

Quality Management System

Final Internal Audit Report

June 2024

Swansea Bay University Health Board

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Executive Summary

Purpose

To review the progress made to implement the Quality Management System. To include focus on the health board quality priority for falls prevention.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Strengthening business continuity arrangements in the absence of key staff within the Quality, Safety, and Improvement (QSI) team.
- Reviewing the Quality Strategy’s implementation plan to ensure that improvement goals are achievable.
- Developing a communications plan to detail the regularity of communication and engagement of the Quality Strategy.
- Improvements to the reporting of risk and performance for quality priorities, including an agreed definition of ‘business as usual’.
- Reviewing the governance structure that provides oversight over quality, safety, and improvement arrangements.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend



2022/23

Assurance summary¹

Objectives	Assurance
1 Quality Management System Implementation	Reasonable
2 Falls Prevention Quality Priority Risks	Reasonable
3 Falls Prevention Quality Priority Performance	Reasonable
4 Governance Arrangements	Reasonable

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Business Continuity Arrangements	1	Medium
2	Quality and Safety Priorities	1	High
3	Communications Plan	1	Medium
4	Risk & Performance – Falls Prevention Quality Priority	2,3	Medium
5	Governance Arrangements	3,4	Medium

1. Introduction

- 1.1 A core value detailed in Welsh Government's, 'A Healthier Wales: our Plan for Health and Social Care' (2021) is, "putting quality and safety above all else – providing high-value evidence-based care for our patients at all times." The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force in April 2023, places an enhanced duty of quality and an organisational duty of candour on NHS bodies to strengthen their approach in providing high quality and safe care.
- 1.2 In 2021/22, Swansea Bay University Health board ('the health board') undertook a review to consider the quality governance arrangements within its service groups, which coincided with an Audit Wales review of Quality Governance arrangements identifying significant weaknesses in arrangements both corporately and operationally; and an internal audit review of the health board's implementation of its Quality and Safety Framework that was assigned 'limited' assurance.
- 1.3 Further work was undertaken by the health board to assist with strengthening arrangements, which included developing a quality management system incorporating three key elements:
- Quality Strategy – setting out visions and values;
 - Quality Management Framework – outlining the systems for delivering quality care; and
 - Quality Improvement Framework – driving improvement at every level.
- 1.4 In May 2023, internal audit carried out a further review providing 'reasonable' assurance noting the progress of actions to establish its wider quality management system and the revision of its quality governance structure, although recognising that it was still at an early stage of implementation. In June 2023, the Institute for Healthcare Improvement and Improvement Cymru identified improvements as part of a quality review with data, staff training, and lineation of aims and trajectories and improvement methodologies.
- 1.5 Audit Wales reported in its 'Structured Assessment – October 2023' that, "although the Health Board has taken positive steps to improve its quality governance arrangements, including the approval of a five-year Quality Strategy and the recent approval of the Quality Framework (approved October 2023), it still has work left to do. This includes improving scrutiny of the quality and safety of services and embedding the quality framework".
- 1.6 The health board's IMTP Recovery & Sustainability Plan 2023/24 – 2025/26 details the following key principle, "reducing harm, improving quality and safety, delivering outcomes that matter to people, delivering value, and driving performance excellence." Further, the following strategic objective for the health board is recorded on the Board Assurance Framework (ref 1) 'Demonstrably

Improved Quality, Safety & Reduced Harm'. The health board is currently in targeted intervention for performance and outcomes.

- 1.7 The key risks considered in this review are that quality and safety governance arrangements are ineffective with issues not escalated to and addressed by the health board, potentially resulting in poor quality services and / or patient harm.
- 1.8 Our audit has reviewed the progress made to implement the Quality Management System, with two of the objectives (objectives 2 and 3) focussing specifically on the health board's quality priority for falls prevention.

2. Detailed Audit Findings

- 2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	2	10	-	12
Operating Effectiveness	-	3	-	3
Total	2	13	-	15

- 2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in [Appendix A](#).

Objective 1: The health board is continuing to implement a quality management system that provides clear direction and structure for its quality governance arrangements; and that effectively embeds the Quality Improvement Framework.

- 2.1 The IMTP Recovery & Sustainability Plan (2023/24 – 2025/26) detailed a risk to delivery of the quality management system if there is insufficient infrastructure to provide dedicated support from within the Quality, Safety, and Improvement (QSI) team. Following a report being taken to the Management Board (5 July 2023), staffing resources have increased within the team to include two project officers, administrative support, an additional trainer, and a data analyst.
- 2.2 Noting that arrangements are still embedding within the team and the long-term absence of a senior member of the QSI team during our review, it became apparent through the performance of our fieldwork, there was a lack of awareness and understanding of key processes despite the efforts of staff (see **Matter Arising 1**).
- 2.3 Reporting to the Audit Committee (18 January 2024) detailed the work that has been undertaken to strengthen the quality management system, including a baseline review of quality resources to determine corporate and service group responsibilities; the development of a QSI hub to provide support to staff through

dedicated intranet pages; and the launch of a revised training programme. Regular updates are provided to Quality & Safety Group (QSG) and Management Board on progress with training delivery. For further details on the reporting framework refer to **audit objective 4**.

- 2.4 The Quality & Safety Process Framework (September 2023) has been revised to incorporate changes, including the implementation of the Duty of Quality across Wales, the launch of the Quality Strategy (2023-2028), and the implementation of the quality management system. At the conclusion of our review, a Quality Improvement Framework was being finalised to support the Process Framework.
- 2.5 The Quality Strategy (2023-2028) details the health board's four ambitions for improving quality over the next five years:

Table 1:

Ambition 1	Delivering Safe and Reliable Care
Ambition 2	Becoming an organisation that our patients and communities are proud of
Ambition 3	Empowered staff
Ambition 4	High Quality Accessible Services Now and In the Future

- 2.6 Improvement goals have been identified within each ambition and the Strategy details their forecasted delivery, which has been incorporated into an implementation plan. There is a total of 67 improvement goals to be delivered over the next five years, with an expectation that 30 (45%) of these goals were to be implemented within the first year of the Strategy (2023-24). However, only six (20%) have been completed before the 31 March 2024 timeframe (see **Matter Arising 2**).
- 2.7 Progress with delivery of the implementation plan is monitored monthly by the QSI team, and despite their efforts in chasing updates, 50% of the improvement goals (forecasted for delivery within the first year) did not record recent progress nor was there a prioritisation criterion recorded to define categorisation of RAG (Red Amber Green) status (see **Matter Arising 2**). 67% of goals are reported as 'on-track' (yellow) despite the target date for completion being before 31 March 2024. Now the health board has been escalated to Targeted Intervention by Welsh Government for performance and outcomes, this provides an opportunity to reflect and put in place achievable strategic priorities within the Quality Strategy (see **Matter Arising 2**).
- 2.8 Progress with delivery of the implementation plan is reported quarterly to QSG, Management Board, and Quality & Safety Committee (QSC). The reporting for Quarter 2 (December 2023) and Quarter 3 (March 2024) provided a thematic focus on progress with the delivery of improvement goals within one ambition rather than a detailed overview of all goals, as was the case for Quarter 1 (August 2023). Whilst this condensed reporting assists with reducing the information flow to committee members, it does not provide adequate oversight of all goals that are

overdue or 'off-track' to ensure that any issues are escalated promptly (see **Matter Arising 2**).

- 2.9 It is also unclear why the total number of improvement goals have differed over the three quarters from 68 in Quarter 1 to 52 by Quarter 3 (see Table 2 and **Matter Arising 2**):

Table 2:

	Quarter 1	Quarter 2	Quarter 3
Completed	2	5	5
On track	28	45	37
Overdue/Off track	0	1	0
Not started	38	21	10
Total	68	72	52

- 2.10 Extensive communication and engagement had been carried out with staff as part of the Quality Strategy's launch (March 2023). Both the Quality Strategy and reporting to Audit Committee (18 January 2024) refers to the development of a Communication Plan to detail the regularity of communication and engagement of the Strategy, but there has been a delay in progressing this due to capacity issues within the team (see **Matter Arising 3**).

Conclusion:

- 2.11 The Quality Strategy is at an early stage of implementation, but would benefit from a review, including the detail and number of improvement goals, now the health board has been escalated to Targeted Intervention by Welsh Government. This should also consider the capacity of the QSI team where current business continuity arrangements need to be strengthened in the absence of key staff. Enhancements to the reporting of the implementation plan will ensure there is appropriate oversight where delivery of the Strategy is at risk, and developing a Communications Plan will ensure there is an appropriate level of engagement. The QSI team has provided dedicated support through various mechanisms including training and provision of the QSI hub. We assign this objective **reasonable** assurance.

Objective 2: There is appropriate identification and monitoring of key risk areas of the health board quality priority for falls prevention.

- 2.12 In addition to the ambitions and the improvement goals set out in the Quality Strategy, annual quality priorities have been agreed to focus on making improvements in the safety of care. We reviewed the quality priority for falls prevention where there is a dedicated Falls Quality Improvement Lead within the QSI team since January 2022.

- 2.13 There is no documented risk register that clearly identifies and manages issues that may impact the achievement of quality priorities, e.g. the Quality Priority Programme Board (QPPB) does not have a programme risk register (see **Matter Arising 4**). Instead, risks are reported in narrative format to QSG, Management Board, and QSC quarterly as part of the Quality Priorities Highlight report or twice-yearly within 'deep dive' reporting (provides a deeper understanding of risks and progress with performance for quality priorities). However, reporting does not outline risk scores, clear ownership, or controls to mitigate the risk, e.g. next steps were documented as 'explore options'.
- 2.14 There is also no continuity of reporting to demonstrate that risks previously highlighted have been addressed (see **Matter Arising 4**). For example, falls training not being mandatory was detailed as a risk previously, but no update has been provided on subsequent reporting.
- 2.15 One risk that continues to be highlighted within reporting is in relation to data informatics. The 'deep dive' report (June 2023) details that a dashboard is not yet in place impacting the service groups' ability to have access to real time falls data, but the latest report (March 2024) records the dashboard is in development (see **Matter Arising 4**).
- 2.16 Quality and safety risks are reported to the committees where the risks are assigned; and that falls prevention, which has been considered through our review, is evidenced as reported to Quality & Safety Committee including as a control relating to risk 3.3 (Access to Unscheduled Care) on the health board's risk register. We note that there has been training with nursing homes on the management of patient falls; and collaboration with the Welsh Ambulance Services University NHS Trust to identify further opportunities for partnership working around falls in the community (this forms part of a project to identify alternative pathways and reduce reliance on ambulances where falls occur). There is also targeted work being carried out in Acute Medical Units to reduce falls.

Conclusion:

- 2.17 While risks relating to the falls prevention quality priority have been reported, the process needs to be more structured within risk registers to capture and prioritise risks consistently and monitor the effectiveness of mitigations. Wider consideration of risk relating to falls prevention has been considered and there are projects to target areas to reduce falls and the reliance on ambulances in the community. Therefore, we provide **reasonable** assurance for this objective.

Objective 3: Key performance indicators have been identified in relation to the health board quality priority for falls prevention, which support the monitoring of the quality of services and patient outcomes as the arrangements transition to 'business as usual'.

Monitoring

- 2.18 Several mechanisms are used to capture and monitor performance outcomes for the quality priority for falls prevention. These include monitoring Serious Reportable Incidents (SRIs), carrying out audits, and reviewing progress with the delivery of goals, methods, and outcomes (GMOs).
- 2.19 There was a lack of clarity amongst QSI staff as to what GMOs related to the quality priority, noting that there could be other GMOs for falls prevention that do not necessarily relate to the quality priority. The IMTP Recovery & Sustainability Plan (2023/24 – 2025/26) details six goals and methods for falls prevention.
- 2.20 Both the 'deep dive' and Quality Priority Highlight reports (as per para. 2.13) detail progress with the GMOs, but reporting is not always clearly aligned to the GMOs set out in the Plan (see **Matter Arising 4**). The 'deep dive' report (June 2023) detailed eight goals and nine methods and that approximately 75% of these have been completed. The report notes that, *"in order to ensure continued improvement the GMOs for 2023/2024 have been revised"*, and four GMOs are detailed.
- 2.21 However, the subsequent 'deep dive' report (March 2024) details the progress with the six GMOs as outlined in the Plan (see below). There is a lack of continuity in reporting as no update is provided with the achievement of the performance measures detailed in the June 2023 report (see **Matter Arising 4**):

QS_FP_001	Develop joint quality improvement workstreams with partners within the community falls provision against best practice in order to identify gaps and potential areas of duplication	2 projects completed	Green		On Track
Qs_FP_002	Continue to reduce inpatient falls by 10%	Av 174 falls	Green		On Track
QS_FP_003	Strengthen use and application of Multi Factorial Risk assessments for all over 65s – target 100%	70% compliance in 4 main hospital sites	Amber	Last audit reported 60% compliance – delay on updated report – WNCR compiling report, ED'A will update	Off Track (Manageable)

				when completed	
QS_FP_004	Deliver quality improvement project to reduce conveyance as part of Safe Care Collaborative	Agree project parameters	Green	On track – partners agreed, baseline data analysis commenced	On Track
QS_FP_005	Participate in and implement recommendation from NAIF (National Audit of Inpatient Falls)	Improvement in 1 recommendation to national average	Amber	On track with plan in place	On Track
QS_FP_006	Embed Hot debrief tool across all site areas	Tool in regular use in 60% of ward areas	Green	Delay in implementation in Morriston – SGH trialling online version	On Track

- 2.22 Similarly, there is no continuity between the Quality Priority Highlight reporting of progress with GMOs or actions (see **Matter Arising 4**).
- 2.23 The ‘deep dive’ report (March 2024) provides a detailed overview with performance of falls prevention noting that “*the first year of Falls Prevention as a Quality Priority saw the target of 10% reduction of injurious inpatient falls exceeded*”, but that “*falls remain however, one of the highest cause of incidents within the HB, and nationally it is the second leading cause for accidents in the home*”. While there has been a significant reduction in both the falls rate per 1,000 bed days and SRIs, there was a significant increase in falls incidents in Morriston Hospital during Quarter 4 (2023-24) pushing the rolling average up to 167 falls per month.
- 2.24 Several opportunities for improvement have been identified as part of a falls focussed audit at Morriston, and a ‘Baywatch’ initiative was launched during December 2023. This involves having dedicated members of staff based within a ward bay where patients have been assessed as being at high risk of falling.
- 2.25 While there is no benchmarking of performance data, the health board submits data to the National Hip Fracture database (NHFD) and was also subject to a National Audit of Inpatient Falls (NAIF) audit (December 2022). Management Board received a recent progress update on actions relating to the NAIF audit as part of ‘deep dive’ reporting (March 2024). The Falls Quality Improvement Lead is actively involved in discussions at both a regional and national level, e.g. Public Services Board, Regional Falls Prevention Taskforce, etc.

Governance

- 2.26 The governance framework for the falls prevention quality priority within the health board consists of the Falls Prevention Quality Priority Delivery Group (FPQPDG) (also known as the overarching steering group), which reports into the Quality Priority Programme Board (QPPB). The finalised version of the terms of reference

for the FPQDG was not evidenced. Due to a lack of administrative support, we note only an action log is completed for each meeting and written reports are rarely provided for agenda items – this does not provide sufficient evidence of key decisions and scrutiny of agenda items (see **Matter Arising 5**).

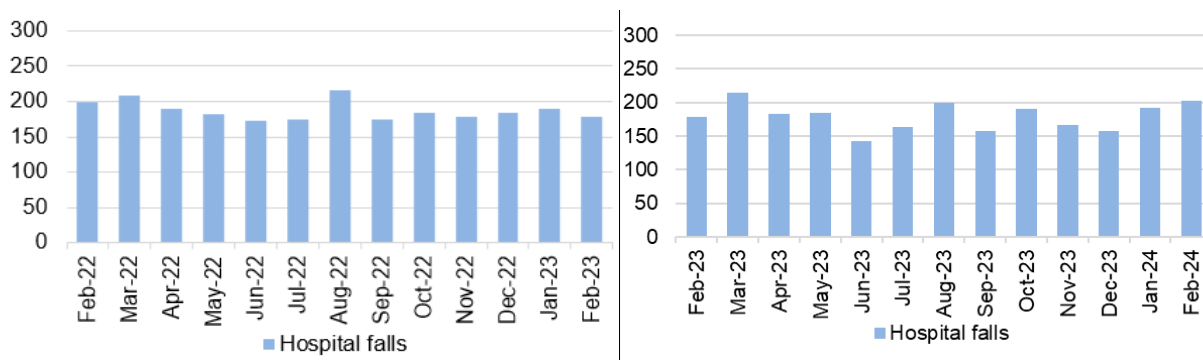
2.27 The IMTP Recovery & Sustainability Plan (2023/24 – 2025/26) detailed a risk to the achievement of quality priorities if there is insufficient clinical engagement and from within service groups. The FPQPDG is supported by the service groups who have their own falls scrutiny groups that the Falls Quality Improvement Lead attends. There had been an issue with the attendance and engagement from Primary, Community and Therapies Service Group (PCTSG), but this has now been resolved as they have a dedicated falls lead and falls prevention group.

2.28 There is regular reporting of performance with the falls prevention quality priority to QSG, Management Board and QSC, as well as in Integrated Performance Reporting (IPR) to the Performance & Finance Committee and the Board. IPR reporting details the number of inpatient falls reported via the Datix system (see **Table 3**):

Table 3:

	Number of Inpatient Falls
February 2024	203
February 2023	179
February 2022	199

2.29 The graphs below represent the trajectory of performance for the total number of inpatient falls for February 2023 to February 2024 compared against the same period for 2022-23:



2.30 While the GMO for reducing inpatient falls by 10% was achieved by February 2023, it was not achieved for February 2024 (note: ‘deep dive’ reporting details that this is ‘on track’ as it is based on an average of 174 falls, but we have not seen the rationale for this figure). Performance has been stable but does not demonstrate a marked improvement despite efforts, and as initiatives such as ‘Baywatch’ have only recently been implemented, it may take time for the benefits to be realised.

Business As Usual (BAU)

- 2.31 Falls prevention has been a quality priority within the health board since 2021. Initially, it was planned for falls prevention to revert to 'business as usual' by April 2024 (where service groups continue to deliver the improvements that the QSI team have supported), but now it will form part of a workstream to support the new frailty quality priority.
- 2.32 We note that there is no documented criteria to determine when BAU has been achieved. Each of the quality improvement leads have been asked to define this for their quality priority, but while this is noted as an action on the Quality Priority Highlight report (February 2024) for falls prevention, it has not yet been completed (see **Matter Arising 4**).

Conclusion:

- 2.33 There are several mechanisms for monitoring performance with the quality priority for falls prevention, but clarity is needed amongst the QSI staff to confirm the correct number of GMOs to assist with the consistency and continuity of reporting, and an agreed definition of when a quality priority can be taken to 'business as usual' stage. Despite the initiatives put in place, there has not been a significant improvement in the reduction of falls to date. Governance arrangements are improving with increased engagement at service group level, and partnerships continue to strengthen both on a regional and national level. We assign this objective **reasonable** assurance.

Objective 4: An appropriate governance framework is in place to provide oversight of quality and safety issues within the health board, ensuring key risks and issues are reported and escalated where necessary.

- 2.34 Audit Wales reported in its '*Structured Assessment – October 2023*' that some of the operational quality and safety structures were not operating as intended because of the staff resource required, that there needed to be a stronger focus on quality and safety in the Integrated Performance Report (IPR), which should be presented by a clinical executive director. It also commented that the health board's work to develop its quality governance arrangements has taken a considerable amount of time.
- 2.35 The Quality and Safety Process Framework outlines the governance and assurance mechanisms, which includes providing clarity around the roles and responsibilities for quality and safety within the organisational structure. This includes the following sub-groups which reporting into the Quality & Safety Group (QSG):
- Quality Priorities Programme Board (QPPB),
 - Patient Safety & Compliance (PSC); and
 - Patient & Stakeholder Experience (PSE).

The QSG provides regular reports to the Quality & Safety Committee (QSC) and Management Board (who has a dedicated monthly meeting focused on quality and improvement issues).

- 2.36 It has been recognised within the health board that further enhancements to the quality and safety governance structure are required, including ensuring the key people are attending meetings, appropriate level of discussion and scrutiny of agenda items.
- 2.37 Commonalities were identified across quality priorities and therefore to enable the sharing of good practice and reduce duplication, the Quality Priority Collaborative Group was formed. An initial meeting was held in November 2023 with bi-monthly meetings planned for 2024. However, we have not been able to evidence the outcomes of these meetings (see **Matter Arising 5**).
- 2.38 Enhancements in relation to sub-group reporting and escalation were identified in our review of *'Quality and Safety Governance Framework'* (May 2023). This included reviewing the terms of reference of the QPPB. The document has been revised and approved by Management Board (6 December 2023). Finalised versions of the terms of reference for other groups have not been reviewed in line with their review dates (see **Matter Arising 5**).
- 2.39 Verbal updates are predominantly provided at some of the meetings of the sub-groups to the QSG, rather than written reports, and highlight reporting did not always utilise the agreed corporate template. While this may be due to staff pressures, there needs to be an appropriate level of oversight and escalation of key issues (see **Matter Arising 5**).
- 2.40 Improvements to the escalation of issues by the PSC to QSG and Management Board was recommended in our review of *'Additional Learning Needs'* (issued January 2024: Limited Assurance). Evidence could be seen of escalation of key issues by sub-groups to QSG, with confirmation of these discussions being contained in subsequent highlight reporting to the QSC and Management Board. However, it should be ensured that the escalation log is regularly updated in line with our previous recommendation (*'Quality and Safety Governance Framework'* (May 2023)).
- 2.41 The Quality Strategy (p46) details that, *"each month, our Board will receive a range of performance data demonstrating progress towards achieving our goals, enabling the board to exercise challenge where necessary"*. The table below details some of the key considerations for continuous improvement:

Table 4:

Quality Strategy (p.47)	<ol style="list-style-type: none"> 1. Are we targeting and measuring what matters most to patients? 2. Do we know how good we are? 3. Do we know where we stand relative to the best? 4. Do we know how much variation in practice we have and where that variation exists? 5. Do we have the right capabilities, tools and engagement to deliver the changes we need to make?
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- 2.42 Recognising the Strategy was approved in January 2023 and the capacity of the QSI team, the health board has not had the opportunity to reflect whether its reporting on continuous improvement encompasses the above areas (see **Matter Arising 5**).

Conclusion:

2.43 It has taken the health board time to establish its quality governance arrangements and they are continuing to embed. There is regular reporting and monitoring on quality and safety of services but there is also recognition within the organisation that there needs to be more scrutiny and strengthening of existing structures. Therefore, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Business Continuity Arrangements (Design)		Impact
<p>Measures have been taken to increase the resource of the Quality, Safety, and Improvement (QSI) team to include the recruitment of two project officers, an administrative support officer, data analyst and a trainer. Noting that arrangements are still embedding within the team and with the long-term absence of a senior member of the QSI team during our review, it became apparent through the performance of our fieldwork that there was a lack of awareness and understanding of key processes relating to the Quality Management system. Improvements in this area will assist with the learning and development of the team.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Insufficient support is provided to meet the duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 resulting in poor quality services and / or patient harm.
Recommendations		Priority
1.1	Appropriate measures should be put in place within the Quality, Safety, and Improvement Team to provide cover in the absence of key staff including having all key documentation stored in a centralised location.	Medium
Agreed Management Action		Target Date
1.1	Arrange a learning meeting for all Senior Members of the Team to ensure greater understanding of the processes of our Quality Management System.	August 2024
	To review and centralise all Quality Management System documentation	August 2024
		Head of Quality & Safety/ Deputy Head of Quality & Safety/ Acting Project Lead

Matter Arising 2: Quality Strategy Priorities (Design)	Impact
<p>An implementation plan was developed to provide focus on the delivery of improvement goals detailed within the Quality Strategy (2023) over the next five years. Despite the efforts of the QSI team in reviewing the plan monthly and contacting action owners for updates on progress, 80% of the 30 improvement goals that were due for implementation during 2023-24 are overdue and 50% did not have a recent update on progress (last updated December 2023). Now the health board is under Targeted Intervention, this provides an opportunity to reflect and put in place achievable strategic priorities within the Quality Strategy.</p> <p>Improvement goals should be clearly categorised to reflect their current status, but there is nothing documented to define the prioritisation criteria used. Arguably, 18 actions that have a due date before 31 March 2024 should now be recorded as 'off-track' (red) instead of 'on-track' (yellow).</p> <p>There is quarterly reporting of progress with the implementation plan to the Quality & Safety Group (QSG), Management Board, and the Quality & Safety Committee (QSC). Quarter 1 reporting provided progress with all the improvement goals, but for Quarter 2 and 3, there was only an overview of delivery detailing the number that had been completed, not started, off-track, etc.</p> <p>Reporting noted that there is now a thematic focus with detailed progress only being provided for one of the four ambitions each quarter (although a link is provided to the whole implementation plan). This does not provide a clear oversight of any issues with delivery of the implementation plan so prompt action can be taken to address any improvement goals that are off-track or overdue.</p> <p>Reporting did not also encompass progress made over the three quarters, so it is unclear why the total number of improvement goals had decreased to 52 by Quarter 3 when there were 72 in Quarter 2.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Non-achievement of the health board's strategic objectives, which is detrimental to the quality-of-service delivery.
Recommendations	Priority
<p>2.1a The Quality Strategy Implementation Plan should be reviewed and redesigned to focus on improvement goals that are relevant and achievable.</p> <p>2.1b The Implementation Plan should incorporate SMART criteria to define success and provide realistic timescales for delivery.</p>	<p style="text-align: center;">High</p>

2.2	Performance reporting of deliverables within governance arrangements should provide effective oversight of progress with delivery of the Implementation Plan that clearly defines risks and enables prompt action to be taken where issues are escalated.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1a	To have a thorough review of the Goals and Actions within the Quality Strategy Implementation plan and bring an update in July for Q&S Group.	August 2024	Head of Quality & Safety/ Deputy Head of Quality & Safety/ Acting Project Lead
2.1b	The review will use SMART criteria in order to clarify realistic timescales and successes.		
2.2	Performance reporting of deliverables should clearly identify progress, risk and actions. Implementation Plan documentation to be reviewed and adjusted to address this.	August 2024	Acting Project Lead

Matter Arising 3: Communication Plan (Design)		Impact	
<p>The Quality Strategy (p46) detailed that, "to make sure that we keep talking about and looking at quality, we will develop a communication plan that outlines how we will regularly engage and promote the strategy." Similarly, reporting to Audit Committee (18 January 2024) noted the development of a communications plan as an action. No copy of the plan could be provided when requested as there has been a delay in progressing this due to capacity issues within the team.</p> <p>A similar enhancement was made as part of our review of the 'Quality and Safety Governance Framework' (May 2023), but this relates to the Duty of Quality Communication Plan that is separate to that referred in the Strategy.</p> <p>Extensive communication and engagement had been carried out with staff as part of the Quality Strategy's launch (March 2023), but nothing has been carried out recently to assist with embedding arrangements.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Opportunities to raise internal and external awareness may be missed. 	
Recommendations		Priority	
3.1a	The health board should develop a communications plan to ensure there is a structured approach to raising awareness of the Quality Strategy both internally and externally.	<p>Medium</p>	
3.1b	Following development, the plan should be shared at an appropriate forum and appropriate staff engagement should be carried out to ensure that arrangements continue to be embedded.		
Agreed Management Action		Target Date	Responsible Officer
3.1a	Communications plan for the Strategy and ongoing implementation plan to be discussed with the Director of Insight, Communications & Engagement and put a plan in place by July.	July 2024	Head of Quality & Safety/ Deputy Head of Quality & Safety
3.1b	Communication Plan to be put on all QSI Meetings and to be taken to Board and Committee Meetings. Follow up Engagement Process to be arranged with senior leads across the Health Board.	August 2024	

Matter Arising 4: Risks and Performance relating to Quality Priorities (Design)	Impact
<p>Our audit focused on Falls Prevention, which was identified as a Quality Priority by the Health Board in 2021. However, some of the following enhancements could apply to other quality priorities.</p> <p>Risks: There is no documented programme risk register that records what could impact the achievement of quality priorities. While there is escalation of risks, they are not clearly defined, e.g. detailing RAG status, risk owner, controls to mitigate the risk, etc.</p> <p>Additionally, there is not always the continuity in risk reporting to confirm that they have been addressed if they are no longer documented in subsequent reports. An exception to this is the reporting of the risk in relation to data informatics (service groups not having access to real time performance information for falls incidents). Instead, this is reviewed retrospectively the following month, and there is also disparity between clinical assessments and systems data.</p> <p>Performance: There is inconsistency in the reporting of progress with the goals, methods, and outcomes (GMOs) so it is unclear why the total number of GMOs has differed and to identify the progress made.</p> <p>Similarly, the reporting template for the Quality Priority Highlight report could also be improved to confirm the progress made with actions in relations to the falls prevention quality priority and to clearly document any issues or items for escalation.</p> <p>Business as Usual: There is no documented criteria to determine when BAU has been achieved, but the leads for each quality priority have been tasked with defining this for their area. This is noted within the 'deep dive' report for the End-of-Life Care Quality Priority (as reported to QSC - March 2024). However, the Falls Quality Improvement Lead has not defined BAU, but this is documented as an action on the Quality Priority Highlight Report (February 2024). The Quality Priority Collaborative Group could be used as a mechanism to share good practice in defining BAU.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Risks impacting the achievement of health board quality priority are not identified and managed effectively and impact adversely. • Performance is not effectively monitored leading to poor decision making and a failure to deliver the health board quality priority. • Resources are used inefficiently or there is duplication of effort due to a lack of clarity over 'business as usual' for health priorities.

Recommendations		Priority	
4.1a	Risks relating to the achievement of quality priorities should be captured in a programme risk register detailing their RAG status, risk owner, and noting the appropriate mitigating controls in place.	Medium	
4.1b	Risks should be regularly reported noting any amendments to their controls or categorisation.		
4.1c	A robust system should be implemented to ensure that service groups have access to up-to-date and consistent performance information for falls rates.		
4.2a	Performance measures relating to quality priorities should be reviewed to clarify the GMOs; with any outstanding activities transferred to the new workplan for the Frailty Quality Priority.		
4.2b	Performance should be regularly reported utilising SMART criteria, noting any amendments to that previously reported, and clearly highlighting items for escalation.		
4.3	'Business as Usual' stage should be clearly defined to ensure that staffing resource within the QSI team does not duplicate that within service groups.		
Agreed Management Action		Target Date	Responsible Officer
4.1a	Quality Priority Risk Log to be added to the Quality Priority reporting system and updates given each month.	June 2024	Deputy Head of Quality & Safety
4.1b	Update on Risks to be reported at Quality Programme Board.	July 2024	All Quality Priority Leads
4.1c	Ongoing development of Q&S Dashboard which will include Falls Data at ward level.	September 2024	Business Intelligence Partner (Digital Intelligence)

4.2a	GMO's will be owned by the Service Groups but QSI Clinical Leads will attend the Integrated Planning Group meetings to support and advice service groups on the GMO's. Quality Priority Programme Board will have oversight and updates bimonthly.	Commenced June 2024 then ongoing	Head of Quality & Safety/ Deputy Head of Quality & Safety/ Quality Priority Leads
4.2b	<p>QI methodology and measurement will underpin our Performance Report.</p> <p>Items for escalation will be discussed in Quality Priority Programme Board and reports taken to Management Board and Committee monthly.</p>		
4.3	To review with all QP Leads what they feel Business as usual would look like and review in Quality Priority Programme Board. QP Leads all asked to feed back on generic themes that would indicate Business as Usual.	August 2024	Deputy Head of Quality & Safety



Matter Arising 5: Governance Arrangements (Operation)	Impact
<p>Recognising the capacity of the QSI team there has not been the opportunity to enhance governance arrangements that have already been identified by the health board, e.g. attendance of meetings, the triangulation of reporting, and scrutiny of agenda items. Our review identified the following enhancements:</p> <p>Terms of Reference:</p> <ul style="list-style-type: none"> The terms of reference for the QSG and two of its sub-groups (Patient Safety and Compliance (PSC) and Patient and Stakeholder Experience (PSE)) detail they will be reviewed annually, but we have been unable to confirm they have been reviewed since January 2023. A draft version of the terms of reference was provided for the Falls Prevention Quality Priority Delivery Group (FPQPDG). <p>Meeting Outcomes:</p> <p>We have not been able to evidence the outcomes of the Quality Priority Collaborative Group meetings. Similarly, due to a lack of administrative support, there is only an action log completed for each FPQPDG meeting that provides insufficient evidence of key decisions made and scrutiny of agenda items.</p> <p>Reporting:</p> <p>At some meetings, there were no written reports provided for key agenda items within the governance structure (service group reporting to the PSE and PSC; written updates not always provided by the PSE or Safer Care Collaborative to the QSG; and both the FPQPDG and the QPPB mostly had verbal updates). Highlight reporting by the PSE to QSG did not always follow the agreed format to allow for appropriate escalation of key issues.</p> <p>Organisational Learning:</p> <p>The health board arrangements in seeking continuous improvement (as per the Quality Strategy p46-47) have not had the opportunity to reflect on its success or lessons learnt on its reporting.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Unclear roles and responsibilities or ineffective reporting could result in poor decision making and a lack of accountability and oversight. Resources being used inefficiently if boards and groups duplicate in their undertaking of roles and responsibilities.

Recommendations		Priority	
5.1a	To demonstrate effective governance arrangements, the health board should review its structure for oversight of quality management arrangements to ensure there is appropriate attendance at the meetings, and to improve the quality and scrutiny of reporting and documenting of meeting outcomes.	Medium	
5.1b	Once this review is complete, there should be finalised versions of the terms of reference for all boards and groups within the governance structure. Documentation should be updated to reflect the date the terms of reference were agreed and the date of their next review.		
5.2	Once the governance structure has been reviewed, a mechanism to enable post-implementation learning should be developed to completely capture and report good practice and lessons learnt relating to quality management system reporting.		
Agreed Management Action		Target Date	Responsible Officer
5.1a	Falls Overarching Group – New admin staff in place to be allocated to take the minutes from the meeting to ensure all papers and discussions are captured.	May 2024	Deputy Head of Quality & Safety
5.1b	Tracking of attendance at QS meetings and identify actions required regarding attendance.	June 2024	Head of Quality & Safety/ Deputy Head of Quality & Safety/ Acting Project Lead
	Reviewing the terms of reference for Patient Safety and Compliance Group, Patient Stakeholder and Experience Group, COEG and to take to PSG. Meeting arranged for 16 th July 2024.	August 2024	
5.2	Report to be sent to Q&S Group in March 2025 regarding the updated Governance Structure and identifying good practice and lessons learnt.	March 2025	Head of Quality & Safety/ Deputy Head of Quality & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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