



Annual Governance Statement - 2014/15

1. Scope of Responsibility

ABM University Health Board was formed on 1st October 2009 and covers a population of approximately 500,000 people. In 2014/15 it had a budget of £1.2 billion employing around 16,500 members of staff, 70% of who are involved in direct patient care.

During the summer of 2014 the Health Board undertook a major listening event to develop its values and behaviour framework. This included:

- 66 staff listening events – *In Our Shoes*, involving more than 1,650 staff;
- *Leading and Managing for Values* events to prepare managers to support the listening events involving 425 leaders and managers;
- 18 patient listening events – *In Your Shoes*, involving 120 patients; and
- staff and patient surveys

This resulted in over 6,000 contacts the outputs of which were analysed and draft values developed. The outputs and draft values were then shared at staff and patient workshops in November 2014 and the value statements were refined. The words used in the value statements and the underpinning behaviours have all been extracted for the words used by 6000 contacts.

A *Values and Behaviour Framework* was approved by the Board in January 2015 and launched in early March 2015, with over 1700 staff attending the events. Our values are:

- Caring for each other;
- Working together; and
- Always Improving.

The Health Board has a clear purpose from which its strategic aims and priorities have been developed:

“To fulfil our civic responsibilities by improving the health of our communities, reducing health inequalities and delivering effective and efficient healthcare in which patients and users feel cared for, safe and confident.”

During the year we produced an *Integrated Medium Term Plan* (IMTP) to align the public health, service quality, financial and workforce objectives of the organisation to ensure that its purpose could be fulfilled. The following six strategic aims were also adopted:

- Excellent Population Health;*
- Excellent Patient Outcomes;
- Excellent People;**
- Sustainable & Accessible Services;
- Strong Partnerships; and
- Effective Governance

**amended in March 2015 to: healthier communities*

***amended in March 2015 to: fully engaged and skilled workforce*

Within these strategic aims, we recognise that their successful delivery is underpinned by the modernisation and redesign of services. It is therefore extremely important to engage with patients, carers and families to ensure that any proposed service redesign reflects the needs of all individuals who either use or engage with its services. In 2014/15 we continued to build on its engagement activities to incorporate these critical views in its plans.

The Board is accountable for 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 this organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales.

We have continued to develop our systems of governance and assurance over the year. The Board sits at the top of the organisation's governance and assurance systems and sets strategic objectives, monitors progress, agrees actions to achieve these objectives and ensures appropriate controls are in place and are working properly throughout the organisation. To do this the Board also takes assurance from its Committees and also its assessments against the Standards for Health Services in Wales and other professional standards and regulatory frameworks.

Our governance and assurance arrangements have been established in accordance with Standing Orders and Standing Financial Instructions. Our plans also seek to ensure we meet national priorities set by Welsh Government, locally determined priorities and also national and professional standards throughout the conduct of our business. Reporting and monitoring against these objectives, and the risks associated with their delivery and achievement, are received by the Health Board and its Committees.

In recognition of the need to ensure that the governance and accountability arrangements in place across all our services are robust and that these are operating as intended, the Chairman and I, supported by the Board Secretary took forward a fundamental review of governance arrangements. This was reported to the Board in the autumn of 2014.

i) Board Function

The Board generally meets on alternate months in public and comprises individuals from a range of backgrounds, disciplines and areas of expertise. Details of those who sit on the Board is published on our website at: www.abm.wales.nhs.uk. It comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and seven Executive Directors. There are also three Associate Independent Members. Details of when the Board met during 2014-15 are set out in Appendix 1 which also sets out the level of attendance at such meetings.

The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. It also ensures that we have an open culture and high standards in the ways in which its work is conducted. Board members share corporate responsibility for all decisions and play a key role in monitoring the performance of the organisation. Key issues considered by the Board during 2014-15 included:

- AQuA Report (May 2014);
- 'Trusted to Care' Report - (May 2014 with progress on recommendations updated at each meeting following this);
- Integrated Performance Report (May 2014 and at each meeting following this)
- Finance Report (May 2014 and at each meeting following this);
- Public Health Strategic Framework (May 2014);
- Primary Care Annual Report (July 2014);
- Western Bay – Statement of Intent (July 2014);
- Complaints and Concerns (July 2014);
- Mortality Review (July 2014);
- Research & Development Report (July 2014 & January 2015);
- Funded Nursing Care (July 2014);
- Children's & Young People's Services (July 2014);
- Children's Charter (September 2014);
- Prudent Healthcare (September 2014);
- Children & Adolescent Mental Health Services (CAMHS)(September 2014);
- Data Quality Annual Report (September 2014);

- Public Health Annual Report (November 2014);
- Capital Programme (November 2014 & March 2015);
- Seasonal Pressures (November 2014);
- Cardiac Surgery – 12 month Review (November 2014);
- Continuing Healthcare (November 2014);
- Western Bay Health & Social Care Programme (November 2014);
- 'Together For Mental Health' Annual Report (November 2014);
- Integrated Medium Term Plan (November 2014 & March 2015);
- Organ Donation (January 2015);
- South Wales Programme – Equality Impact Analysis (January 2015);
- Voluntary Sector Funding (January 2015);
- Annual Screening Report (January 2015);
- Public Health Work Programme (January 2015);
- Wales Audit Office - Annual Audit Report (March 2015);
- Risk Management Strategy, Claims Policy and Corporate Risk Register (March 2015).

The above reports and others received by the Board during the course of the past 12 months and the relevant Board minutes indicating action agreed by the Board are published on the ABMU website at www.abm.wales.nhs.uk.

ii) **Health Board's Structure**

Our governance structure operates within the Welsh Government's Governance e-manual & Citizen Centred Governance Principles in that the seven principles together with their key objectives provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These arrangements support the principles included in Her Majesty's Treasury's 'Corporate Governance in Central Government Departments: Code of Good Practice 2011'.

iii) **Committees of the Board**

A range of committees which are chaired by Independent Members of the Board have key roles in relation to the system of governance and assurance, decision making, scrutiny, development discussions, an assessment of current risks and performance monitoring. The Audit Committee is the Committee which supports the Board in obtaining assurance that the governance and risk management frameworks are effective. These are set out in **Appendix 1**.

The committees provide regular reports to the Board to contribute to its assessment of assurance and to provide scrutiny on the delivery of objectives. The Chairs Advisory Group, consisting of the Board Chairman and the chairs of Board committees meets on a bi-monthly basis to support the connection between the business of key committees and also to seek to integrate assurance reporting. In

particular, this Group has received regular reports around the review of Board committee structures undertaken during the year.

The chair of each of the Board committees submits a report to each Board meeting held in public (once every two months). Each committee also produces an Annual Report for submission to the Health Board. These are generally received each summer in respect of the previous financial year. Board Members are also involved in a range of other activities on behalf of the Board, such as Board development sessions (at least six a year), meetings of committees of the Board, service visits and a range of other internal and external meetings. The Board also meets in public in June to formally approve its annual accounts following detailed consideration by the Audit Committee.

Meetings of the Board and its committees during 2014/15 were quorate with the exception of parts of the Quality & Safety Committee held in October and December 2014. Any decisions taken at those meetings were ratified when the Committee became quorate or at its next meeting.

iv) Advisory Groups

In support of the Board, the Health Board is also required to have three Advisory Groups which also report key issues to the Health Board following their meetings.

These are:

- **Stakeholder Reference Group (SRG)**

The SRG provides a forum to facilitate full engagement and active debate. Its membership includes representatives from specific groups of the community, such as children and young people, sexual orientation, older people, ethnic minorities etc. Members also include statutory bodies such as Police, Fire and Rescue, Environment Agency, etc. This group therefore has excellent links to the wider general public and each representative's role is to highlight the issues raised by their particular groups.

- **Health Professionals Forum (HPF)**

The HPF's role is to provide a balanced, multidisciplinary professional advice to the Board on local strategy and delivery. The HPF has responsibility for facilitating engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity.

- **Local Partnership Forum (LPF)**

The LPF's role is to provide a formal mechanism whereby the Health Board, as the employer, and trade unions/professional bodies representing the Health Board employees' work together to improve health services for the citizens of the ABMU area. Key stakeholders engage with each other to inform debate and seek to agree local priorities on workforce and health service issues. The chairmanship of the LPF is alternated between management and staff side.

v) Welsh Health Specialised Services Committee (WHSSC)

In addition to the above, the Welsh Health Specialised Services Committee (WHSSC) (Wales) Regulations 2009 (SI 2009 No. 3097) made provision for the constitution of a "Joint Committee". This committee comprises all the Local Health

Boards and is effectively seen as a sub-committee of each Board, with ABMU being represented by the Director of Finance. The Emergency Ambulance Services Joint Committee was established under WHSCC in 2014 at which ABMU is represented by the Chief Executive who attended four of its five meetings.

The Health Board also has representation on a Committee of NHS Wales Shared Services Partnership which is considered as a sub-committee of the Board, at which ABMU is represented by the Director of Finance who attended three of its six meetings. The Health Board is also continuing to develop and embed policies and procedures in the organisation to enable successful delivery of its governance and assurance arrangements. This includes the further development of the Board's 'Scheme of Delegation' to ensure that decision making is enabled and supported by the appropriate staff and teams at the most appropriate levels. This is designed to encourage further local decision making with clearly understood local accountability for delivery and improvement.

The Board along with its internal sources of assurance, which includes its internal audit function, also uses sources of external assurance and reviews to inform and guide our development. These comprise reports from the Wales Audit Office, such as the comprehensive annual *Structured Assessment*. The outcome of the assessment carried out in 2014 was received by the Board at its development session in February 2015 and was referenced in the Annual Audit Report which was presented to the Board at its meeting in March 2015 and is publicly available at <http://www.wao.gov.uk/>. The Structured Assessment is used by the Health Board to further inform our improvement planning and the embedding of good governance.

The Health Board has put in place a scheduling tool providing a process for the reporting of planned inspections from external assessors to the Audit Committee and Quality & Safety Committee identifying any risks prior to the inspection taking place and advising of actions to be taken as appropriate. The process also provides for the retrospective reporting of any unplanned inspections. The Board is aware of planned external inspections and the approximate time that the Board or subcommittee of the Board will expect the outcome reports.

The Health Board also has in place a tracking system for audit recommendations and the agreed management actions, which is regularly reported to the Health Board's Audit Committee. This mechanism is overseen on a routine basis by the Executive Team to ensure appropriate and timely responses to audit recommendations.

We use reports from Healthcare Inspectorate Wales (HIW), the Welsh Risk Pool (WRP) and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation.

HIW provides us with independent and objective assurance on the quality, safety and effectiveness of the services it delivers. This includes unannounced spot-checks, themed reviews and follow-up reviews. All this work is reported to the relevant Board Committee with an accompanying action plan to ensure standards are continuously improved and that any lessons learned are shared throughout the organisation. The Health Board has also undertaken HIW's annual Governance and

Accountability Module self-assessment for 2014/2015 and the outcome of this assessment is set out on page 22.

Welsh Risk Pool (WRP) is a mutual self-assurance scheme for all health bodies in Wales. The Risk Pool Scheme covers all risk relating to NHS activity, subject to Welsh Health Circular (2000) 04, Revised WRP management arrangements from 1st April 1999 and WHCs (2000)12 and 51, Insurance in the NHS in Wales. WRP undertake annual reviews the outcomes of which are reported to the Quality & Safety Committee and the Audit Committee as appropriate.

vi) Governance Framework

The Health Board has approved Standing Orders, reviewed regularly, for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations 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 range of corporate policies set by the Board make up the Governance Framework.

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

We have continued to develop and embed our approach to risk management over the last year, but recognises that further work is required to ensure risk systems continue to be streamlined and inter-connected. This understanding of risks actively informs the Board's key priorities and actions and its overall approach to risk governance.

We see active and integrated risk management as key elements of all aspects of our functions and responsibilities especially in order to support the successful delivery of our business. This assists in ensuring high quality and safe health care is provided to local people, that we contribute to improving the health and well being of our population and that a safe and supportive working environment is provided for our staff.

As Chief Executive, I have overall responsibility for the management of risk for the Health Board. The Executive Lead for risk management is the Director of Nursing & Patient Experience and has delegated responsibility for ensuring that arrangements are in place to effectively assess and manage risks across the Health Board

including responsibility for maintaining and co-ordinating a corporate risk register and the corporate reporting of risks. The Health Board and its Committees identify and monitor risks within the organisation. Specifically, the Executive Team meetings present an opportunity for the executives to consider, evaluate and address risk and actively engage with and report to the Board and its Committees on the organisation's risk profile.

During the latter part 2014/15, the Director of Nursing & Patient Experience led on the review of our *Risk Strategy* which was approved by the Health Board at its meeting in March 2015 as an interim working document. The Risk Strategy had previously been reviewed by the Audit Committee and will be subject to a further review in 2015/16 to reflect the revised risk management arrangements that will be in place following the planned operational management restructuring taking place during 2015/16.

We are committed to ensuring staff throughout the organisation are trained and equipped to appropriately assess, manage escalate and report risks and further work continues to embed good risk management throughout the organisation. This work is being informed by best practice examples and through advice from the Internal Auditors, the Wales Audit Office and the Delivery & Support Unit.

i) Health Board's Risk Profile

The delivery of healthcare services carries inherent risk and our risk profile is continually changing. The key risks that emerge which can impact upon our achievement of objectives is captured in the Board's 'Corporate Risk Register' which can be accessed on the Health Board's intranet site. This was received by the Board at its March 2015 meeting and is updated quarterly. It is available on our website at www.abm.wales.nhs.uk

Risk Registers are used to identify and manage significant risks within the Health Board. In addition internal and external reports/reviews are used to inform the framework and register in terms of new risks or amendments to existing risks.

In acknowledging that effective risk management is integral to the successful delivery of its services, we have systems and processes in place which identifies and assesses risks, decides on appropriate responses and then provides assurance that the responses are effectual. The implications of risks taken by management in pursuit of improved outcomes in addition to the potential impact of risk-taking on and by its local communities, partner organisations and other stakeholders, is understood by the Board.

The overall assurance arrangements are set out in the System of Assurance that was considered by the Audit Committee in November 2014. This will be kept under regular review in 2015/16 to ensure it reflects any changed arrangements as a result of the operational management restructuring.

During 2014/15 serious risks have been identified from the register and in March 2015 contained risks linked to the objectives (aims and priorities) of the Health Board and included within the Health Board's IMTP for 2015/18 (see page 19-20 for further detail around the IMTP).

Achieving financial balance was a moderate risk for the Health Board through the year until the third quarter when the risk increased and was significant in the last quarter. Subject to audit, the draft financial position shows £99,000 under-spend against its resource limit at year end. The risk of financial balance at the start of 2015/16 remains a significant risk for the Health Board and is linked to the organisation's IMTP.

At the end of March 2015 there were a number of continuing risks of concern to the Health Board which are highlighted below:

- Unscheduled Care
- Effectiveness of Care
- Financial Risk

The Board has a series of controls in place to manage and mitigate these risks which are documented within the register. In addition to the three key risks set out above, the following issues were also considered a significant concern during 2014/15:

- Cardiac Services
- Workforce risks
- Care and treatment provided at the Princess of Wales Hospital
- Concerns Management.

As a result of action taken these risks have since decreased, although it is recognised that further work in these areas is required to reduce the risk further and there are detailed action plans in place to support this work including further reviews by external organisations. Further details in relation to the risks and also the controls in place and actions to be taken can be found within the Corporate Risk Register.

ii) Management of Risk

Effective risk management is integral in enabling us to achieve our objectives, both strategic and operational in delivering safe, high quality services and patient care. The Health Board manages risk within a framework that devolves responsibility and accountability throughout the organisation. Each Executive Director is responsible for managing risk within their area of responsibility and they ensure that:

- there are clear responsibilities for clinical, corporate and operational governance and risk management
- staff are appropriately trained in risk assessment and manage
- there are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Executive Board, relevant Board Committees and the Board.
- there are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required.

- details of the key risks within their area of responsibility are reported to the Board.
- there is compliance with Health Board policies, legislation and regulations and professional standards for their functions.

Executive Directors are supported in these duties by Assistant Directors, Clinical Directors and Locality Directors. Together they ensure that robust systems are in place for risk management. In addition, the Director of Nursing & Patient Experience has specific responsibility for progressing compliance with *Doing Well, Doing Better Standards for Health Services in Wales* as well as specific strategic responsibility for key areas of patient safety.

The Director of Finance also has specific responsibility for financial risk management and for providing regular, timely and accurate financial reporting to the Board in line with requirements and professional standards.

iii) Operational Risk Management Arrangements

Clinical/Locality Directors are responsible for the management of risk within their Directorate/ Locality/Directly Managed Unit. They must ensure that they have effective arrangements in place to identify and manage risk. When risks are identified outside their control, they must communicate this effectively through to the Chief Operating Officer or for risks relating to Princess of Wales Hospital the Executive Lead for Princess of Wales Hospital. Professional issues will also be highlighted to the relevant Executive Lead eg Medical Director and Director of Nursing and Patient Experience.

Each Directorate/Locality/Directly Managed Unit has a clearly defined structure to ensure the appropriate management of risk which has been confirmed within their mid-year and end-of-year annual return of their Letter of Representation on Internal Control for their specific areas of responsibility. This includes Directorates/Localities maintaining up to date Risk Registers and maintain a log of risks they have mitigated to a risk tolerated level and risks that have been terminated. Generally these provided positive assurance. Any issues raised that are not highlighted in the IMTP will be considered by the Executive Team to ensure any residual risk is managed appropriately.

iv) Risk Management Training

A three-year training programme commenced in April 2013 and continued in 2014/15. Level 1 risk management training is available to all grades of staff and is part of mandatory/statutory training. It provides an overview of risk management as well as how to complete a risk assessment and highlights the importance of identifying mitigating actions to reduce and manage those risks. Level 2 risk management training is aimed at enabling managers to identify and take mitigating action to reduce risks if those risks cannot be eliminated. Performance against risk management training is reported to and monitored by the Assurance & Learning Group on a quarterly basis.

v) Working with Partners/Stakeholders

The Board recognises that there is risk associated with every decision it takes and within any proposed change in service. Therefore the Board is keen to engage and

consult with staff, the public and stakeholders to identify areas of concern and solutions. Working with partner organisations is critical to successful integrated working and delivering services with partners can bring significant benefits and innovation. It is recognised that working in this way can also lead to risks around failing to align agendas and ineffective communication.

Some examples of how the Health Board engages the public in terms of areas of risk include:

- Changing for the Better – considerable engagement recognised by Welsh Government as good practice;
- South Wales Programme;
- Development of organisational values, including and In Your Shoes/ In Our Shoes events for patients/relatives/carers and staff;
- Patient Surveys;*
- Engagement on service delivery;
- Internet;
- Information Screens;
- Information Campaigns;
- Pathways; and
- Concerns

*these included 'iwantgreatcare', the use of the SNAP 11 system and the *See It, Say It* campaigns which are referenced in the next section.

vii) Quality Governance Arrangements

The Quality & Safety Committee of the Health Board met six times during 2014/15. Its main responsibilities are to provide:

- evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The Committee is supported by the Standards for Health Services in Wales Scrutiny Panel and provides evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare. Internal Audit Reports on quality & safety issues are received by the Committee on a regular basis which include actions to address findings. These are in turn reported to the Board as part of the key issues report this Committee submits following each of its meetings. Amongst the key issues considered by the Committee during 2014/15 were the following:

- Draft Quality Strategy
- In-hospital mortality
- Infection prevention and control
- Safeguarding
- Concerns (including reports published by the Public Service Ombudsman for Wales relating to ABMU), claims and lessons learned
- Annual Reports (Patient Experience & Volunteering)
- Nutrition & Catering
- Quality & Safety (External & Internal Audit Reports & Spot Check Inspections)
- Annual Quality Statement
- Quality & Safety Performance Reports
- Unscheduled Hospital Care
- Cardiac Review Action Plan
- Medical Revalidation
- Patient experience;
- Progress with issues raised in the Advancing Quality Alliances (AQuA) and Trusted to Care reports;
- Unscheduled care;
- Continuing care;
- Primary and community care governance arrangements;
- Medicines management;
- Cardiac surgery; and
- Cancer services.

a) Quality Strategy

Our first and main priority is to deliver health services that embody the principles of prudent healthcare and are consistently of the highest quality; by this we mean safe, effective, person-centred, caring and compassionate services that respect people's needs and empowers them to make informed decisions and choices.

During 2014/15 we took significant steps to strengthen the Health Board's quality assurance, patient feedback and quality improvement arrangements. However, we recognised that further work was still needed and we recognised that we must continue to transform how we work if we are to place people always at the centre of the services we provide and prevention, quality and transparency at the heart of the healthcare we deliver.

In January 2015, the Board were presented with and approved the Quality Strategy. Setting out the steps being taken to improve the quality of its services and achieve excellence consistently. We are seeking to achieve this by ensuring that quality assurance and quality improvement are at the forefront of all our thinking and embedded in everything that we do. It describes what we want to achieve (our strategic quality objectives), the approach being taken and how success will be measured (our quality measures). It is relevant to all services (health promotion, prevention, primary/ community, secondary and tertiary); and provides a shared vision of how we will:

- Put the people of Bridgend, Neath Port Talbot and Swansea, our wider communities and the experiences of all our patients at the heart of our services by promoting and encouraging patient and carer decision-making and involvement in everything that we do.
- Support and enable our staff to deliver high-quality, evidence-based care and prevention compassionately by making it easier for them to consistently do the right thing;
- Make tangible and measurable improvement to the aspects of quality that people have told us are important to them;
- Become a 'high reliability' organisation that has quality and improving the experiences of our patients at the core of all our services.

Responding to what people have told us is important to them and recognising the foundations put in place nationally, we have adopted the following definition of quality:

‘Quality services, care and treatment are safe, effective, person-centred, caring, compassionate and respect people's needs and their right to make informed decisions and choices’.

Through the implementation of our strategy we will focus on delivering high quality services by addressing those matters that will contribute to the achievement of the following strategic quality objectives:

Quality Objective 1: To plan and deliver our services with the people living in the communities we serve, so that they are person centred, caring and responsive to need;

Quality Objective 2: To deliver excellent, effective and efficient services based on evidence and standards;

Quality Objective 3: To make sure that everything we do is as safe as possible; and

Quality Objective 4: To organise the Health Board for excellence and continuous improvement.

The strategy is not just about restating the aims and objectives we have previously set or renewing policies and approaches. It builds on the foundations put in place nationally (by the Welsh Government) as well as our local quality improvement and assurance arrangements. The findings of the Berwick report (2013) have also been reflected as have the lessons we have learned from the independent review commissioned by the Welsh Government (Professor June Andrews) in 2014. This outlined the importance for health organisations, whether they provide or

commission health related services, to place quality, especially safety, above all other aims.

The high level objectives and actions and measures set out in the strategy will be supported by detailed Annual Quality Plans which will make it clear who is responsible for the delivery of each objective and includes agreed milestones and timescales. The Annual Quality Plan for 2015-16 has been included in the 2015-2018 IMTP. The strategy will be reviewed each year as part of the Annual Quality Statement review process which reports publically on progress in the priority areas.

b) Review of Governance Arrangements

During the year, the Medical Director and Director of Nursing and Patient Experience commissioned a review of the governance and accountability arrangements operating at a local level i.e., locality, directorate, ward and service level. The aim of this review was to assess how well the governance arrangements at a local level support the delivery of services that are safe and of the required quality. The findings arising from this review are being used to strengthen the quality assurance arrangements across the health board.

c) Response to the AQuA and Trusted to Care reports

In our IMTP for 2014-2017 we highlighted that we had identified particular concerns about the care of older people at the Princess of Wales Hospital. One of the actions we put in place in 2013, was to commission the *Advancing Quality Alliance* (AQuA) to undertake a wide-ranging, independent quality and safety review of the care provided at Princess of Wales hospital. Their final report, received in May 2014, set out 51 recommendations to address concerns related to:

- The use of mortality data
- Clinical care
- Reliable care systems
- Leadership
- Roles and responsibilities
- Documentation and informatics
- End-of-life care

The Board recognised that the findings of the AQuA report were equally applicable to all of the ABMU hospitals and so in 2014/15 we took action in relation to all 51 recommendations and started to redesign our systems to ensure consistent delivery of high quality care 24/7.

In May 2014 *Trusted to Care* (also known as the 'Andrews Report') was published. This was an independent review of care at Princess of Wales Hospital and Neath Port Talbot Hospital commissioned by the Minister for Health and Social Services at Welsh Government. The Board received this report at its meeting in May 2014 and planned action to respond to the report recommendations. The Board has continued to receive regular progress reports on actions taken since this date, examples of progress include:

- Commissioning a nationally recognised team of clinical leaders in the field of frail elderly care to help us develop more rigorous ways of ensuring high

standards are consistently maintained. This has resulted in the Board approving standards for the frail elderly;

- Engaging external experts who have supported other NHS organisations in major change programmes to help in developing a values and behaviour framework. The Board agreed a values and behaviour framework in January 2015, following extensive staff and patient engagement;
- Putting in place a taskforce of experienced staff from various disciplines and professions to supplement the ongoing improvements and push ahead with the report's recommendations; and
- Reinforcing standards through strengthened inspections and monitoring by senior clinical staff and directors.

In terms of practice that should **never** happen in any of our hospitals the following were identified:

- Patients being given prescribed medication but then not being observed taking it;
- Staff signing the medicines chart to say that a patient has taken medication when they have not seen this;
- Inappropriate use of sedation for “aggression”;
- Patients being told to go to the toilet in bed;
- Patients not being appropriately hydrated.

To tackle this immediate action was taken, including:

- Additional staff training on each of the specific issues listed above. This training will be guided by external experts;
- An urgent review of the use of sedation;
- Using a checklist specifically developed to check medication, continence and hydration, both regular and unannounced spot-check inspections carried out by senior personnel and Board members;
- A review of the environment of wards for dementia care.

Building on the *AQuA* and *Trusted to Care* report recommendations, in our 2014-2017 IMTP, we identified six main safety and quality challenges:

- Outcomes for patients
- Culture
- Communication
- Guidelines
- Pathways
- Feedback from Patients, Citizens and Staff.

We have taken steps to get a better understanding of the experience we give those who use our services and the outcomes that they want by:

- Developing systems for collecting and acting on feedback from patients, citizens and staff that value this as a golden opportunity for quality improvement. Specifically, we:
 - ✓ Introduced an organisation-wide patient experience barometer utilising the *Friends & Family Test* to provide a real time indication of the quality of care being delivered in all hospital services. This will be further embedded during 2015/16 and also rolled-out to primary care services;
 - ✓ Began the roll-out of a web-based patient experience system to routinely capture patient experience and patient outcome data that will be used to improve quality of care and services. The SNAP 11 system will be embedded across all hospital sites during 2015/16 and primary and community care during 2016/17; and
 - ✓ Adopted *You Tell Us*™ as the ABMU's Patient Experience 'brand' that is widely promoted.

- Working with and supporting staff to ensure that listening to patients is seen as part of the 'day job' and is valued and embedded across all areas. This included staff attending listening events with patients (In your Shoes). During 2014/15, we:
 - ✓ Introduced a Patient Advisory Liaison Service (PALs) to provide patient focussed advice and support seven days a week that will be implemented across all acute hospital sites. This was piloted at the Princess of Wales hospital during 2014/15 and will be rolled-out across the Health Board during 2015/16;
 - ✓ Introduced concerns clinics, which gave people the opportunity to discuss any issues they may have with senior clinicians and managers. (see page 18 for more information around these); and
 - ✓ Began to explore how we can design services around the outcomes and experience valued by patients and citizens ensuring dignity, respect and compassionate care for all.
 - ✓ Improving the way we address and learn from complaints, concerns and incidents by putting mechanisms in place to ensure timely, open and respectful response to complaints. Our systems are now designed to learn from complaints and protection of vulnerable adult incidents.

- We:
 - ✓ established a clinically-led integrated and properly resourced Patient Feedback Team (PFT) that includes patient experience, Protection of Vulnerable Adults (PoVA), and previous Department of Investigation and Redress) to ensure the Health Board values patient experience, that we learn from when things go wrong have a co-ordinated patient focussed approach and effectively and efficiently receives and responds to all patient experience feedback that we learn from experience and improve quality;

- ✓ Developed an integrated web-based reporting system for, PoVA, complaints, claims, and incidents that works across all healthcare settings to facilitate more efficient and effective reporting, and better analysis of information down to patient, ward, GP practice, clinical levels;
 - ✓ Improved the way we deal with the investigations of complaints and incidents making our response timelier, thorough and reporting the outcomes to the Board, with a detailed monthly “ward to board” analysis of all themes arising from complaints, patient experience, incidents and claims; and
 - ✓ Improved mechanisms for providing clinical and managerial staff with learning from sentinel events such as incidents, complaints, claims, never events, ombudsman and coroner reports and mortality reviews so that this information is used to improve the care.
- Started on a journey to improve the care we provide to the elderly and frail by:
- ✓ Creating a set of clear standards for the care of frail older people in Accident and Emergency and general medical and surgical wards, with the support and input from a nationally recognised expert on the care of frail older people and the Royal College of Nursing (RCN). These were subject to patient and public engagement;
 - ✓ Reviewing how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying at both hospitals, covering physical design of the clinical spaces and equipment available. An action plan has been developed to address the shortcomings identified;
 - ✓ Implementing a skills and knowledge programme to ensure all staff working in our hospitals understand and are equipped to meet their obligations to frail older people;
 - ✓ Rolling-out an intensive education programme on delirium, dementia and dying in hospital;
 - ✓ Developing more cohesive multi-disciplinary team practice in the medical wards at the two hospitals, built around shared responsibility and accountability for patient care and standards of professional behaviour; and
 - ✓ Put steps in place to ensure good hydration, mobility, toileting and feeding practice for all older patients and publish audited results on a quarterly basis.
- Developed a positive culture of quality improvement through openness, no blame and zero tolerance to poor care and avoidable patient harm, by reliable delivery of best practice standards. During 2014/15 we:
- ✓ Adopted a “zero tolerance” approach to the improper administration of medicines for all clinical staff;
 - ✓ Ensured that all relevant patient safety alerts were implemented;
 - ✓ Worked to reduce the incidence of all healthcare associated infections in hospital and community settings to a level comparable with “best in

class". We didn't achieve our goal and will try even harder in the years ahead;

- ✓ Took steps to improve communication and collaboration between secondary and primary care, and the third sector; and
 - ✓ Began to address inconsistencies in the use of interventions that are proven to have the highest impact in terms of good outcomes such as deep vein thrombosis (VTE) assessment and appropriate prophylaxis and other care bundles that guard against other causes of avoidable harm. While there has been some improvement in each of these areas we are clear that further work is needed to ensure the sustainability of such systems and the consistent application of such interventions.
- Improved the way in which we address concerns during 2014/15 by:
- ✓ Establishing Complaints Clinics which were widely advertised for the purpose of discussing any concerns about care and treatment; and
 - ✓ Changes were made to the approach taken to respond to concerns which now means that patients and their relatives are now offered the opportunity to meet with relevant staff as soon as a matter is highlighted. Offers are also made for patients to return after changes have been made to services so that they are able to see these for themselves.
 - ✓ The way in which we deal with patient feedback has been praised by the Public Service Ombudsman as well as the Older Person's Commissioner and Community Health Council so much so that we are now regarded as an exemplar in complaints management. The Welsh Risk Pool is planning to undertake an annual review in June 2015 (as part of their programme of all-Wales assessments) on both concerns and claims management. This will be reported to the Quality and Safety Committee.

Following the Andrews review, the Health Board was placed under 'enhanced monitoring' under the joint Escalation and Intervention Framework reflecting the active engagement required to monitor the extent to which the issues identified by the review were being addressed.

viii) Continuous Improvement

We have continued to engage with the 1000 Lives Improvement Programme team to promote and deliver improvement across a wide number of areas including both National (N) and more Local (L) improvement initiatives:

- Prudent Health Care(N)/Co-Creating Health(L)
- Improving Quality Together(N) – Bronze, Silver and Gold, and pilot Silver Programme (L)
- Planned Care(N) - Clinical Priority Areas
- Enhanced Recover after Surgery(L)
- Rapid Response to Acute Illness/Sepsis(N) – Identifying the Sick Patient(L)

Key prudent healthcare areas include:

- Prudent audiology to improve services for Patients with adult hearing loss, tinnitus and balance disorders
- Prudent therapy services to improve access to therapy services via walk-in clinics and piloting 7 day working.
- Co-creating health programme.

We have reached over 1800 staff with Bronze level *Improving Quality Together* (IQT) which equates to approximately 12% of the workforce, in line with the national average. We are now looking to build on this platform to deliver increasing numbers of staff delivering improvement and receiving recognition for their achievements. We have our maintained commitment to the *Enhanced Recovery After Surgery* (ERAS) programme and improvement work is ongoing across a number of disciplines including orthopaedics, burns and plastics and urology. We have also been piloting a programme for more rapid identification of the sick patient and learning from this pilot programme will contribute to more effective utilisation of *NHS Early Warning Scores* (NEWS) and will be reflected in better clinic communication and action to improve patient experience and outcomes.

ix) IMTP 2014/17 and 2015/18

We met our statutory duty to prepare and submit a Board approved IMTP 2014/17 for approval by Welsh Ministers. The IMTP was approved by Welsh Ministers in June 2014 and sets out the organisational priorities and objectives along with the risks and assumptions associated with achieving the Plan. The Health Board met many of the objectives set out in the IMTP particularly in relation to strategic change. However, there were key areas where we did not deliver its objectives, particularly in terms of meeting Tier 1 targets for unscheduled care and planned care. We did however deliver a balanced financial plan by 31st March 2015.

Following approval of the 2014/17 IMTP, we prepared a refreshed IMTP for 2015/18. The IMTP 2015/18 was approved by the Board for submission to Welsh Government for further discussion at the end of March 2015, in accordance with the statutory duty under the National Health Service Finance (Wales) Act 2014. Since then feedback has been received from the Welsh Government and further work has been undertaken to set out how we will meet national and local priorities within a balanced financial envelope.

In enacting the risk appetite of the organisation, the Board has given consideration to its principle objectives, both strategic and operational, and identified the principal risks that may threaten the achievement of those objectives. In doing so, the Board is aware that the process involves managing potential principal risks and not merely being reactive in the event of any risk exposure. It acknowledges that the modernisation of delivery of health care services cannot be achieved without risks being taken, the subsequent consequences of taking those risks and mitigating actions to manage any such risks. The risk management arrangements in place enable the principal risks to be identified whilst also ensuring that these risks are not considered in isolation as they are derived from the prioritisation of all risks flowing through the organisation.

x) **Corporate Governance**

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 transposes to 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.

The Health Board assessment of compliance with the Code of Corporate Governance is informed by:

- a. The Board review of performance against the NHS Wales *Governance & Accountability Module*;
- b. The outcome of the Wales Audit Office Structured Assessment;
- c. The Internal Audit In-Year Review of Governance Arrangements, which reviewed the role of the Board, Board effectiveness, and risk management, and derived a Reasonable level of assurance.

The Health Board is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. The Board recognises that not all reporting elements of the Code are outlined in this Governance Statement but are reported more fully in the Health Board's wider Annual Report.

We use *Doing Well, Doing Better: Standards for Health Services in Wales* as our framework for gaining assurance on its ability to fulfil its aims and objectives for the delivery of safe, high quality health services. During 2014/15 the senior leadership teams of directorates and localities were required to attend scrutiny panels which reviewed their progress against all the standards. A revised system of scrutiny enabled directorates/localities to feedback on the standards from an outcome and improvement perspective. Panels were held from December 2014 to March 2015 (with an additional panel in May 2015). The outcomes are reported to the Quality & Safety Committee. The Chief Executive and Executive Director Team also attend a scrutiny panel in April 2015. The 2014/15, scrutiny panels were framed around the three key themes set out in the *Governance and Accountability Module* issued by Welsh Government, namely:

Setting the Direction:

- Is your locality/directorate clear about its purpose and role, its direction and how it meets the needs of your user community?
- Are you good at listening to your users and partners, and responding to what they say?
- Does locality/directorate have a strong value base?

Enabling Delivery:

- Does the organisation have the right people, with the right skills, using the right equipment, in the right environment, and using the right information to do the right things in the right way to deliver high quality, safe services?

Delivering Results, Achieving Excellence:

- Is your locality/directorate performing well?
- Do you know where its strengths and weaknesses lie?
- Do you ensure areas of weakness are proactively identified for development, is action taken and do improvements follow?
- Do you learn from your own and others experiences and do you share that learning with others?

The interim process was adopted to reinforce the fact that self-assessment against the Standards, should focus on outcomes and that where possible outcome measures already collected and included in directorate and locality performance reports should be used to evidence compliance.

The scrutiny panel for 2014/15 comprised the Chair of the Quality and Safety Committee and Chair of the Audit Committee along with the Director of Nursing and Patient Experience. The Head of Internal Audit or her Deputy attended in the capacity of observer.

The scrutiny panel members considered the new approach to be robust and fit for purpose and enabled the panel to gain a much better understanding of how well the Standards were embedded and the level of compliance with the standards throughout the organisation. They found standards were still not fully embedded into routine governance and performance management arrangements and that Directorates/Localities tended to assess themselves on the basis of actions rather than outcomes.

As part of this process, the Board has completed the *Governance and Accountability Assessment Module* and has openly assessed its performance using the maturity matrix.

Noting that the current Standards are being replaced in 2015/16 by new Health & Care Standards, it was acknowledged that the 2014/15 process was an interim one. We have plans in place to improve the way in which use of the new Standards becomes embedded within the service and to align service outcomes to Standard measures; Internal Audit support this plan of action.

Abertawe Bro Morgannwg University Health Board					
Governance & Accountability Module	does not yet have a clear, agreed understanding of where they are (or how they are doing) and what / where they need to improve.	are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	are developing plans and processes and can demonstrate progress with some of their key areas for improvement.	have well developed plans and processes and can demonstrate sustainable improvement throughout the organisation / business.	can demonstrate sustained good practice and innovation that is shared throughout the organisation/ business, and which others can learn from.
Setting the Direction				X	
Enabling Delivery			X		
Delivering results achieving excellence			X		
Overall Maturity Level			X		

The score for 'Setting the Direction' has increased during 2014/15 as the board considered it had shown evidence of a sustained commitment citing as examples:

- Values and behaviour framework
- Quality Strategy
- Western Bay programme
- South Wales programme

Following the Board assessment an improvement plan has been developed, aligned to the IMTP.

Other control framework elements

1. Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with. The Health Board has a Strategic Equality Plan 2012-2016 that sets out our equality objectives to ensure that everyone is treated fairly. We report annually on progress against the objectives. Assurance is provided to the Health Board through the Workforce and Organisational Development Committee.
2. Any breaches in Standing Orders are reported to the Audit Committee. There was one breach reported in 2014/15 which related to an authorisation of payment for a legal claim which was not completed in-line with procedures. The staff concerned have been made aware of their error and a revised template to request such authorisations is now in place.
3. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained

within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the scheme rules and that member's records are accurately updated in accordance with regulation rules.

4. In accordance with emergency preparedness and civil contingency requirements (as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with), we have contingency plans for extreme weather conditions. We have also secured ISO14001 accreditation for our environmental management systems and through our Strategic Environmental Management Group (which formally reported to the Audit Committee but as of March 2015 now reports to the Strategy, Planning and Commissioning Committee) have plans in place to reduce our carbon footprint by reducing energy consumption. With the exception of vehicle usage, these plans address scopes 1 and 2 of the Green House Gas Protocol (as set by World Resources Institute and World Business Council on Sustainable Development).

Scope 1 - Direct emissions are emissions from sources that are owned or controlled by the company. For example, emissions from combustion in owned or controlled boilers, furnaces and vehicles carbon footprint through reducing its energy consumption.

Scope 2 - Accounts for emissions from the generation of purchased electricity.

5. New buildings are designed to be energy efficient, complying with the energy standards for new buildings and where cost effective energy saving systems are installed on new builds.
6. In respect of significant data security lapses in 2014/15, there were three separate instances where facsimile transmissions were erroneously sent (misdialling) by three different departments to the same external agency. This matter was reported to the Information Commissioner's Office who investigated and concluded that no further action was necessary as we had put in place an action plan to increase the security of the information.
7. In reviewing governance arrangements as outlined earlier in this statement and taking into account its assessment against the *Governance & Accountability Module*, the Health Board is clear that it is operating in accordance with the Corporate Governance Code and that there have been no departures from the Code.
8. The Welsh Government has issued Non-Statutory Instruments and reintroduced Welsh Health Circulars in 2014/15. Details of these and a record of any ministerial directions given is available at :
<http://wales.gov.uk/legislation/subordinate/nonsi/nhswales/2013/?lang=en>

4. Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

Work has continued to improve the performance information provided to the Board and its Committees so that the Board can be assured on the accuracy and reliability of the information it receives as well as ensuring this is focussed on the achievement of organisational objectives. An Annual Report on data quality was considered by the Quality and Safety Committee in August 2014. This sets out levels of compliance with data quality and the actions required to continually improve performance.

As part of its revised committee arrangements the Board has established a Performance Committee in late 2014/15 and its work programme for 2015/16 includes a review of the Board's performance management framework and data quality.

The Board, functioning as a corporate decision making body, has regularly considered assurance reports, whilst also receiving updates on key issues. Full details of board reporting are set out in Section 1. The Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is primarily supported in this role by the work of the Audit Committee and the Quality & Safety Committee (details around the role of the latter are set out on page 11).

a) Audit Committee

The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. It undertakes these duties by providing advice and assurance to the Board on the effectiveness of arrangements in place around strategic governance, assurance framework and processes for risk management and internal control. The Committee independently monitors, reviews and reports to the Board on the processes of governance and where appropriate, facilitates and supports the attainment of effective processes. In discharging its duties, the Audit Committee, working to an agreed annual work programme, reviewed the assurance and prepared an Annual Report highlighting the following areas:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- Adequacy of disclosure statements which are supported by the Head of Internal Audit Opinion and other opinions;
- The adequacy of relevant policies, legality issues and the Codes of Conduct, underpinned by review of the Health Board's Hospitality Register and Single Tender Actions summary;
- The policies and procedures related to fraud and corruption, together with information on particular cases and outcomes;

- That the system for risk management is robust in identifying and mitigating risks, providing assurance to the Board that the risks impacting on the delivery of the Health Board's objectives are being appropriately managed.

In providing the above assurance to the Board, the Audit Committee has specifically:

- Approved risk-based Internal Audit plans and considered the opinions given on reports with Executive/Assistant Directors held to account where appropriate;
- Considered the Head of internal Audit Opinion for 2014/15 on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
- Discussed and approved for recommendation to the Board, the Health Board's audited financial statements and Auditor General's Opinion;
- Reviewed and approved the Health Board's governance framework, including Standing Orders, Standing Financial Instructions and Scheme of Delegation.

b) External / Independent Assurance

In order to fully discharge its responsibilities the Board draws on a wide range of information sources to assure itself of the quality and safety of the services the Health Board provides and commissions. Such information sources includes outcome data, performance against local and national targets, clinical and internal audit reports, internal spot checks and 15 Step Challenge visits and the findings of external regulators and inspectorates such as Medicines and Healthcare Products Regulatory Agency and Health Care Inspectorate Wales.

Underpinning assurance arrangements facilitate and support the assessment and addressing of quality and safety issues at a local level and appropriate escalation and highlight reporting. They provide assurance to the Board that those delivering and leading services understand what good looks like, that the right measures and indicators are in place to ensure the timely identification of issues that require addressing as well as to measure progress, those leading services address issues in a timely, open and appropriate manners, escalating concerns and reporting progress as and where necessary.

During the year Healthcare Inspectorate Wales (HIW) undertook a number of unannounced Dignity and Essential Care visits and unannounced Mental Health and Learning Disability visits to hospitals across the Health Board. While each visit report highlighted areas for further improvement, with exception of the report on Cefn Coed Hospital, the feedback from HIW was generally positive. However, HIW's unannounced Mental Health and Learning Disability visit to Cefn Coed hospital in November 2014, raised some concerning issues in relation to the Health Board's quality and safety arrangements and audit processes.

The Health Board responded immediately to address the shortcomings identified at Cefn Coed hospital and improvement plans focus on addressing the key findings from each inspection; these have been submitted to HIW in line with the required deadlines. The action plans clearly state when and how the findings identified will be addressed and set out clear timescales for implementation of the agreed actions. All issues reported by HIW have been reported to the Quality and Safety Committee.

Should there be any areas of concern the Committee seeks an update on action within a defined period.

■ **Internal Audit and Assurance**

The service provided from Internal Audit has been enhanced through the introduction of an Internal Audit Charter setting out the purpose, authority and responsibility of Internal Audit. The role of Internal Audit is to provide an independent and objective opinion on the system of control. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Board's objectives. The work of Internal Audit is undertaken in compliance with the Public Sector Internal Audit Standards, with the annual audit programme based on the outcomes from an audit risk assessment matrix.

The Audit Committee has received progress reports against delivery of the plan at each meeting with individual assignment reports also being received. Internal Audit reports the findings of its work to management, and action plans are agreed to address any identified weaknesses. The outcome of each audit, providing an overall conclusion on the adequacy and application on internal controls for each area under review was considered by the Committee. Where appropriate, Executive Directors or other officers of the Health Board have been requested to attend in order to be held to account. The assessment on adequacy and application of internal control measures can range from "No Assurance" through to "Substantial Assurance". A schedule tracking the implementation of all agreed audit recommendations is also provided to the Committee.

■ **Wales Audit Office (WAO)**

The Wales Audit Office scrutinises the Health Board's financial systems and processes, performance management, key risk areas and the Internal Audit function on behalf of the Auditor General for Wales, the Health Board's external auditor. The WAO undertake financial and performance audit work specific to the Health Board and also provide information on the Auditor General's programme of national value for money examinations which impact on the Health Board, with best practice being shared. During the year, WAO undertook the Structured Assessment review. This was reported to the Board in March 2015.

This concluded that: "Arrangements which support good governance, quality assurance and the efficient, effective and economical use of resources continue to evolve, but further improvement is needed in some important aspects and achieving financial balance for 2014-15 remains a major challenge".

It also set out the challenges facing the Board: "The Health Board continues to control budgets and monitor savings plan effectively but the scale of savings required over the next three years raises significant financial risks to the financial position and services. The Board has set a clear vision and is promoting a quality culture. There have been improvements to governance arrangements and in the management of concerns but further improvements are needed to strengthen important aspects of quality governance, build organisational capacity and fully embed organisational learning. Whilst performance work has identified some examples of good practice, there are opportunities to secure better use of resources in a number of key areas".

The findings and appropriate actions have been incorporated into the IMTP 2015-2018. The IMTP is the subject of ongoing dialogue with the Welsh Government and has yet to be approved by the Minister.

5. Internal Audit

Internal audit provide me as Accountable Officer and the Board mainly through the Audit Committee and Quality & Safety Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with Public Sector Internal Audit Standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit has concluded:

“In my opinion the Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Several significant matters require management attention with moderate impact on residual risk exposure until resolved.

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

In overall terms we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- *Financial Governance and management*
- *Operational services and functional management*
- *Capital and estates management*

More specifically we give substantial assurance on the internal financial controls operating within the health board and shared services and these findings have been taken into account by WAO in the external audit of the financial statements.

However the significance of the matters raised in those areas where there are clearly improvements to be made in governance, risk management and control impacts upon our overall audit assessment in the following assurance domains:

- *Corporate governance, risk management and regulatory compliance*
- *Strategic planning, performance management and reporting*

- *Clinical governance quality and safety*
- *Information governance and security*
- *Workforce management*

During the year internal audit issued the following audit report with a conclusion of 'of 'no assurance':

Clinical governance quality and safety:

- World Health Organisation (WHO) checklist (although this received a rating of 'limited assurance' when the audit was subject to a follow-up review).

The following reports received a conclusion of 'limited assurance'

Clinical governance quality and safety:

- WHO checklist follow-up
- Clinical Governance Framework
- Infection Control
- Infection Control follow-up
- Clinical Audit follow-up
- Learning Lessons follow-up
- Funded Placements
- Complaints, Incidents and Redress

Corporate governance, risk and regulatory:

- Standards for Healthcare Services in Wales
- Health and Safety follow-up
- Fire Safety follow-up
- Legionella

Strategic planning, performance management and reporting:

- IMTP

Information governance and security:

- Data Quality - care metrics follow-up
- Data Quality – Emergency department waiting times at Morriston Hospital
- Mortality Reviews

Operational service and functional management:

- Informatics Directorate – Out patient department
- Workforce Directorate – Well being through work
- Mental Health Directorate

Workforce management:

- Medical Appraisal to support revalidation
- Staff Personal Development Reviews (PDR)
- Management of Nurse Rostering/Resource

Capital and estates management:

- Health Vision Swansea (HVS) phase 1B Scheme

Detailed action plans have been agreed to improve performance in all these areas and this will be monitored through the Audit Committee, with follow up Internal Audit reviews undertaken where necessary.

6. Review of Economy, Efficiency and Effectiveness on the Use of Resources

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 responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) will take place at the end of 2016/17, being the first 3 year period of assessment

Subject to audit, the Health Board has achieved the two new financial duties. From 1st April 2014 the Health Board has a statutory duty to:

- Ensure that its expenditure does not exceed the aggregate funding allotted to it over a 3 year period. 2014/15 is Year 1 of the 3 year period and the Health Board has reported an under-spend of £0.099m against its Revenue Resource Performance, and an under-spend of £0.083m against its Capital Resource Performance; and
- Prepare a plan in accordance with the planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 of the NHS (Wales) Act, while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

We achieved this financial duty since:

- ABMU submitted an IMTP for the period 2014/15 – 2016/17 in accordance with the directions;
- The Minister for Health and Social Services approved the Plan
- The Health Board met its statutory duty under section 175 (2A) of the NHS (Wales) Act 2006

There is also a further Welsh Government administrative target the aim of which is to pay 95% of the number of non-NHS creditors within 30 days of delivery. Subject to audit, the Health Board achieved 91.5% against this target for 2014/15.

7. Conclusion

As Accountable Officer and based on the review process outlined above I have reviewed the relevant evidence and assurances in respect of internal control. The Board and its Executive Directors are alert to their accountabilities in respect of internal control. The Board has had in place during the year a system of providing assurance aligned to both the corporate objectives and the Standards for Health Services in Wales to assist with the identification and management of risk.

A major focus during the year was the Board's response to *Trusted to Care*. This resulted in the Health Board being placed under 'enhanced monitoring' arising from the joint *Escalation and Intervention Framework* reflecting the active engagement required to monitor the extent to which the issues identified by the review were being addressed.

Key improvements put into place include:

- The development of a Quality Strategy
- A values and behaviour framework
- Standards for the frail elderly
- Substantial improvement in the management of complaints.

Professor Andrews is due to undertake a re-review in the summer of 2015.

The IMTP for 2014/17 is an integrated plan, incorporating the Quality Delivery, Workforce and Financial Plans in order to continue to meet the strategic aims of the Board. This was approved by Welsh Government in June 2014 and provided a basis for planning during the year. The IMTP for 2015-18 is the subject of ongoing dialogue with the Welsh Government and has yet to be approved by the Minister.

My review confirms that the Board has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and through the Internal Audit work programme. Internal Audits identified areas requiring action to strengthen systems and processes as listed on pages 27-29.

Detailed action plans have been agreed to improve performance in all these areas and this will be monitored through the Audit Committee, with follow up internal audits undertaken where necessary.

Signed by:

(Chief Executive)

Date:

Appendix 1. (AGS 2014/15)

Board/Committee	Dates of meetings in 2014/15						
Board	22 nd May 2014	3 rd June 2014	31 st July 2014	25 th September 2014 (inc. AGM)	27 th November 2014	29 th January 2015	26 th March 2015
Audit	17 th April 2014	15 th May 2014 & 3 rd June 2014	28 th July 2014	18 th September 2014	20 th November 2014	19 th February 2015	19 th March 2015
Charitable Funds	12 th June 2014	11 th September 2014	16 th December 2014	10 th March 2015			
Quality & Safety	1 st May 2014	19 th June 2014	14 th August 2014	23 rd October 2014	4 th December 2014	12 th February 2015	
Mental Health Legislative	20 th May 2014	19 th August 2014	18 th November 2014	24 th February 2015			
Workforce & Organisational Development	19 th November 2014	16 th February 2015					
Remuneration & Terms of Service	22 nd May 2014	31 st July 2014	30 th October 2014	18 th December 2014	26 th February 2015		
*Performance	30 th October 2014	20 th January 2015					
* Strategy, Planning & Commissioning	11 th November 2014	22 nd January 2015	9 th March 2015				

Membership of committees was reviewed during the summer of 2014 and new membership arrangements became effective as of October 2014.

*New committee

Name (& champion role)	Position & Area of Expertise	Health Board (8 inc AGM)	Q&S (6)	Audit (8)	W&OD (2)	RATS (6)	Perform (2)	Strat (3)	SRG (3)	P' ship (5)	MHLC (4)	HMPDOD* (2)	CFC (4)	HPF
Andrew Davies	(Chair) Independent Member	8				6		3						
Edward Roberts	(Vice-Chair) Independent Member (Mental Health)	8	4			6					4	1	2	
Paul Newman	Independent Member (Legal)	8	6			5					2	1	2	
Chantal Patel	Independent Member (Community)	8	4		1						3	1		
Ceri Phillips	Independent Member (University)	8	5				2	3						
Charles Janczewski	Independent Member (Finance)	8	4	7		6							4	

Name	Position	Health Board (8 inc. AGM)	Q&S (6)	Audit (8)	W&OD (2)	RATS (5)	Perform (2)	Strat (3)	SRG (3)	P' ship (5)	MHLC (4)	HMPO D* (2)	CFC (4)	HPF
Melvyn Nott	Independent Member (Local Authority)	7		5	1									
Gaynor Richards	Independent Member (Third Sector)	4			2	2							1	
Michael Williams	Independent Member (Capital/Estates)	8		7				1					2	
Barry Goldberg	Independent Member (Information, Communications & Technology)	8		7		4	2					1		
Sandra Miller	Independent Member (Trade Union)	6		4	2		2			3	1	1		

Name	Position	Health Board (8 inc. AGM)	Q&S (6)	Audit (8)	W&OD (2)	RATS (5)	Perform (2)	Strat (3)	SRG (3)	P'ship (5)	MHLC (4)	HMPOD* (2)	CFC (4)	HPF
Rhian Evans/ Maggie Berry	Associate Member	4							3					
Sue Cooper	Associate Member	4												
Alan Stevenson	Associate Member	5												2
Paul Stauber (until February 2015)	Associate Member	5					2							
Paul Roberts	Chief Executive	8				3		3						
Alexandra Howells	Chief Operating Officer	8					2			1				
Eifion Williams	Director of Finance	7		7			2			4			4	
Hamish Laing	Medical Director	6	5				2							1
Rory Farrelly (from June 2014)	Director of Nursing & Patient Experience	4	5	2	1				3	2			0	2
Siân Harrop-Griffiths (from November 2015)	Director of Strategy	3					1	3	1					

[illegible]

Key to Acronyms:	
W&OD = Workforce & Organisational Development Committee	Partnership = Local Partnership Forum
Q & S = Quality & Safety Committee	RATS = Remuneration & Terms of Service Committee
MHAC = Mental Health Manager's Committee	CFC = Charitable Funds Committee
Perform = Performance Committee	Strat = Strategy, Planning & Commissioning Committee
HPF = Health Professionals Forum	HMPOD* = Health Managers Power of Discharge Committee (ceased to be a Board Committee as of October 2014)
AGM= Annual General Meeting	

The Health Board also operates a Pharmaceutical Applications Committee the chairmanship of which alternates between Ed Roberts, Charles Janczewski and Paul Newman and meets on an ad hoc basis when Pharmacy Applications need to be considered. It also reports its meetings to the Health Board.