y	Y										

		21.4.16	19.5.16	23.6.16	21.7.16	18.8.16	22.9.16	20.10.16	17.11.16	15.12.16	19.1.17	16.2.17	16.3.17		AGM 6.9.16
Public Health															
Miss Teresa Owen	Member from Jan 2017										Y	Y	A		Y
Mrs Vicky Morris Interim Executive Director Nursing, Midwifery, Therapies and Health Sciences	Member to July 2016	Y	Y	A	Y										
Mrs Gill Harris Executive Director Nursing and Midwifery	Member from August 2016					Y	Y	Y	A	Y	A	Y	Y		A
Mr Adrian Thomas Executive Director Therapies and Health Sciences Interim from Sep 2016 Substantive Feb 2017	Member from Sept 2016						P	Y	P	Y	Y	Y	Y		Y
Mr Martin Jones Executive Director of Workforce & OD	Member	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	A	Y		Y
Mr Geoff Lang Executive Director of Strategy	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Ms Morag Olsen Chief Operating Officer	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Mr Andy Roach Director Mental Health & Learning Disabilities	In attend an-ce wef June 2016			Y	Y	Y	Y	Y	Y	Y	Y	P	Y		A
Mr Chris Wright Director of Corporate Services	In Attend -ance	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	A	A		A
Mrs Grace Lewis-Parry Board Secretary	In Attend -ance	Y	Y	Y	Y	Y	A	P	Y	Y	Y	Y	Y		Y
Ms Nicola Stubbins representing *Directors Social Services*	Associate Member	A	P	Y	Y	A	Y	A	A	Y	Y	P	Y		Y

		21.4.16	19.5.16	23.6.16	21.7.16	18.8.16	22.9.16	20.10.16	17.11.16	15.12.16	19.1.17	16.2.17	16.3.17		AGM 6.9.16
Prof Michael Rees Chair of Healthcare Professionals Forum	Associate Member	A	Y	Y	A	Y	Y	A	Y	Y	A	A	Y		P
Cllr Phil Edwards Chair of Stakeholder Reference Group	Associate Member	Y	Y	Y	Y	A	A	Y	Y	Y	Y	Y	Y		Y

Footnote: Information relating to the Directors' Report is contained throughout this document. With regard to Company Directorships and other significant interests, information on environmental, social & community issues and sickness data – this information is contained within the Health Board's Annual report 2016/17.