1. **Scope of Responsibility**

ABMU health Board was formed on 1st October 2009 and serves a population of approximately 500,000 people. In 2015/16 it had a budget of £1.2 billion employing 15,761 members of staff, 70% of who are involved in direct patient care.

The Board has adopted the following six strategic aims:

- Excellent Patient Outcomes;
- Healthier Communities
- Fully Engaged & Skilled Workforce
- Sustainable & Accessible Services;
- Strong Partnerships; and
- Effective Governance

We recognise that successful delivery of these is underpinned by the modernisation and redesign of services. This in turn requires us to engage with patients, carers and families to ensure that any proposals reflect the needs of all individuals who either use or engage with our services. In 2015/16 we continued to build on our engagement activities to incorporate these critical views in our plans. Examples of how we did this will be set out in our annual report due to be published on our website [www.abm.wales.nhs.uk](http://www.abm.wales.nhs.uk) in September 2016.

ABMU’s 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. This is supported by the work of Board committees (page 4 – 6 and Appendix 1) and the assessments against the Welsh Government’s *Health and Care Standards* (pages 13, 15-16) for further information about these). This is undertaken within the context of professional standards and regulatory frameworks.
One of the key pieces of work taken forward in 2015/16 was the implementation of our Values and Behaviour Framework which was approved by the Board in January 2015.

Our values are:

- **Caring for each other** - *in every human contact in all of our communities and each of our hospitals.*
- **Working together** - *as patients, families, carers, staff and communities so that we always put patients first*
- **Always improving** - *so that we are at our best for every patient and for each other.*

Following the launch of the *Values* we started a programme of embedding them led by our *Values Programme Board* chaired by ABMU’s Chairman, Andrew Davies. This reports directly to the Board with the role of ensuring effective delivery of the programme objectives and bringing synergy between the values delivery plans and other organisational priorities.

The Board also 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 prudent healthcare in which patients and users feel cared for, safe and confident.*

During 2015/16 we also developed our second *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 process for Welsh health organisations requires a three year forward looking plan to be developed each year, which are then refreshed on an annual basis. In order to ensure that the plans are as comprehensive as possible, each year’s refresh is updated in terms of policy changes, target changes and or where planned trajectories have been revised.

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 a matter for the Board and its committees.

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 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.

2. 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. Details of when the Board met during 2015/16 and its Board members are set out in Appendix 1 along with the level of attendance at such meetings.

There are also usually three associate independent members who sit on the Board, although in 2015/16, ABMU operated with two for much of the year. This was due to the third associate member (who is also the Chair of the Health Professionals Forum) completing their term of office. Arrangements are in place to seek a replacement during the Spring/Summer of 2016.

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. Each Board meeting begins with a patient story which sets out an individual's personal experience of the service. Such feedback is invaluable and is used to learn lessons, further improve services and is channelled into the future planning of services.
3. Committees of the Board
The Board has the following committees:

- Audit Committee
- Quality & Safety Committee
- Workforce & Organisational Development Committee
- Remuneration & Terms of Service Committee
- Strategy Planning & Commissioning Committee
- Performance Committee
- Charitable Funds Committee
- Mental Health & Learning Disabilities Legislative Committee.

Dates when these committees met and their membership and attendance levels are set out at Appendix 1.

Board committees are chaired by independent board members and 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.

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 committee 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 in the spring/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 development sessions (at least six a year), service visits and a range of other internal and external meetings. The Board also meets in public in June each year (to formally approve its annual accounts following detailed consideration by the Audit Committee) and September (to approve its annual report, the annual report of the Director of Public Health and the Annual Quality Statement). All these documents are available via www.abm.wales.nhs.uk.

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 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 2015/16 on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes;
- Discussed and approved for recommendation to the Board, ABMU’s audited financial statements and Auditor General’s Opinion;
- Reviewed and approved the ABMU’s Governance Framework, including Standing Orders, Standing Financial Instructions and Scheme of Delegation and the System of Assurance set out in Appendix 2.

A list of key issues considered by the Board (and the Audit Committee and Quality & Safety Committee) during 2015/16 is set out in Appendix 3. Reports received by the Board during the course of the past 12 months and the relevant minutes indicating the resultant action are available at www.abm.wales.nhs.uk.

Three advisory groups also support the Board. 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. The Chair of the SRG is an associate Board member.

- **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 ABMU’s area of activity. The Chair of the HPF is an associate member of the Board.

- **Local Partnership Forum (LPF)**
  The LPF’s role is to provide a formal mechanism whereby AMBU, as the employer, and trade unions/professional bodies representing employees work together to improve health services. 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.

The Board has two other all-Wales ‘joint committees’ as follows, the outputs from which are reported to the Board:

- **Welsh Health Specialised Services Joint Committee (WHSSC)**
  The Chief Executive is the designated representative for ABMU and attended three of five meetings during 2015/16.

- **The Emergency Ambulance Services Joint Committee**
  ABMU is also represented by the Chief Executive who attended three of its five meetings in 2015/16.

  The Board is also represented on the all-Wales Shared Services Partnership Committee. The Director of Finance is the ABMU representative and during 2015/16 he nominated a deputy to attend four of five meetings.

The Health Board works in partnership with a number of organisations including:

- Local Authorities, mainly through Western Bay
- Swansea University, through the Collaboration Board
- A Regional Collaboration for Health (ARCH)
- The NHS Collaborative and Acute Care Alliances
Some of these arrangements are still developing and some will change as a result of the Health, Social Care and Well-Being Act and Future Generations Act. Areas of partnership working are reported directly to the Board.

4. **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 ABMU’s business conduct 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*.

In order to ensure that the values and behaviours drive a caring, supportive and ambitious culture within the organisation, the Board decided that we needed to change our operational management arrangements. This was part of a review of governance arrangements. The changes aimed to:

- Simplify our operational management structures – shorter lines of communication between senior management and front-line staff;
- Accelerate progress on development of new models of care at primary and community level rather than continuing to operate a secondary care focused service;
- Base care delivery on how patients experience our services – putting the patient at the heart of what we do;
- Bring clarity about who is responsible and accountable at all levels and on all sites so that there is more local ownership and clinical engagement; and
- Provide a better framework for joined-up working about service improvement, major operational challenges and performance issues.

This resulted in a proposal to change our operational management arrangements which was subject to consultation with staff in January and February 2015. Our previous structure of 13 Directorates/Localities were then replaced with six delivery units which came into being in interim form in October 2015:

- Neath Port Talbot Hospital
- Mental Health & Learning Disability Services
- Morriston Hospital
- Princess of Wales Hospital
- Singleton Hospital
- Primary Care and Community Services

Each delivery unit is lead by a core ‘triumvirate’. This triumverant consists of the Service Director, Unit Medical Director and Unit Executive Director and at the end of March 2016 the majority of these appointments had been made. Transitional
arrangements were put into place whilst the implementation of the complete management structure is being established. It is anticipated that this will be concluded by the autumn of 2016.

5. Governance & Assurance Arrangements
We are continuing to develop and embed policies and procedures in the organisation to enable successful delivery of its governance and assurance arrangements. During the year a review of current assurance arrangements was undertaken and an assurance map was produced (Appendix 2) and agreed by the Audit Committee.

The Board along with its internal sources of assurance 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 which examines the arrangements that support good governance and the efficient, effective and economical use of resources. As in previous years, the work in 2015 assessed the robustness of the financial management arrangements, the adequacy of its governance arrangements and the management of key enablers that support effective use of resources. The outcome of the assessment was received by the Board in March 2016 along with the Annual Audit Letter which was presented to the Board at the same meeting and both are publicly available at on the WAO website at: http://www.wao.gov.uk/

The outcome of the Structured Assessment is used by the organisation to further inform our improvement planning and the embedding of effective governance.

We have 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. Systems are monitored through the Audit Committee in terms of the tracking of audit recommendations and the agreed management actions arising from them. 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 Board has also undertaken HIW’s annual Governance and Accountability Module Self-Assessment for 2015/2016 and the outcome of this assessment undertaken by Board members on 28th April 2016 (page 20-21).

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.

<table>
<thead>
<tr>
<th>Area for Assessment</th>
<th>2014/15 Scores</th>
<th>2015/15 Scores</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns Structure</td>
<td>-</td>
<td>91.5%</td>
<td>-</td>
</tr>
<tr>
<td>Concerns Management</td>
<td>-</td>
<td>66.28%</td>
<td>-</td>
</tr>
<tr>
<td>Concerns – Informal</td>
<td>-</td>
<td>70.25%</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care Concerns</td>
<td>-</td>
<td>68.5%</td>
<td>-</td>
</tr>
<tr>
<td>Redress</td>
<td>-</td>
<td>74.13%</td>
<td>-</td>
</tr>
<tr>
<td>Compensation Claims Management</td>
<td>84.43%</td>
<td>95.43%</td>
<td>+11%</td>
</tr>
<tr>
<td>Learning from Events</td>
<td>48.25%</td>
<td>49.91%</td>
<td>+1.66%</td>
</tr>
</tbody>
</table>

The assessment in 2015/16 was revised and as a result direct comparison is only applicable in two areas; compensation claims management and learning from events.

ABMU has Standing Orders which are regularly reviewed which regulate 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 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.
6. **The Purpose of the System of Internal Control**

Our systems of internal control are 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 31st March 2016 and, up to the date of approval of the annual report and accounts.

7. **Capacity to Handle Risk**

We have continued to develop and embed our approach to risk management over the last year to ensure risk systems continue to be streamlined and inter-connected. The 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 with the executive lead for risk management being the Director of Nursing & Patient Experience. They have delegated responsibility for ensuring that arrangements are in place to effectively assess and manage risks across the organisation including maintaining and co-ordinating a ‘Corporate Risk Register’ and the corporate reporting of risks.

During 2015/16, the Director of Nursing & Patient Experience led on the review of our Risk Strategy which was subsequently approved by the Board at its meeting in March 2016. The Strategy will be subject to a further review in 2016/17 to reflect the revised operational management arrangements in place.

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 Welsh Government’s Delivery Unit.

a) **ABMU’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 documented within ABMU’s ‘Corporate Risk Register’. This was most recently received by the Board at its March 2016 meeting and is
updated quarterly. Risk Registers are used to identify and manage significant risks within an organisation. 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, regularly reviewed by the Audit Committee most recently in March 2016. The document will be kept under regular review in 2016/17 to ensure it reflects any changed arrangements as a result of the operational management restructuring. During 2015/16 serious risks have been identified from the register and in March 2016 contained risks linked to the ABMU's objectives (aims and priorities) and included within ABMU's IMTP for 2015/18 (page 19).

Achieving financial balance was a high risk for the organisation until the fourth quarter when the risk decreased and was moderate. Subject to audit, the draft financial position shows an £0.086m under-spend against its resource limit at year-end. The risk of financial balance at the start of 2016/17 remains a moderate risk and is linked to the organisation's IMTP.

At the end of March 2016 there were a number of continuing risks set out in the risk register the main issues are highlighted below:

- **Unscheduled Care Tier 1 target (Risk Ref 1) linked to Health Board Objectives Excellent Patient Outcomes & Experience and Sustainable & Accessible Services**
  The performance and improvement actions identified have previously been submitted to the Quality & Safety Committee and are summarised in the Register. The committee receives regular progress updates on unscheduled care. This risk was increased from risk level 20 to 25 by the Executive Team in the first quarter of 2015/16 and the level of risk remains the same for the second, third and fourth quarter.
Workforce planning and ensuring appropriate levels of skilled staff are in place within the Health Board (Risk Ref 3) linked to the Health Board's objective Sustainable & Accessible Services
The controls in place and actions being taken to decrease the risk are provided within the entry on the Corporate Risk Register for the risk identified. The risk ranged from 16 to 20 during the year and is currently assessed as 16.

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 two key risks set out above, the following issues were also considered a significant concern during 2015/16:

- Financial Risk (risk level 16)
- Infection Prevention and Control (risk level 16)
- Clinical Information Systems (risk level 16)

It is recognised that further work in these areas is required to reduce the risk further and detailed action plans are in place to support this work. The risks and controls in place and planned actions are set out in the 'Corporate Risk Register'.

b) Management of Risk
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 healthcare 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 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. 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.

We manage 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 and managing significant risks through regular, timely and accurate reports to the executive team, relevant Board committees and the Board itself.
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 ABMU policies, legislation and regulations and professional standards for their functions.

Executive directors consider, evaluate and address risk and actively engage with and report such matters to the Board and its committees. They are supported in these duties by assistant directors, delivery unit triumvirate. 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 the Healthcare Standards framework 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.

Service delivery unit directors are responsible for the management of risk within their Units and must ensure that they have effective arrangements to carry this out. Any risks outside their control are communicated to the Chief Operating Officer. Professional issues are relayed to the relevant executive lead e.g. Medical Director and Director of Nursing & Patient Experience.

Transitional arrangements have ensured business continuity during the transition to new management structures and the establishment of revised governance arrangements within the six delivery units. These are supported by legacy statements from the previous directorate/locality structures so that key issues and risks are managed. Units have also undertaken a self-assessment against the Health and Care Standards and have attended the ABMU Health and Care Scrutiny Panel to discuss performance. Finally, each unit has attended an end-of-year Performance Review with the Executive Team, chaired by the Chief Executive to discuss performance and governance arrangements. Each unit is developing structures to ensure the appropriate management of risk which has been confirmed within their mid-year and end-of-year performance reviews.
c) Risk Management Training

There are two levels of risk management training available within ABMU - Level 1; and Level 2. 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 where risks cannot be eliminated.

Performance against risk management training is reported to and monitored by the Assurance & Learning Group and Audit Committee on a quarterly basis. A three-year training programme, delivering level 2 training, in April 2013 concluding in March 2016 with 94% of the target of staff identified as requiring training being met.

A revised training programme commenced in March 2016 based on the training requirements in line with the new management structures which will be reviewed at regular periods as the new operational management structures mature.

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.

Examples of how we engaged with the public in terms risk areas are as follows:

- Changing for the Better – considerable engagement recognised by Welsh Government as good practice;
- Patient Surveys;*
- Engagement on service delivery;
- The Internet;
- Information Screens;
- Care Pathways;
- Concerns (Service Experience)
*these included ‘iwantgreatcare’ and the use of the SNAP 11 which enable us to gather feedback from patients about their impression of the care and treatment they received.
8. **Quality Governance Arrangements**

Around 18 months ago we developed our Quality Strategy which this gives a clear direction to everyone who works for, or on behalf of, ABMU and emphasises the importance we place on quality and the experiences of our patients. It sets out a vision of what we can, and will achieve through a focus on delivering high quality services by addressing those matters that will contribute to the achievement of the following strategic 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.

Progress in terms of the strategy is reported to the Quality & Safety Committee. Amongst the quality priorities identified for 2015/16 on which have been delivered are:

- Improving the way we collect and use Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs).
- Further developing our stroke services by reconfiguring the patient pathway.
- Improving the way we identify and manage a patient whose condition deteriorates by spreading across all hospitals and wards the 'spotting the sick patient' initiative.
- Improving end of life care by implementing the new all-Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).
- Reducing medication errors by implementing electronic prescribing and administration (EMPA).
- Spreading the 'Big Fight' campaign – Targeting *Clostridium difficile* infection and antibiotic resistance in primary care.

Our Quality & Safety Committee met six times during 2015/16. 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 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.
Reports submitted to the committee are available at the following link: www.abmu.Wales.nhs.uk/sitesplus/863/page/75780.

The committee is supported by the Health and Care Standards 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.

A summary of key reports considered by the committee during 2015/16 is set out in Appendix 3. These are received from a broad range of specialist groups such as the Effective Practice Approval Committee, Infection Control Committee, Decontamination Committee and Medical Exposure Committee. Each meeting begins with a patient story and presentation on governance and performance management arrangements from a service delivery unit team.

Key items regularly reported to the committee include:

i. **Performance Reports** – in terms of quality and safety this is triangulated through a Quality & Safety Dashboard which is presented to the committee at each meeting. It contains a number of key measures such as:

   - never events
   - medicines management, nutrition, hydration, continence
   - discharge summaries
   - National Early Warning System (NEWS) reporting

ii. **The Older Persons Dashboard** – which contains measures related to the Older Persons Standards such as pain control, dignity and respect, assessment of anxiety, depression and continence. The Older Persons Standards are displayed throughout the organisation and the training and education programme for the frail elderly continues. We have worked closely with the Older Person’s Commissioner in the development of the dashboard.

iii. **Assurance Mechanisms - Ward to Board** assurance is a key requirement and our service delivery units are developing frameworks that will complement an approach that is being considered on an All-Wales level. An example of this is the First Friday initiative at Morriston Hospital where the senior team work alongside clinicians on the first Friday of every month undertaking audit and gaining patient and staff feedback using bespoke methodology that is linked to the Health and Care Standards. In addition to this, a programme of peer review

16
spot-checks have been carried out both inside and outside normal working hours.

We have systems in place which facilitate non officer members and executive directors to make unplanned visits to service areas as part of our 15 Step Challenge Programme. The methodology considers the following aspects of the clinical care environment to confirm if it was welcoming, safe, staff were caring, well organised and calm. The findings of such reviews are recorded and any required action is taken forward locally and overseen by the respective management team.

The committee also values the reports produced as a result of Internal Audit Reviews which help to ensure that we continue to make improvements in our systems and practices.

Various inspections from external agencies including Health Inspectorate Wales (HIW) and the ABM Community Health Council (CHC) also take place. In particular, HIW wrote to the Chief Executive regarding a follow-up visit to our mental health services on Ward 14 and the Psychiatric Intensive Care Unit (PICU) at the Princess of Wales Hospital as a number of actions relating to staff personal alarms, nurse call systems, allowing patients to make food choices and staff training issues remained outstanding. As a result the Service Director for Mental Health & Learning Disabilities gave a presentation to the committee to provide assurance that action was being taken and further arrangements were set in place to monitor systems by way of our Scrutiny Panel process. The ABM CHC has introduced a system of reporting the findings of their visits to the Quality and Safety Committee which adds valuable information.

iv. **Patient Experience** – such feedback is a key part of the delivery of quality services and ABMU has achieved a great deal in terms of broadening the scale of engagement with both staff and service users. A report is presented to the Quality and Safety Committee at every meeting that outlines feedback gathered from our *Friends and Family* initiative, the all-Wales Patient Experience Framework results, complaints, compliments, incidents, risk management and patient safety alerts.

*Trusted to Care* was the independent review of care at Princess of Wales and Neath Port Talbot Hospitals commissioned by the Minister for Health and Social Services of Welsh Government and published in May 2014. Examples of the work that arose from the review findings were set out in our 2014/15 AGS. The Minister commissioned a follow-up review to check on progress one year on. This was entitled ‘*Trusted to Care - Review 2015*’ and was published by Welsh Government in September 2015. Welsh Government stated that:
'the public can be reassured that care of frail older people in the two hospitals is much improved’ and that ‘the action taken by the Board over the last year has addressed the main issues which had led to unacceptable quality of care and standards of services at the time’.

Work on addressing the recommendations of the Trusted to Care Review 2015 is continuing, led by the service delivery units and relevant executive directors. The Board has continued to receive bi-monthly updates in this respect.

9. Commissioning for Quality
Commissioning is a key element of our strategic approach to planning; ensuring our strategic priorities and clinical services strategy are translated into service change plans. The Board has established six commissioning Boards;

- Cancer
- Children & young people
- Long term conditions
- Planned care
- Unscheduled care and most recently
- Mental Health and Learning Disabilities

These co-chaired forums afford an opportunity for leaders from across clinical and local government sectors to drive forward proposals for change which improve population health, reduce variation and improve quality.

All of the commissioning Boards have agreed commissioning priorities linked to the IMTP. Improvement proposals have been developed in relation to gastric cancer, orthopaedics, child and adolescent mental health services and atrial fibrillation. These have been developed using a highly engaged approach with patients, clinicians and stakeholders with identification of opportunities to improve quality through reallocation of existing resource from lower value to higher value clinical interventions where possible. Further proposals relating to lung cancer, stroke, pain management, breast feeding, diabetes and unscheduled care have all been initiated for inclusion in the 2016/19 IMTP.

A Programme Board oversees progression of all aspects of commissioning within ABMU and provides assurance that the quality of the commissioning approach and our plans for its further development are robust. We have begun to use our systems to support to further develop our understanding of variance, the impact of inequalities and delivery of health outcomes.
The Board has established six commissioning Boards which provide a means by which our strategic priorities and clinical services strategy are translated into service change plans. They lead the development of individual commissioning plans culminating in the production of proposals to create models of care which increase standards of care, meet the needs of the population, improve outcomes, quality and patient experience and eliminate interventions which cause harm or provide no clinical benefit.

Throughout 2016/17 ABMU will continue to work with partner agencies such as the 1000 Lives Delivery Team, the Bevan Commission and the Bevan Commission’s Advisory Board to improve the quality and effectiveness of services that are provided to our patients. We have also 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)**
  We continue to contribute to the growing body of work around Prudent Health Care including Prudent Therapy Provision through walk-in clinics in Podiatry and Physiotherapy. Staff have recently produced a video explaining co-production and providing some local examples.

- **Planned Care(N) - Clinical Priority Areas**
  Our ABMU Eye Care Group has been re-structured into sub-groups to target the key priorities in the National Ophthalmic Implementation Plan building on the work already undertaken as part of the previous *Together for Health – Eye Health Care* action plan.

- **Enhanced Recover after Surgery (ERAS) (L)**
  Our ERAS project manager has continued to work with clinical leaders in the operational delivery units to support enhanced recovery after surgery in line with best practice.

- **Rapid Response to Acute Illness/Sepsis (N) – Identifying the Sick Patient(L)**
  We have developed and completed a successful pilot programme to support the more rapid identification and response to deteriorating patients. This is due to be rolled out across the organisation during 2016/17.

10. **IMTP 2015/18 – 2016/2019**
The IMTP is an integrated plan, incorporating the service, quality, workforce and financial plans along with the risks and assumptions associated with their achievement. Whilst a number of the objectives set out in the IMTP for 2015/16 were met, there were other areas where we faced significant challenges in delivering performance improvement, particularly in terms of meeting Tier 1 targets in respect of unscheduled care. We did however improve planned care waiting times and the 31
day cancer access times. We did however deliver a balanced financial position by 31st March 2016.

Regular IMTP reports were submitted to the Strategy Planning and Commissioning Committee which oversees the strategic direction and development of the IMTP. The Performance Committee also developed a tracking tool during the year which provided a means of assessing performance against the IMTP. Regular reports on the IMTP are also provided to the Board.

We prepared a refreshed IMTP for 2016/19 which was submitted in draft to Welsh Government at the end of January 2016. Since this time feedback has been received from the Welsh Government and further work has been undertaken to describe within the plan how we will meet national and local priorities. As of May 2016, the 2016/19 IMTP has yet to be approved. Discussions are ongoing with Welsh Government.

11. 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. An assessment of compliance with the **Code of Corporate Governance** is informed by:

- The review of performance against the NHS Wales Governance & Accountability Module;
- The outcome of the **Wales Audit Office Structured Assessment**;
- The Internal Audit In-Year Review of Governance Arrangements, which reviews the role of the Board, its effectiveness, and risk management.

The 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 ABMU Annual Report published in September each year.

We use **Health and Care Standards** as our framework for gaining assurance on its ability to fulfil its aims and objectives for the delivery of safe, high quality health services. The current standards came into effect as of April 2015 incorporating the *Standards for Health Services in Wales (2010)* and the *Fundamentals of Care Standards (2003)*. The standards place the person at the centre and emphasise the importance of strong leadership, governance and accountability and form the Welsh Government’s common framework of standards to support the NHS and partner
organisations in providing effective, timely and quality services across all healthcare settings.

Service directors, unit medical directors and unit directors of nursing are collectively responsible for ensuring that the Health and Care Standards are embedded across their particular service delivery unit and they self-assess against each of these including the new Governance, Leadership and Accountability standard to ensure there is effective scrutiny. The ABMU (Health & Care Standards) Scrutiny Panel is comprised of three non officer members (including the chairs of the Audit Committee and Quality & Safety Committee) together with the Director of Nursing and Patient Experience. Panel meetings are framed around the three key themes set out in the Governance and Accountability Module issued by Welsh Government details of which are set out in the following table.

The Board has completed the Governance and Accountability Assessment Module and has openly assessed its performance using the maturity matrix and deliberations included a review of the WAO’s Structured Assessment and a report from the members of the Scrutiny Panel. This Board discussion took place on 28th April 2016 and referenced the individual responses to the following survey:

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

This concluded that the overall maturity level should remain at level three.

In comparing the 2015/16 results with the Governance and Accountability Module Assessment for 2014/15, the category of ‘setting the direction’ had reduced which is
felt to be related to the changes in operational management arrangements having a short-term impact.

Following the Board assessment an improvement plan will be developed, aligned to the IMTP.

14. Other control framework elements

i. Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with. We have a Strategic Equality Plan 2012-2016 that sets out our equality objectives to ensure that everyone is treated fairly. We engaged and consulted with individuals and organisations to review our equality objectives in 2015/16. The feedback was used to refresh our equality objectives together with the strong evidence base within ‘Is Wales Fairer’ (Equality and Human Rights Commission, 2015). Our equality objectives are reflected within our Integrated Medium Term Plan 2016-2019 and support the delivery of its strategic aims. We report annually on progress against the objectives. Assurance is provided to the Board through the Workforce and Organisational Development Committee.

ii. Any breaches in Standing Orders are reported to the Audit Committee. A breach was reported to the Audit Committee in April 2015 relating to November 2014 in relation to a legal claim that was not relayed to the Board for ratification. No further breaches have been reported in the meantime.

iv. 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.

v. 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 Environment Committee, (chaired by ABMU’s Chairman and attended by the Director of Strategy) which reports to the Board through the Strategy, Planning and Commissioning Committee. This committee oversees ABMU’s long-term carbon reduction strategy which is set to align with the objectives determined within the Environmental (Wales) Act 2016 and the Well-being of Future Generations Act 2015.
vi. We have also secured ISO14001 accreditation for our environmental management systems and through our Strategic Environmental Management Group (which reports to the Strategy, Planning and Commissioning Committee) has 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.

   a. **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.

   b. **Scope 2** – Accounts for emissions from the generation of purchased electricity.

vii. 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.

viii. In respect of significant data security lapses in 2015/16 There have been two significant incidents reported and both have warranted notifying the Information Commissioner’s Office (ICO).

   a. Medical records were sent to a patient following a Subject Access Request (SAR). The envelope was wrongly addressed. The documents were recovered and redelivered.

   b. Medical records were sent following a SAR. The folders contained items relating to other patients.

In both cases, an internal investigation was completed, actions followed through and the ICO has taken no further action.

ix. In reviewing governance arrangements as outlined earlier in this statement and taking into account its assessment against the Governance & Accountability Module, the Board is clear that it is operating in accordance with the Corporate Governance Code and that there have been no departures from the Code.

x. 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
Ministerial Directions
A number of Ministerial Directions were given during the year, this information being available by accessing the following links:


These mainly related to changes to allowances and inflation uplifts in relation contracts held with ABMU’s independent contractors (general practitioners, opticians, dentists and community pharmacists) which would be implemented through the health board’s arrangements with NHS Wales Shared Services Partnership.

17. 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 executives within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their Annual Audit Report and other reports.

Work has continued to improve the performance information provided to the Board and its committees so that it 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 February 2016. This sets out levels of compliance with data quality and the actions required to continually improve performance. A decision was made at the beginning of 2016 that matters around information governance would be submitted (by ABMU’s Information Governance Board) to the Audit Committee which addressed the Wales Audit Office Structured Assessment findings that there was a need to review board committee reporting arrangements around issues of information governance.

As part of its revised committee arrangements we established a Performance Committee in late 2014/15 and its work programme for 2015/16 included a review of the Board’s performance management framework and data quality. The committee oversaw the development of a tool to track progress in terms of the delivery of our IMTP.

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 arrangements 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. Further information about both these committees can be found at Appendix 1 (and on pages 4-6 and 15).

a) 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 ABMU provides and commissions. Such information sources include outcome data, performance against local and national targets, clinical and internal audit reports, internal spot checks and the findings of external regulators and inspectorates such as Medicines and Healthcare Products Regulatory Agency and Healthcare Inspectorate Wales (HIW).

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.

b) Internal Audit and Assurance
The service provided from Internal Audit operates within the terms 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, and in accordance with an annual audit programme based on the outcomes from an audit risk assessment, discussed with senior management and agreed by the Audit Committee.

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 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 WAO 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, ABMU’s external auditor.

WAO undertake financial and performance audit work specific to the ABMU 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 the outcome of which was reported to the Audit Committee in February 2016 and to the Board in March 2016. The Structured Assessment concluded that:

‘Our overall conclusion from 2015 structured assessment work is that arrangements that support good governance are in place but are subject to revision in the context of new operational structures. Achieving financial balance for 2015/16 appears unlikely with the Health Board facing a growing funding gap with workforce and capacity risks.’

The full conclusions from the Structured Assessment are available via the WAO website http://www.wao.gov.uk

Management actions arising from the Structured Assessment are currently being incorporated into the IMTP.

18. 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 that 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. Some significant matters require management attention with moderate impact on residual risk exposure until resolved.
The scope of the opinion is confined to those areas examined in the risk based audit plan. The opinion should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as internal driver for continuous improvement.

In reaching this opinion the Head of Internal Audit has identified that whilst the substantial assurance was derived in respect of Financial Governance & Management limited assurance opinions derived following audits within the primary assurance domains of Corporate Governance, Risk & Regulatory Compliance and Clinical Governance, Quality & Safety have been most influential in forming the overall opinion. Additionally, were a number of audits deriving limited assurance in other domains within the audit plan.

During the year, Internal Audit issued the following final audit reports with a conclusion of ‘limited assurance’:

- Discharge Processes
- Policies & Procedures
- Regulatory Compliance: Skin Bank
- Security Framework
- Health Board Committees: Mental Health & Learning Disabilities Legislative Committee & SDU Assurance
- GP Out Of Hours Administration
- Continuing Healthcare & Jointly Funded Care
- Information Governance Framework: Information Assurance
- Data Quality: Stroke
- Princess of Wales Managed Unit
- Mental Health & Learning Disabilities: Ward Inspections
- Home Oxygen Services
- Private Patient Income
- Patients Monies & Property
- Statutory & Mandatory Training
- Medical Staff Appraisal to Support Revalidation (Follow Up)
- Nurse Rostering
- Management of Temporary Staffing (Bank & Agency)
- Junior Doctor Bandings

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.

Seven further reports have been issued in draft form to management indicating limited assurance conclusions. These have been detailed within the Head of Internal Audit Opinion & Annual Report.
The overall Head of Internal Audit opinion also took into account a number of areas of moderate risk discussed with executive officers. These included:

- HVS Phase 1B Consultancy Assignment
- Patient Experience
- WHO Surgical Safety Checklist: Follow Up
- Western Bay
- Stakeholder Engagement & Communication
- Performance Management Framework
- Transitional Planning.

19. **Review of Economy, Efficiency & Effectiveness of 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 three-year statutory duty under section 175 (1) will take place at the end of 2016/17, being the first three year period of assessment.

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

- ensure that its expenditure does not exceed the aggregate funding allotted to it over a three-year period. 2014/15 is year one the three-year period and the ABMU has reported an under-spend of £0.086m against its Revenue Resource Performance, and an under-spend of £0.037m 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 as:

- ABMU submitted an IMTP for the period 2015/16 – 2017/18 in accordance with the directions and this was approved by the Minister for Health & Social Services;
- ABMU 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, ABMU achieved 95.3% against this target for 2015/16.

20. **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 assessed itself against the *Health and Care Standards* to assist with the identification and management of risk.

A major focus during the year was involved the continued work to respond to *Trusted to Care*. Whilst ABMU was initially placed under ‘enhanced monitoring’ by Welsh Government arising from the joint *Escalation and Intervention Framework* this was subsequently lifted following a re-review in the summer of 2015 by Professor Andrews and her team. The Board were pleased at the outcome of the re-review as this demonstrated that the vast majority of the required recommendations had been met. The report conclusions also provided assurances in regard to patient safety. However due to levels of performance around unscheduled care pressures ABMU remained on an enhanced level of monitoring by Welsh Government.

Looking ahead to 2016/17 at our key priorities, these are based on five key performance areas which form part of the conditions of approval for the current IMTP. These are unscheduled care, planned care, stroke, cancer and infection control. All of the above need to be achieved within a sustainable workforce model and a robust financial framework. Details of our key areas of risk are set out on pages 9-14. We have series of controls in place to manage and mitigate these risks which are documented within our ‘Corporate Risk Register’.

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 26 onwards.

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:  

Date:

PAUL ROBERTS  
(Chief Executive)
<table>
<thead>
<tr>
<th>Board/Committee</th>
<th>Dates of meetings in 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audit</strong></td>
<td>30(^{th}) April 2015 21(^{st}) May 2015 2(^{nd}) June 2015 13(^{th}) August 2015 17(^{th}) September 2015 19(^{th}) November 2015 4(^{th}) February 2016 24(^{th}) March 2016</td>
</tr>
<tr>
<td><strong>Charitable Funds</strong></td>
<td>9(^{th}) June 2015 8(^{th}) September 2015 2(^{nd}) November 2015 12(^{th}) January 2016 14(^{th}) March 2016</td>
</tr>
<tr>
<td><strong>Quality &amp; Safety</strong></td>
<td>16(^{th}) April 2015 20(^{th}) June 2015 20(^{th}) August 2015 15(^{th}) October 2015 10(^{th}) December 2015 18(^{th}) February 2016</td>
</tr>
<tr>
<td><strong>Mental Health Legislative</strong></td>
<td>25(^{th}) August 2015 8(^{th}) December 2015 3(^{rd}) February 2016</td>
</tr>
<tr>
<td><strong>Workforce &amp; Organisational Development</strong></td>
<td>12(^{th}) June 2015 11(^{th}) August 2015 3(^{rd}) November 2015 11(^{th}) March 2016</td>
</tr>
<tr>
<td><strong>Remuneration &amp; Terms of Service</strong></td>
<td>23(^{rd}) April 2015 27(^{th}) August 2015 27(^{th}) October 2015 10(^{th}) February 2016</td>
</tr>
<tr>
<td><strong>Strategy, Planning &amp; Commissioning</strong></td>
<td>11(^{th}) June 2015 1(^{st}) October 2015 3(^{rd}) December 2015 18(^{th}) January 2016 29(^{th}) February 2016 23(^{rd}) March 2016</td>
</tr>
<tr>
<td>Name</td>
<td>Position &amp; Area of Expertise</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Andrew Davies</td>
<td>(Chair) Independent Member (IM)</td>
</tr>
<tr>
<td>Edward Roberts</td>
<td>(Vice-Chair) IM (Mental Health)</td>
</tr>
<tr>
<td>Paul Newman</td>
<td>IM (Legal)</td>
</tr>
<tr>
<td>Chantal Patel</td>
<td>IM (Community)</td>
</tr>
<tr>
<td>Ceri Phillips</td>
<td>IM (University)</td>
</tr>
<tr>
<td>Charles Janczewski</td>
<td>IM (Finance)</td>
</tr>
<tr>
<td>Melvyn Nott</td>
<td>IM (Local Authority)</td>
</tr>
<tr>
<td>Gaynor Richards</td>
<td>IM (Third Sector)</td>
</tr>
<tr>
<td>Barry Goldberg</td>
<td>IM (Information, Communications &amp; Technology)</td>
</tr>
<tr>
<td>Name</td>
<td>Position &amp; Area of Expertise</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Sandra Miller</td>
<td>IM (Trade Union)</td>
</tr>
<tr>
<td>Maggie Berry</td>
<td>IM</td>
</tr>
<tr>
<td>Sue Cooper</td>
<td>Associate Member</td>
</tr>
<tr>
<td>Alan Stevenson</td>
<td>Associate Member</td>
</tr>
<tr>
<td>(until Sept 2015)</td>
<td></td>
</tr>
<tr>
<td>Alison James</td>
<td>Associate Member</td>
</tr>
<tr>
<td>(from Sept 2015)</td>
<td></td>
</tr>
<tr>
<td>Paul Roberts</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Alexandra Howells</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Eifion Williams</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Hamish Laing</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Rory Farrelly</td>
<td>Director of Nursing &amp; Patient Experience</td>
</tr>
<tr>
<td>Name</td>
<td>Position &amp; Area of Expertise</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Siân Harrop-Griffiths</td>
<td>Director of Strategy</td>
</tr>
<tr>
<td>Beverley Edgar</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Amanda Hall</td>
<td>Interim Director of Therapies &amp; Health Sciences</td>
</tr>
<tr>
<td>Sara Hayes</td>
<td>Director of Public Health</td>
</tr>
</tbody>
</table>

*CJ kindly attended particular Q & S committee meetings at the request of the Chairman
*SM kindly attended particular Audit committee meetings at the request of the Chairman
*Chantal Patel kindly attended particular Audit committee meetings at the request of the Chairman
*Maggie Berry became a member of the Audit Committee in August 2015 and changed from Chair of the Stakeholder Reference Group to its non-officer member representative from October 2015 (replacing Barry Goldberg).

**Key to Acronyms:**

- **W&OD** = Workforce & Organisational Development Committee
- **Q & S** = Quality & Safety Committee
- **MHAC** = Mental Health Manager’s Committee
- **Perform** = Performance Committee
- **CFC** = Charitable Funds Committee
- **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 Board.

Where any board committee meetings were inquorate, escalation arrangements were in place to ensure that any matters of significant concern that could not be brought to the attention of the committee could be raised with the ABMU Chair.
<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Interests Declared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Davies Chairman</td>
<td>- Welsh Commission on Co-operative and Mutuals (non-remunerated) – chairman</td>
</tr>
<tr>
<td></td>
<td>- Localist Limited – a not-for-profit company running hyper-local media sites (FYI</td>
</tr>
<tr>
<td></td>
<td>Neath) (non-remunerated) – director</td>
</tr>
<tr>
<td></td>
<td>- National Dance Company of Wales (non-remunerated) – chairman</td>
</tr>
<tr>
<td></td>
<td>- Ospreys in the Community; not-for-profit body managing the Ospreys’ community</td>
</tr>
<tr>
<td></td>
<td>activities (non-remunerated) – Board member</td>
</tr>
<tr>
<td></td>
<td>- Swansea Early Years Strategy Steering Group (non-remunerated) – chairman</td>
</tr>
<tr>
<td></td>
<td>- TATA Task Force (non-remunerated) – member</td>
</tr>
<tr>
<td></td>
<td>- Pobl Housing Association (non-remunerated) – chairman</td>
</tr>
<tr>
<td>Ed Roberts Vice-Chairman</td>
<td>- Neath Port Talbot Carers Service – trustee</td>
</tr>
<tr>
<td></td>
<td>- Neath Port Talbot Council for Voluntary Services Board – vice-chair</td>
</tr>
<tr>
<td>Paul Roberts Chief Executive</td>
<td>- Association of UK University Hospitals (AUKUH) – Vice-Chair</td>
</tr>
<tr>
<td>Eifion Williams Director of Finance</td>
<td>- Swansea University – Member of Finance Committee</td>
</tr>
<tr>
<td></td>
<td>- Chartered Institute of Public Finance and Accountancy – Member of health panel</td>
</tr>
<tr>
<td></td>
<td>- Hywel Dda Health Board – wife is a senior manager</td>
</tr>
<tr>
<td></td>
<td>- Yorath Chapel – member/deacon</td>
</tr>
<tr>
<td></td>
<td>- Wales Quality Centre – director (non-officer)</td>
</tr>
<tr>
<td>Rory Farrelly Director of Nursing &amp; Patient Experience</td>
<td>- Association of British Paediatric Nurses (ABPN) – chair and president</td>
</tr>
<tr>
<td></td>
<td>- University of Swansea – honorary professorial post in nursing</td>
</tr>
<tr>
<td>Name/Title</td>
<td>Interests Declared</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Alexandra Howells</td>
<td>- Nothing to declare.</td>
</tr>
<tr>
<td>Chief Operating Officer / Deputy Chief Executive</td>
<td></td>
</tr>
<tr>
<td>Sara Hayes</td>
<td>- Nothing to declare.</td>
</tr>
<tr>
<td>Director of Public Health</td>
<td></td>
</tr>
<tr>
<td>Beverley Edgar</td>
<td>- Nothing to declare.</td>
</tr>
<tr>
<td>Director of Human Resources</td>
<td></td>
</tr>
<tr>
<td>Siân Harrop-Griffiths</td>
<td>- Nothing to declare.</td>
</tr>
<tr>
<td>Director of Strategy</td>
<td></td>
</tr>
<tr>
<td>Andrew Phillips</td>
<td>- Health and Care Professions Council – partner</td>
</tr>
<tr>
<td>Director of Therapies and Health Sciences (until 12th April 2014)</td>
<td>- The Health Foundation - member of college of assessors</td>
</tr>
<tr>
<td>Amanda Hall</td>
<td>- British Psychological Society (remunerated) – national lead co-ordinator of</td>
</tr>
<tr>
<td>Interim Director of Therapies and Health Sciences</td>
<td>training and exam Board member and assessor</td>
</tr>
<tr>
<td>Steve Combe</td>
<td>- Swansea University (remunerated) - contracted lecturer for MSc module annually</td>
</tr>
<tr>
<td>Board Secretary</td>
<td>- Private Practice – small practice for non-NHS appropriate clients</td>
</tr>
<tr>
<td>Hamish Laing</td>
<td>- ABMU Health Board – wife and daughter are employees of the Health Board.</td>
</tr>
<tr>
<td>Medical Director</td>
<td>- Maggie Keswick Jencks Cancer Caring Centres Trust (Maggie’s) – member of</td>
</tr>
<tr>
<td></td>
<td>professional advisory Board (UK and international)</td>
</tr>
<tr>
<td>Name/Title</td>
<td>Interests Declared</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Amanda Hall</td>
<td>- British Psychological Association – national lead co-ordinator of training and</td>
</tr>
<tr>
<td>Interim Director of Therapies</td>
<td>exam Board member and assessor (remunerated)</td>
</tr>
<tr>
<td>&amp; Health Science</td>
<td>- Swansea University – contracted lecturer for MSc module annually (remunerated)</td>
</tr>
<tr>
<td></td>
<td>- Private practice – small practice for non-NHS appropriate clients</td>
</tr>
<tr>
<td>Barry Goldberg</td>
<td>- Swansea University – honorary research associate, medical college</td>
</tr>
<tr>
<td>Non-Officer Member</td>
<td></td>
</tr>
<tr>
<td>Ceri Phillips</td>
<td>- Mundipharma - honoraria for attending advisory Boards</td>
</tr>
<tr>
<td>Non-Officer Member</td>
<td>- Sunovion - honoraria for attending advisory Boards</td>
</tr>
<tr>
<td></td>
<td>- Vifor - honoraria for attending advisory Boards</td>
</tr>
<tr>
<td>Charles Janczewski</td>
<td>- Centre for Business Ltd - business advisor</td>
</tr>
<tr>
<td>Non-Officer Member</td>
<td>- Dasi Business Solutions – proprietor</td>
</tr>
<tr>
<td>Paul Newman</td>
<td>- MP properties – partner</td>
</tr>
<tr>
<td>Non-Officer Member</td>
<td>- MPJ properties – partner</td>
</tr>
<tr>
<td></td>
<td>- Bexmoor Ltd - director and shareholder</td>
</tr>
<tr>
<td></td>
<td>- Penman Properties Ltd - director and shareholder</td>
</tr>
<tr>
<td></td>
<td>- Copper Court Ltd - director and shareholder</td>
</tr>
<tr>
<td></td>
<td>- Rivalslot Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Longpark Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Leapgold Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Maysouth Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Magnetrade Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Sureco Ltd – director</td>
</tr>
<tr>
<td></td>
<td>- Melin Property Partnership - partner</td>
</tr>
<tr>
<td>Name/Title</td>
<td>Interests Declared</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sandra Miller</td>
<td>Non-Officer Member - Neath Port Talbot County Borough Council – cabinet member</td>
</tr>
<tr>
<td>Maggie Berry</td>
<td>Non-Officer Member - Swansea Care and Repair - part-time change manager. Swansea Care and Repair has a small service level agreement with ABMU Health Board to support the Welsh Government funded rapid response adaptations programme for Swansea.</td>
</tr>
<tr>
<td>Gaynor Richards</td>
<td>Non-Officer Member - Neath Port Talbot Council for Voluntary Services – executive director - Bobath Cymru – volunteer and daughter is events/fundraising co-ordinator - BIG Lottery Wales – Board member - Welsh Government – European funding ambassador - NPTC group of colleges – chair of Board of governors</td>
</tr>
<tr>
<td>Chantal Patel</td>
<td>Non-Officer Member - Head of inter-professional studies at Swansea University - Indian Society of South West Wales – secretary - Gwalia Grwp - Board member - Glamorgan House Family Contact Centre Magistrate – chair - Gower College – chair of human resources - Harbourside Medical Centre - husband is principle GP</td>
</tr>
<tr>
<td>Melvyn Nott</td>
<td>Non-Officer Member - Bridgend County Borough Council – elected member and Leader of Council - St Brides Minor Community Council – councillor</td>
</tr>
</tbody>
</table>
ABERTAWE BRO MORGANNWG UNIVERSITY
HEALTH BOARD

SYSTEM OF ASSURANCE

Revised February 2016
1. **INTRODUCTION**
The Welsh Government’s Citizen Centred Governance principles embody what the Welsh Government wants public services to be focused on the needs of citizens, with citizens who are engaged and involved in the development of services and who receive services which are efficient, effective and innovative in their design and implementation. The principles are:

- **Putting the citizen first** – Putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation’s purpose the delivery of a high quality service
- **Knowing who does what and why** – making sure that everyone involved in the delivery chain understands each other’s roles and responsibilities and how together they can deliver the best possible outcomes
- **Engaging with others** – working in constructive partnerships to deliver the best outcome for the citizen
- **Living public sector values** – being a value-driven organisation, rooted in Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership
- **Fostering innovative delivery** – being creative and innovative in the delivery of public services – working from evidence, and taking managed risks to achieve better outcomes
- **Being a learning organisation** – always learning and always improving service delivery
- **Achieving value for money** – looking after taxpayers’ resources properly, and using them carefully to deliver high quality, efficient services.

These principles establish the standards of good governance for the NHS in Wales and are designed to ensure:

- **Clarity** for everyone working within the NHS system, those working in partnership with the NHS, those receiving NHS services themselves; and carers and relatives of those receiving NHS services;
- **Responsibility** is placed with those who are best equipped to meet those responsibilities;
- **Recognition** for those achieving their objectives; and
- **Action** to ensure activities remain on track.

The extent to which individual NHS organisations are able to demonstrate their alignment with the citizen centred governance principles will contribute to the annual review of NHS bodies performance.
2. WHAT IS ASSURANCE?
There are many definitions of assurance, most of which centre around common themes of confidence and certainty. Assurance in respect of Abertawe Bro Morgannwg University Health Board can be defined as follows:

**Assurance** provides Board members with the evidence that the Health Board is operating effectively, achieving desired outcomes, delivering on its strategic vision, meeting its strategic objectives through effective risk management, in a manner which upholds the Citizen Centred Principles and is in accordance with all statutory requirements.

Welsh Government has issued guidance for Boards on Risk /Assurance, This is summarised as follows:-

In February 2011, Health Inspectorate Wales (HIW) set out its expectations that the "Standards for Health Services should be the main framework through which NHS organisations seek to gain and provide assurance on their ability to fulfil their aims and objectives for the delivery of safe, high quality services". An overarching Governance
and Accountability module and supporting guidance was issued for Boards to undertake a self-assessment against three key themes:

- setting the direction;
- enabling delivery;
- delivering results, achieving excellence.

Welsh Government have recently indicated that, following the issuing of revised Health and Care Standards (WHC(2015)015 refers), Boards are no longer required to complete this module. However there is currently a lack of clarity as to what will replace this module so it will continue to be used as the outcome of this self-assessment is a fundamental component of the Annual Governance Statement.

**Reasonable Assurance**

It should be recognised that any assurance, whatever its source, will not be a guarantee that offers absolute certainty. As such the Board must look to gain ‘reasonable’ assurance that the organisations ways of working enable it to perform effectively across the full range of its activities (the “breadth” of assurance) in order to deliver its strategic vision. Defining what is considered ‘reasonable’ provides the Board with the opportunity to discuss and debate the importance of assurance in a meaningful way, taking into account the nature of the Health Board’s activities and its core values, as well as the views of its citizens, community partners and other stakeholders on what ‘reasonable’ might mean to them. The result of the Board’s deliberations will determine the level of assurance that it requires (the “depth” of assurance) in relation to particular activities. Specifying both the breadth and depth of assurance required is sometimes described as ‘risk appetite’.

3. **WHAT IS A SYSTEM OF ASSURANCE?**

This sets out the systems, processes and staff that enables the organisation to focus on its overall priorities and the risks associated with their achievement so these can be mitigated/managed effectively through

- **Systems, processes and staff** are operating in a safe and effective manner, focused on the delivery of the organisation’s strategic objectives
- There is a framework for reporting key information to the Board which provides a structured level of assurance in respect of the management of risks in relation to the achievement of the Board’s objectives
- There is a structured process in place to provide evidence to support the Annual Governance Statement and Annual Quality Statement.

The overall system of assurance operating within the Health Board is set out diagrammatically at Appendix I. This provides an overview of ward/department to Board assurance arrangements.
4. BASIS FOR THE SYSTEM OF ASSURANCE

Organisational Values

During 2014/15 the health board developed its values and behaviour framework. Our values are:

- **Caring for each other** in every human contact in all of our communities and each of our hospitals.
- **Working together** as patients, families, carers, staff and communities so that we always put patients first
- **Always improving** so that we are at our best for every patient and for each other.

Organisational Aims and Objectives

The first stage in developing a system of assurance involves setting out the principal aims and objectives against which the Board requires assurance. These are set out in the Integrated Medium Term Plan (IMTP) which indicates the purpose of ABMU is

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

We wish to be an excellent healthcare, teaching and research organisation for the Abertawe Bro Morgannwg region and the wider regions that we serve. This means that:

- We will respect people's rights in all that we do and plan our services and their care with them. Wherever it is provided, care will be safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it could be.
- We will make it easy for everyone to get the information and advice they need to be in control of their own health and to live healthier lives.
- We will work in partnership with our communities, our staff and other agencies to meet our citizens’ health and social care needs in an integrated way, usually in or near to where they live.
- We will support high-quality research, education and innovation that benefit our patients and staff and we will encourage everyone to share their care experiences with us so that we can learn how we can do even better.

We have six strategic aims:-

- Healthier communities;
- Excellent patient outcomes and experience;
- Sustainable and accessible services;
- Strong partnerships;
- Fully engaged and skilled workforce;
- Effective governance.
For each strategic aim we have identified objectives, outcome measures and delivery mechanisms, which set out what we intend to do and how we will measure and deliver success. These are set out in the IMTP.

5. **OBTAINING ASSURANCE**

One of the tasks of the Board is to provide assurance to the public, Welsh Government and other bodies that it is operating effectively and is providing safe and effective services. All Board Members, both Executive and Non Officer Members will have ways of seeking and gaining assurance from a variety of sources to help them discharge this function. These will include receipt of reports, informal walkrounds and asking critical questions. This section sets out the formal arrangements in place within the Board to provide assurance and provide more detail on the arrangements set out in Appendix I. These are:

**IMTP and progress reports**

The IMTP sets out the organisational objectives for the years ahead, together with the risks associated with their achievement. This includes quality objectives based on the Health Boards Quality Strategy. Progress against the Plan and any areas of emerging risk are reported to the Board / Board Committees. This includes the IMTP tracker tool and regular performance management reporting which are considered by the Performance Committee and the Board, linked to the Performance Management Framework.

**Unit and Corporate Department Objectives**

The organisational objectives will form the backbone to individual Unit and corporate department objectives.

**Personal Objectives**

Once organisational objectives have been approved by the Board through the IMTP they should be used as the basis of the objectives of the Chairman and Chief Executive. The Chairman will then use these as the basis for Non Officer Member (NOM) objectives and the Chief Executive will do the same for the Executive Team. These will then be cascaded through the organisation using the Personal Development Review (PDR)/job planning process so everyone sees how their role helps meet the objectives of the organisation.

Progress against these objectives will be monitored through mid year and end of year PDR reviews

**Annual Governance Statement (AGS)**

This is the overarching vehicle used to provide assurance and is included in the Annual Accounts each year. The draft Statement will be prepared by the Board Secretary and shared with the Chairman of the Audit Committee, Internal Audit and the Wales Audit Office. The final draft will be considered by the Audit Committee and Board as part of the approval of the Annual Accounts each year.
The overall approach is set out below.

**Annual Quality Statement**
The Annual Quality Statement aims to provide assurance on the quality of services provided by the Health Board. The draft Statement is considered by the Quality and Safety Committee and Audit Committee prior to being submitted to the Board. The Quality Assurance reporting Framework is attached at Appendix II.

**Health and Care Standards**
The organisations self assessment against the Health and Care Standards are a critical element of the governance and risk management arrangements and help underpin the AGS.

The Governance and Accountability module which in itself is the subject of an annual self assessment by the Board, is a key and over arching element supplementary to the Standards (see comments above).

At the same time the annual Structured Assessment undertaken by the Wales Audit Office provides levels of assurance regarding governance arrangements and the action plan following the Structured Assessment is integrated into the Governance and Accountability module, which forms part of the overall Health and Care Standards improvement plan. Regular progress against this action plan will reduce gaps in assurance each year.

The Director of Nursing and Patient Experience is the Executive lead for the Standards and will arrange for the Standards to be considered by a Scrutiny panel made up of
Non Officer members. The outcomes of the Scrutiny Panel will be reported to the Board as part of its consideration of the Governance and Accountability module.

The improvement plan following the self assessment against the Standards will be reported to the Quality and Safety Committee

**Governance in Year Reviews**
Each year Internal Audit undertake an in year review of governance to assess progress and report key findings to the Audit Committee, together with an agreed action plan.

**Board Business Cycle**
The Board considers reports throughout the year as part of the business cycle and many of these reports will provide the Board with assurance. These include:

- **Annual Accounts**
The Annual Accounts process is well established and provides assurance to the Board each year on financial governance

- **Annual Report**
Each September the Board receives the Annual Report that sets out the main achievements within the Health Board for the previous financial year

- **Board Committee reporting**
The key Board Committees that provide assurance to the Board regarding risk management arrangements are the:
  - Audit Committee
  - Quality & Safety Committee
  - Workforce and OD Committee
  - Performance Committee

In addition there are all Wales joint committees (WHSSC and EASC) and the All Wales Shared Services Committee. The outputs from these meetings are reported to the Board and the Chair/Chief Officer of each of these Committees attends the board meeting once a year

The terms of reference of all Board Committees are set out in Standing Orders

In addition the Chairs Advisory Group co – ordinates Board Committee arrangements and assists with assurance functions.

Each Committee produces an Annual Report setting out areas of assurance and risk. A summary of these reports will be considered by the Audit Committee/Chairs Advisory Group as part of the annual review of the Board and its Committees

Each Board Committee routinely provides reports to the Board setting out its activities and issues it wishes to bring to the attention of the Board.

46
• **Performance Management Framework**
An Integrated Performance Management Framework has been agreed and can be accessed separately. This is based on regular performance review meetings with Units and corporate departments. This then feeds into the Board Integrated Performance reports which sets out current performance against agreed indicators and is cross referenced to the risk register.

• **Partnerships**
The Health Board works in partnership with a number of organisations including:

- Local Authorities, mainly through Western Bay
- Swansea University, through the Collaboration Board
- A Regional Collaboration for Health (ARCH)
- The NHS Collaborative and Acute Care Alliances

Some of these arrangements are still developing and some will change as a result of the Health, Social care and Well Being Act and Future Generations Act. Areas of partnership working are reported directly to the Board.

**4.3 EXTERNAL ASSURANCE**
As already indicated, the Board will also receive assurance from external sources. A key vehicle for receiving external assurance will be through the Structured Assessment undertaken by the Wales Audit Office, which will be used to inform the annual governance and accountability review.

Alongside this assurance will be received through Health inspectorate Wales assessment of progress against the Standards for Health and Care and other reports.

The key sources of evidence currently available and routinely used to provide assurance are:

<table>
<thead>
<tr>
<th>Internal Sources of Assurance</th>
<th>External Sources of Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI’s, Performance Dashboard &amp; management reports</td>
<td>External audit reports/reviews</td>
</tr>
<tr>
<td>Standards for Health and Care and the HB’s self assessment of performance</td>
<td>Healthcare Inspectorate Wales</td>
</tr>
<tr>
<td>Clinical Audit reports</td>
<td>Welsh Risk Pool</td>
</tr>
<tr>
<td>Internal Audit reports</td>
<td>Licensing &amp; Regulatory body reports</td>
</tr>
<tr>
<td>Adverse and serious incident reports</td>
<td>Welsh Government reports and reviews</td>
</tr>
<tr>
<td>Counter fraud reports</td>
<td>Royal College visits</td>
</tr>
<tr>
<td>Quality and Outcomes Framework Assessments</td>
<td>Deanery visits</td>
</tr>
<tr>
<td>Staff appraisals</td>
<td>External audit reports/reviews</td>
</tr>
<tr>
<td>Complaint reports</td>
<td>Feedback from service users</td>
</tr>
<tr>
<td>Infection Control reports</td>
<td>Feedback from clinical networks</td>
</tr>
<tr>
<td><strong>Internal Sources of Assurance</strong></td>
<td><strong>External Sources of Assurance</strong></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Caldicott Guardian reports</td>
<td>External benchmarking</td>
</tr>
<tr>
<td>Cleanliness reports</td>
<td>Community Health Councils</td>
</tr>
<tr>
<td>Staff satisfaction surveys</td>
<td>Ombudsman reports</td>
</tr>
<tr>
<td>Training records</td>
<td>Information Commissioner reports</td>
</tr>
<tr>
<td>Internal investigations</td>
<td>Older Peoples, Childrens and Welsh Language Commissioner reports</td>
</tr>
<tr>
<td>Workforce/HR Reports</td>
<td>External advisors/peer review reports</td>
</tr>
<tr>
<td>Patient satisfaction surveys</td>
<td></td>
</tr>
<tr>
<td>IMTP tracker reports</td>
<td></td>
</tr>
</tbody>
</table>

Details of Executive leads for these areas and Board/Committee reporting arrangements are set out in Appendix III

6. **RISKS AND CONTROLS**
Against each strategic objective, there will be a need to assess the risk of achievement prospectively as a fundamental part of the planning process. This should be undertaken in a structured way and in accordance with the Risk Management Strategy.

This will form the basis of the corporate risk register at the beginning of the year.

Operational risks will be managed by Units in accordance with the Risk Management Strategy. High level risks will be discussed with Units as part of the monthly performance review meetings. Where these risks are of a level to impact on the ability of the Health Board to meet its objectives, it will be reported to the Board/Board Committee.

Major risks to the delivery of the IMTP will be reported to the Board either through the regular performance reports or through exception reports.
ABMU BOARD ASSURANCE MAP

Delivery of ABMU Vision, Aims, Values and Behaviours, Objectives, Measures and Trajectories and management of associated risks

Controls and Assurance Mechanisms

Planning and Commissioning

** Controls: evidenced within
- IMTP – Strategic and annual objectives
- Commissioning intentions and plans
- Capital and Estates Plans
- Quality Impact Assessment protocol
- Equality Impact Assessment Protocol

** Assurance: gained via
- Executive – Strategic Planning and Commissioning Board
- Strategic Planning and Commissioning Committee

Performance Management

** Controls: evidenced within
- PDPs
- Performance targets
- Performance Dashboards/statements
- Regular Performance and Quality reports inc Pt and Staff feedback reports

** Assurance: gained via
- Performance Review Meetings at Corporate, Unit and Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Team meetings
- Performance, Quality and Safety, Workforce and OD, Remuneration Committees

Risk Management

** Controls: evidenced within
- Risk management strategy
- Risk registers at Corporate and Unit levels

** Assurance: gained via
- Exec and Unit Committee Mgs
- Quality and Improvement Board
- Quality and Safety Committee
- Audit Committee
ABMU – OPERATIONAL LEVELS OF ASSURANCE

First Line of Assurance – Dept / Service Ward

Example of control mechanisms:
• PDP
• Service / Dept / Ward annual plans aligned to IMTP (inc Quality Strategy)
• Dashboards / performance statement etc
• Adverse and serious incident reports and risk assessments
• Self Assessment against Health and Care Standards / Ideal Ward
• Patient and staff experience and feedback mechanisms

Examples of performance management mechanisms
• Local reviews (inc case notes, mortality, clinical outcomes, audits, visits)
• Local Quality and Performance Meetings with Sub - Units
• Ward Peer Reviews

Second Line of Assurance – Sub Units

Example of control mechanisms:
• Sub-Unit annual plans aligned to IMTP (inc Quality Strategy)
• Dashboards / performance statement etc
• Adverse and serious incident reports and risk assessments
• Self Assessment against Health and Care Standards / Ideal Ward
• Patient and staff experience and feedback mechanisms

Examples of performance mgt mechanisms
• Local reviews (inc case notes, mortality, clinical outcomes), audits, visits
• Local Quality and Performance Meetings with Units
• Ward monthly assurance checks

Third Line of Assurance – Units and Corporate Functions

Examples of Control mechanisms:
• IMTP (inc Quality Strategy) strategic priorities
• Risk Register
• Regular performance and quality reports
• Performance statements/reports, outcome measures and benchmarks
• Adverse and serious incident reports
• Alerts and notices
• Self assessment against Health and Care Std
• Patient and staff experience and feedback mechanisms
• Annual Governance and Quality Statements

Examples of Performance Management mechanisms
• Unit Meetings (Quality and Performance) with Exec Team
• Local Audits, visits and spot checks

SCRUTINY
Independent assessment eg
• Internal Audit
• Healthcare Inspectorate Wales
• Human Tissue Authority
• Medicines and Healthcare Products Regulatory Agency (MHRA)
• United Kingdom Accreditation Service
• Welsh Risk Pool
• Royal College Visits
• Deanery Visits
• Community Health Council
• Information Commissioner reports
• Ombudsman Reports
• Older People’s, Children’s and Welsh Language Commissioner reports
• Peer review reports
ABMU – CORPORATE LEVELS OF ASSURANCE

FIRST LINE OF ASSURANCE –
Operational Management (Units, and Corporate functions)
Through organisational control mechanisms, service / departments / wards provide assurance to Unit Directors and Corporate Leads

As evidenced by:
• Unit IMTP
• Service / Dept / Ward annual plans
• Dashboards / performance statements / reports, outcome measures and benchmarks
• Adverse and serious incident reports
• Self Assessment against Health and Care Standards
• Patient and staff feedback mechanisms
• Local reviews (inc case notes, audits, visits)
• Unit risk register
• Unit Annual Assurance Statement

SECOND LINE OF ASSURANCE –
Corporate overview
Through organisational control mechanisms, Executive Leads and their team scrutinise and provide assurance to the Board Committees and the Board

As Evidenced by:
• IMTP
• Corporate Strategies
• Corporate Risk Register
• Regular performance and quality reports
• Performance statements / reports, outcome measures and benchmarks
• Adverse and serious incident reports
• Self assessment against Health and Care Standards
• Patient and staff experience and feedback mechanisms
• Annual Governance Statement
• Annual Quality Statement
• Local Audits, visits and spot checks

ABMU HB Board Committees:
Role: Scrutinise and seek assurance from the Executive Leads and their team. Provide assurance to the Board

ABMU Health Board:
Role: Scrutinise and seek assurance from the Board Sub-Committees and the Executive Team. Provide assurance to Welsh Government

THIRD LINE OF ASSURANCE
Independent assessment
Providing assurance through independent internal and external audit and peer review, eg
• Healthcare Inspectorate Wales
• Human Tissue Authority
• Medicines and Healthcare Products Regulatory Agency (MHRA)
• United Kingdom Accreditation Service
• Welsh Risk Pool
• Royal College Visits
• Deanery Visits
• Community Health Council
• Information Commissioner reports
• Ombudsman Reports
• Older People’s, Children’s and Welsh Language Commissioner reports
• Peer review reports

THE GOLDEN THREADS
Vision, Aims, Values and Behaviours, Objectives, Measures and trajectories,
Appendix II

Annex A – Quality Assurance Framework

Board

Quality & Safety Committee

Quality & Safety Forum

SHSiW Scrutiny Panel

Specialist Quality & Safety Committee
Groups and Committees inc Directorate/Locality Forums

Excellent Patient Outcomes

Improving Safety
  • Assessing & acting on the risk of Thrombo-prophylaxis.
  • Acting on patient observation s that raise concerns.
  • Clean hands.

Improving Effectiveness of Care
  • Daily senior review.

Improving Patient & Service User Experience
  • Review sentinel event.

Improving Efficiency
  • Discharge summaries.

Improving Access
  • Referral to Treatment Time.
  • Unscheduled care.

Improving Equity
  • Stroke.

Quality Assurance Framework

Incorporating Internal & External Quality Requirements / Regulation

External
  • Welsh Government
  • Wales Audit Office
  • Standards for Health Services in Wales
  • Healthcare Inspectorate Wales
  • Welsh Risk Pool
  • Health & Safety Executive
  • HTA/CPA/MHRA
  • Community Health Council
  • Peer Reviews

Internal
  • Risk Management
  • Putting Things Right
  • Patient Experience
  • RAMI & Mortality Reviews
  • Quality Performance Data
  • Quality Statement
  • Fundamentals of Care
  • Critical Care Standards/Cancer Standards
  • Quality Outcomes Framework
<table>
<thead>
<tr>
<th>Source of Evidence for Assurance</th>
<th>Executive Lead</th>
<th>Board / Committee Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance dashboard and supporting reports</td>
<td>Director of Strategy</td>
<td>Board/ Performance Committee/Quality and Safety Committee</td>
</tr>
<tr>
<td>Standards for Health and Care</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Clinical Audit reports</td>
<td>Medical Director</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Internal Audit reports</td>
<td>Director of Finance</td>
<td>Audit</td>
</tr>
<tr>
<td>Adverse and serious incident reports</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Counter fraud reports</td>
<td>Director of Finance</td>
<td>Audit</td>
</tr>
<tr>
<td>Quality and Outcomes Framework Assessments</td>
<td>Deputy Chief Executive</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Staff appraisals</td>
<td>Director of HR</td>
<td>Workforce and OD</td>
</tr>
<tr>
<td>Complaints records and trends</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Information governance reports</td>
<td>Medical Director</td>
<td>Audit</td>
</tr>
<tr>
<td>Cleanliness reports</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Staff satisfaction survey</td>
<td>Director of HR</td>
<td>Workforce and OD</td>
</tr>
<tr>
<td>Training records</td>
<td>Director of HR</td>
<td>Workforce and OD</td>
</tr>
<tr>
<td>Internal Investigations</td>
<td>Chief Executive</td>
<td>Board or Committee Depending on matter</td>
</tr>
<tr>
<td>Source of oversight</td>
<td>Responsibility</td>
<td>Department</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>External audit reports/reviews</td>
<td>Chief Executive</td>
<td>Audit</td>
</tr>
<tr>
<td>Healthcare Inspectorate Wales</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Welsh Risk Pool</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Licensing and Regulatory bodies</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Royal College visits</td>
<td>Medical Director</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Deanery visits</td>
<td>Medical Director</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Feedback from service users</td>
<td>Director of Nursing and Patient Experience</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Feedback from clinical networks</td>
<td>Director of Strategy</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>IMTP tracker reports</td>
<td>Director of Strategy</td>
<td>Performance Committee/Board</td>
</tr>
</tbody>
</table>
Appendix 3

KEY REPORTS RECEIVED in 2015/16 BY:
ABMU Board:

- Emergency Ambulance Services Committee Presentation (May 2015);
- ‘Trusted to Care’ Update Reports - (May 2015 – March 2016);
- Integrated Performance Report (May 2015 and at each meeting following this reported under corporate objective themes);
- Finance Report (May 2015 and at each meeting following this);
- Arts in Health Report (May, November 2015)
- Annual Screening Report (May 2015);
- Diabetes Delivery Plan (May 2015);
- Children & Young People’s Emotional & Mental Health Services Governance Arrangements Report (May 2015);
- Older Person’s Commissioner Reporting Requirements Report (July 2015);
- Public Health Strategic Framework (July 2015);
- Healthcare Inspectorate Wales Annual Letter (July 2015);
- Organ Donation Annual Report (July 2015);
- Research & Development Report (July 2015 & January 2016);
- Continuing Healthcare Compliance Report (July 2015);
- Integrated Medium Term Plan (IMTP)(September, November 2015 & January. March 2016);
- Carer’s Information and Consultation Strategy (September 2015);
- Development of Intermediate Care Services (September 2015);
- Section 33 Report (September 2015);
- Partnership Agreement Report (September 2015);
- Getting It Right First Time (GIRFT) (September 2015);
- Palmer Report Recommendations (November 2015);
- Cancer Services Annual Report (November 2015);
- Seasonal Plan (November 2015);
- GP Sustainability (November 2015);
Concordat with NHS Wales Informatics Service (NWIS) (November 2015);  
Embedding the ABMU Values and Behaviors Framework (November 2015);  
Smoking Cessation (January 2016);  
Areas Planning Board for Substance Misuse (July 2015 and January 2016);  
Flexible Hospital Visiting Policy (January 2016);  
Voluntary Sector Funding Arrangements (January 2016);  
Together for Mental Health Annual Report (January 2016);  
Major Incident Procedures (January 2016);  
Welsh Health Specialist Services Committee Briefing (March 2016);  
Prudent Healthcare Report (March 2016);  
Vaccination Update (March 2016);  
Developing Strategies for Mental Health, Learning and Child & Adolescent Services Report (March 2016);  
Western Bay Care Home Commissioning Strategy for Older People (March 2016);  
A Regional Collaboration for Health (ARCH) Update (March 2016);  
Funded Nursing Care Update (March 2016);  
Wales Audit Office: Annual Audit Letter 2015 (March 2016);  
Wales Audit Office: Structured Assessment 2015 (March 2016);  
Risk Management Strategy and Corporate Risk Register (March 2016).

Audit Committee:

Health Vision Swansea Phase 1B;  
Auditors’ progress reports – internal audit and Wales Audit Office (WAO);  
Risks and controls around financial management;  
Losses and special payment;  
Audit registers and action plans;  
Single tender actions and quotations;  
Management responses to WAO reports which included:
- Direct Nursing Review;
- Maternity Services
- Medicines Management in Acute Hospitals;
- Orthopaedic Services
- Clinical Coding
- Theatre Review
- Follow-up of Outpatient Appointments
- Diagnostic Review of ICT Capacity and Resources

- Hospitality register;
- Post-payment verification reports;
- Audit Committee Annual Report and Accounts;
- Local counter fraud updates;
- Annual Governance Statement;
- System of Assurance;
- Minutes of Governance Committees: Information Governance Committee, Emergency Medical Retrieval and Transfer Service Governance Sub-Committee and Delivery Unit Governance Sub-Committee;
- Clinical Audit;
- Bridgend Clinic Trading Account;
- Changes to Standing Financial Instructions;
- Capital Contracts and Frameworks;
- Declarations of Interest Register;
- Quality and Safety Committee Annual report;
- Electronic Rostering;
- Out-of-hours Call Handling and 111 Service updates;
- Risk Management Register and Strategy;
- Quality Statement
- Health and Safety;
- MEDACs
- Write-off requests.
Quality and Safety Committee:

- 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
- Patient experience;
- Unscheduled care;
- Continuing care;
- Primary and community care governance arrangements;
- Medicines management; and
- Cancer services.