Quality and Safety Governance Framework

Final Internal Audit Report

May 2023

Swansea Bay University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Bae Abertawe
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Executive Summary

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2021/22

Assurance summary [1]

Assurance objectives		Assurance
1	Quality Management System	Reasonable
2	Quality governance improvement plans	Reasonable
3	Duties of Quality and Candour	Reasonable
4	Quality Indicators	Reasonable

Purpose

To review the progress made to implement the framework and assess how it meets the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Overview

In response to recommendations previously raised (both internal audit and Audit Wales), and in preparation of the implementation of the Duties of Quality and Candour, the health board approved a Quality Strategy in January 2023, and has progressed actions to establish its wider quality management system.

It has also revised its quality governance structure, and whilst recognising there will be need for groups to further embed, our review has highlighted some initial areas for consideration to support their design and operation.

The matters requiring management attention include:

- Reporting from newly established subgroups to the Quality and Safety Group requires formalising to capture exceptions and escalations.
- Progress noted in Service Group alignment to corporate quality and safety arrangements, although some variation in approach has been noted.
- Terms of reference for the Quality and Safety Group, and its subgroups, are broadly consistent; however, some minor enhancement opportunity noted.
- Quality and Safety Informatics Group reporting and Service Group engagement in developing dashboard indicators.

Other recommendations / advisory points are within the detail of the report.

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
2	Quality Groups Terms of Reference	1	Design	Medium
3	Subgroup reporting and escalation	1	Operation	Medium
4	Service Group Quality & Safety arrangements	1	Design	Medium
5	Duty of Candour Service Group Standard Operating Procedures	3	Design	Medium
6	Quality Assurance Framework	3	Design	Medium
7	Duty of Quality Communications Plan	3	Design	Medium
8	Quality and Safety Informatics Group	4	Operation	Medium

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

1. Introduction

1.1 In 2021/22, Swansea Bay University Health board ('the health board') undertook a review to consider the quality governance arrangements within its service groups. The timing of this piece of work coincided with Audit Wales review of Quality Governance arrangements which reported '*significant weaknesses in arrangements both corporately and within operational teams'*; and an internal audit review of the health board's implementation of its Quality and Safety Framework which assigned it *'limited'* assurance.

1.2 In responding to the above, the health board has reviewed its requirements for a quality management system, and has developed a Quality Governance implementation action plan which is linked to the key themes of governance, quality and safety, outcomes, and learning and organisational development. A progress update on status of the plan was shared with the Audit Committee in September 2022 with a number of actions, including externally facilitated workshops to support the design of the quality management system, reported as complete.

1.3 A further report, presented to the Board in September 2022, outlined that the system would also address the responsibilities introduced by the Duty of Quality contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ('the Act'). The report noted the development of a quality management system was being taken forward through 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 A task and finish group has also been established, chaired by the Chief Executive Officer, to oversee the implementation of the quality management system, and ensure the robustness of arrangements at service group level. It has been proposed that service groups establish quality group structures to mirror that of the health board.

1.5 The risks considered during the review were:

i. Ineffective or un-cohesive strategy to deliver and monitor the quality and safety of services;

ii. Unclear structures or responsibilities impacting flow of assurance from ward to board; and

iii. Lack of indicators or standards to assess the quality of services and outcomes.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	5	1	6
Operating Effectiveness	-	2	-	2
Total	-	7	1	8

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.

Audit objective 1: The health board is developing a quality management system which provides clear direction and structure for its quality governance arrangements.

Quality Management System

2.3 The March 2022 Board meeting was presented with the Quality Governance Integrated (QGI) Action Plan ('the plan') to address the recommendations raised by the reviews referenced within para 1.1. It also reflected that in emerging/recovering from the pandemic, there was a need for the health board to ensure a '*quality and safety focus at every level*.'

2.4 The development of a quality management system was a key action within the plan, and we note it has been framed around the following four domains, with actions for each assigned to Executive leads:

- Governance;
- Quality;
- Outcomes; and
- Developing a Learning Organisation.

2.5 Actions included within the quality domain included the development of a Quality Strategy. A draft strategy was shared with the Board in September 2022, noting that it would be further influenced by staff, patient, and stakeholder engagement. We note emphasis on links to the health boards quality priorities alongside detail on purpose, strategic alignment, and vision.

2.6 Engagement on the content of the strategy followed, including a staff open access quality congress event in October, presentations disseminated to Service Groups, stakeholders including the Community Health Forum, Partnership Forum, Independent Members through board development and presentation at the Quality and Safety Committee. The health board also initiated its *Big*

Conversation, a staff cultural audit, allowing for the identification of key themes around quality and improvement, and the need for incorporating patient feedback.

2.7 A revised Quality Strategy was approved by the Board in January 2023 and incorporated themes identified through engagement. Notable enhancements included a new vision for quality and clearer outline of the quality management system, including detail of four elements of quality – assurance, control, planning and improvement.

2.8 The strategy also includes reference to quality ambitions (each with a number of supporting improvement goals to be achieved across the 5-year lifespan of the strategy), including:

- delivering safe and reliable care;
- becoming an organisation that our patients and communities are proud of;
- empowered staff; and
- high quality accessible services - now and in the future.

2.9 We reviewed the Quality Strategy and supporting framework documents to establish alignment with health board plans and objectives, findings raised by internal and external reviews, and alignment to Welsh Government Quality and Safety Framework guidance. We are satisfied that there is content to address these areas, either through the strategy and its associated implementation plan, or through the wider development of the quality management system. Although we note it is at too early a stage to comment on the success of all planned actions.

2.10 The health board formally launched the strategy on 2 March 2023, this was accompanied by a dedicated intranet page. The health board internet site still holds the previous Quality Strategy 2015-18, and we have highlighted this to management to remove, ahead of the close of fieldwork therefore no recommendation has been raised at this report.

2.11 The Quality and Safety Process Framework (QSPF) has also been revised in light of recommendations raised by the reviews referenced in para 1.1. The purpose of the QSPF is to describe processes for ensuring the quality and safety of services, and it outlines mechanisms to support this, alongside roles, responsibilities and the health boards quality and safety governance structure.

2.12 The QSPF revision was undertaken in August 2022. When presented to the Quality and Safety Group in September 2022, the accompanying paper noted the QSPF would require further revision in light of the developing Quality Strategy and its implementation plan, the final duty of quality and candour guidance, and further development of the quality management system. **See MA1**

Corporate Quality Structure

2.13 The Quality and Safety Framework audit report (issued January 2022, limited assurance) included a recommendation that *the health board should review the remit and objectives of the Quality & Safety Governance Group (QSGG)*. The QSGG provided a key link between the Service Groups and Quality & Safety

Committee. However, in May 2022, the QSGG was stood down as the wider quality and safety organisational structure was considered.

2.14 To replace the QSGG, in June 2022, a Quality Safety Group (QSG) was established. The QSG reports to the health board's Management Board, which in turn has dedicated quality aligned meetings. The QSG is supported by a number of subgroups:

- Patient Safety and Compliance Group (PSCG) – a newly established group and provides oversight of compliance with licensing and clinical standards and regulations; advises the QSG of significant risks or governance issues / actions.
- Patient and Stakeholder Experience Group (PSEG) – a newly established group and provides oversight and leadership of patient and stakeholder experience, including learning from complaints and serious incidents
- Clinical Outcomes and Effectiveness Group (COEG) – to provide oversight for the development and monitoring of policy and standards relating to local and national clinical audits, mortality reviews, NICE guidance, and local safety standards for invasive procedures.
- Quality Priorities Programme Board - to provide oversight of the monitoring and delivery of the health boards quality priorities.

Also within the structure is the Infection Control Committee which is currently reporting directly to Management Board as a result of enhanced monitoring. A Quality and Safety Informatics Task and Finish Group to develop a Quality Dashboard has also been formed, reporting to the QSG.

2.15 Terms of reference (ToR) have been developed for QSG, PSCG, and PSEG, and after a period of updating and amendment were reviewed for standardisation, finalised, and presented to QSG in January 2023 for approval.

2.16 Review of the QSG, PSCG and PSEG ToR confirmed that they are consistent across purpose, objectives, membership, and administrative requirements. There is small variation in quorum which may benefit from standardisation. **See MA2**. We also note the Quality Priorities Programme Board ToR is in need of review to standardise format, and we were informed this was being taken forward to reflect other changes to the group's remit. **See MA2**

2.17 Review of QSG minutes from June 2022 to February 2023 highlighted that the group has been quorate for all meetings held (December 2022 was cancelled due to industrial action) and confirmed subgroup Chairs are regularly present. Review of PSCG and PSEG minutes, for the same period, noted a small number of meeting cancellations (three meetings) and limited occasions (four meetings) where not all Service Groups were represented within the meetings. **See MA2**

2.18 Both PSCG and PSEG have developed work programmes, and these include sub-groups (8 within PSCG / 6 within PSEG). We confirmed both groups have received reports from the sub-groups listed within their work programmes, in addition to the monthly Service Group reporting, and we note there is ongoing refinement relating to reporting frequency and amalgamation where appropriate.

2.19 The reporting framework is for PSCG and PSEG to submit written reports to the QSG. Review of QSG minutes (see para 2.18) identified the updates provided by subgroup chairs were primarily verbal, alongside occasional use of group minutes. The PSCG Chair did submit an escalation report to the QSG in February, however this was limited to a summary list format. Discussion with subgroup chairs highlighted that both recognise the need to address reporting format, and are keen to incorporate elements from the Quality Dashboard to support escalation and triangulation of trends. **See MA3**

2.20 To avoid duplication of reporting to the QSG and its subgroups, Service Groups provide verbal updates to QSG for any matters not previously reported to subgroups, or for issues that may have arisen in the time between meetings. These are then included within the QSG highlight report provided to Management Board, and we note from November 2022 onwards the format of that report has been enhanced from a narrative structure to a highlight report format.

2.21 We reviewed QSG minutes for June 2022 to February 2023 confirming all issues raised for escalation were captured within the subsequent highlight report to Management Board. Narrative outline has included detail on actions in most cases, but there could be further clarity in how this is captured and monitored. **See MA3**

Service Group Quality Structures

2.22 The Quality Management System Task and Finish Group agenda for November 2022 included *Deep Dive Area: Service Group Quality Governance Arrangements,* alongside a presentation document setting out the revised corporate quality and safety group structure. The presentation was also shared with Service Group Leads for each of the corporate quality and safety groups.

2.23 We discussed progress in implementing the above with Service Group leads alongside review of recent agendas, terms of reference and, where available, business cycles. We were also provided with copies of board papers or presentations which set out how each Service Group intended to align with the revised corporate structure.

2.24 At the March 2023 Quality Management System Task and Finish Group, each Service Group presented an update on their local quality and safety arrangements. Meeting minutes include reflection that there had been considerable work undertaken to review quality and safety structures, but that there were further actions that could demonstrate consistency. There followed agreement that the task and finish group be stood down, with intention to take forward remaining actions through the Management Board Quality and Safety meeting. **See MA4**

Conclusion:

2.25 The health board has reviewed and revised its quality and safety structure through wider consideration of its quality management system, and there has been approval of a Quality Strategy which outlines the health board's direction and ambition in this area. Additional corporate groups are now in place; and Service

Group arrangements have been refreshed noting actions planned to ensure further consistency. We assign this objective **reasonable** assurance.

Audit objective 2: Plans and actions to support the implementation of the quality management system, and respond to both internal and external quality reviews, are monitored, resourced and reported appropriately.

2.26 There are a number of plans relating to quality management system and quality governance, including:

- QGI Action Plan
- Board Effectiveness Action Plan
- Quality Strategy Implementation Plan

2.27 As referenced in para 2.4, the QGI Action Plan has been developed to capture recommendations from both internal and external quality governance reviews. Review of the plan confirmed inclusion of all recommendations raised, with 16 of the 21 completed at the start of March 2023.

2.28 Recommendations from NWSSP Audit & Assurance and Audit Wales are included within the health board's audit recommendation tracker system. We reviewed entries within the QGI Action Plan against the tracker documents, confirming consistency of content within both. As at March 2023, five of the eight actions from our 2021 review had been reported as completed, and those outstanding related to the review of quality resources (para 2.32), and work underway to align Service Group quality and safety arrangements (para 2.22).

2.29 The QGI Action Plan was initially presented to the health board in March 2022. Status updates were shared with the Board in July 2022, and with the Audit Committee in September 2022.

2.30 In October 2022, the Quality Management System (QMS) Task and Finish group was established to take forward 18 actions aligned to the four domains referred to in para 2.4 in developing the health board's Quality Management System. A paper was provided to the group in March 2023 reflecting on progress made and highlighting the areas remaining, which included:

- Development of patient and staff engagement tools and techniques;
- Review of quality resources;
- Development of a communications plan to support the Quality Strategy;
- Mortality reduction plans;
- 'Big Conversation' phase three;
- Creation of a Quality Improvement Academy; and
- Development of a reward/recognition structure.

2.31 Initial implementation dates for the actions above were across the period October 2022 to December 2022. They are also captured within the health board's Board Effectiveness Action Plan, which is regularly reported to assuring committees (Audit Committee, Performance and Finance Committee, Quality & Safety Committee, and Workforce and Organisation Development Committee). The two

exceptions to this are (1) the development of patient and staff engagement tools (but we note these feature within the Quality Strategy implementation plan – see para 2.34) and (2) mortality reduction plans. The paper noted that progress in this area was now at a stage where it was to be taken forward by the Clinical Outcomes and Effectiveness Group.

2.32 One action which may have further resource or structural implications is the review of quality resources. Within its Quality Governance review (January 2022)) Audit Wales identified that there were *limited corporate resources, and quality improvement resources appeared to be working in isolation across the health board*. In response to this, the health board established a Quality Hub (June 2022), combining the corporate teams of Quality & Safety, and Quality Improvement into one team. This was followed by a baseline assessment of Service Group resourcing (November 2022) to compare establishments and quality improvement capacity across the organisation. Following discussion through the QMS Task and Finish Group, a further paper has been requested for the April 2023 Management Board meeting to outline options for progressing this area.

2.33 We also note that there have been a number of additional actions to support quality improvement within the health board. These include establishment of a quality improvement Community of Practice to establish links between quality improvement practitioners, and review of the health board's quality improvement training offer.

2.34 The improvement goals listed within the Quality Strategy have also been collated within an implementation plan, a draft version of which was shared at the Quality and Safety Group in March 2023. Actions are structured in Goal Method Outcome format, with action lead, start and due dates also populated.

2.35 The implementation plan had some areas still to be fully populated at that stage, but we note there is intention to capture any constraints or co-dependencies through a 'dependent on' column within the plan. There may be benefit in outlining milestones for the longer-term actions within the plan as some reflect the lifespan of the Quality Strategy (2024-2027).

2.36 We were informed that once finalised, there is intention to provide monthly progress updates to the QSG, Management Board and the Quality and Safety Committee.

Conclusion:

2.37 In its implementation of the quality management system, the health board has developed and progressed its QGI Action plan. A recent paper to QMS highlighted the remaining actions, the majority (noting two exceptions) will be monitored through the Board Effectiveness Action Plan. A draft Quality Strategy Implementation plan, outlining actions to be taken forward over the period 2024-27, is also in development. We assign this objective **reasonable** assurance.

Audit objective 3: The impact of the duties of Quality and Candour contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 have been assessed and incorporated within health board actions.

2.38 Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 June 2020, and will be implemented by the health board from 1st April 2023. The Act creates two duties of Candour and of Quality, which became a legal requirement for all NHS organisations in Wales from the same date.

Duty of Candour

2.39 The Duty of Candour requires NHS organisations to follow a set procedure should a patient experience unexpected or unintended harm (of moderate or greater level) where health care was or may have been a factor. An annual report to Welsh Government will be required which captures how often the duty has been triggered, with detail including the circumstances leading to the event and associated actions which followed to help prevent re-occurrence.

2.40 The Assistant Head of Concerns, in their role as Duty of Candour implementation lead, has co-ordinated the health board preparations through the use of an implementation handling plan. The plan has mapped local and national meetings, actions, alongside action leads, completion status and RAG rating.

2.41 The draft Duty of Candour policy was provided during fieldwork, and we note it contains detail on guidance, responsibilities, timescales and template documents for use where the duty has been triggered. We were informed that there will also be updates made to the Concerns Management policy to ensure alignment with the new duty.

2.42 Following the end of the national consultation (December 2022) the Assistant Head of Concerns held a Service Group workshop, which included a presentation outlining where the Duty could be applied, the trigger review process, and detail on notification methods and target dates. In March 2023, a weekly operationalisation session was established with Service Group quality and safety leads, to allow for any further support required ahead of the implementation date.

2.43 Each Service Group has returned a training needs analysis document, which included mapping Duty of Candour goals to local leads, and asked that any responsibility or delivery risks be flagged. Returns indicated concerns relating to resource capacity to support Duty of Candour process, and training requirements. We note resource concerns have also been highlighted at a number of management and committee meetings across the health board. Discussion has included highlighting Welsh Government awareness that implementation of changes will need to take place in a phased way.

2.44 The draft Duty of Candour policy also requires Service Groups to develop a Standard Operating Procedure to support staff and detail local arrangements for meeting the Duty. At the date of fieldwork these were at draft stage. **See MA5**

2.45 The Duty of Candour NHS Wales e-learning package was released on the 16th March and shared with Service Group leads for further internal distribution. Prior

to this a SharePoint page holding national guidance had been launched to raise awareness locally.

2.46 Noting that the Duty of Candour also relates to primary care contractors and commissioned services, the Assistant Head of Concerns Management highlighted incident reporting (regarding beds commissioned through local authorities) and the current reporting processes during discussions with the Primary Community and Therapies Service Group. Arrangements were also being made to ensure contract wording reflects the finalised guidance issued by Welsh Government.

2.47 The Quality Strategy includes reference to the Duty of Candour, noting that it is a statutory requirement, will promote a system wide culture of openness and honesty, and the need for a set procedure to evidence action taken when the duty is triggered. Improvement actions which follow include development of a training programme which includes the Duty of Candour, and two performance metrics linked to complaints procedures. Following a suitable period of implementation there could be consideration of developing further Duty specific actions.

Duty of Quality

2.48 The Quality and Engagement Act sets out a definition of quality, which the health board have adopted within its Quality Strategy as '*A system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.*' To deliver this, as referenced within previous audit objectives, the health board has been developing its quality management system, approval of its Quality Strategy, and the review of its quality and safety governance structures.

2.49 The Duty of Quality statutory guidance includes the need to establish effective quality management systems which align to quality planning, quality improvement (see para 2.32), quality control (see paras 2.13-24 relating to associated governance structure), and quality assurance. Each of these is referenced within the Quality Strategy and we considered early progress against key actions related to each. Actions to support quality improvement and quality control actions have been highlighted within previous audit objectives.

2.50 With regard to quality planning, we note progress through the 'Big Conversation' cultural audit, and the establishment of the PSEG which allows regular input from:

- Accessibility Reference Group,
- Volunteer services (including outline of numbers active, achievements/pilots and future priorities such as development of a Volunteer Strategy), and
- Community Health Council/Citizens Voice.

Discussion with the Chair of the PSEG indicated there is still a need to systemise how this feedback can be used within planning, and further developments to assist in delivering the health boards aim of identifying hot spots and areas of good practice which will be facilitated by the Quality Dashboard (see para 2.55)

2.51 In outlining its approach to quality assurance, within its Quality Strategy, the health board references its Quality Assurance Framework (QAF). The QAF is a toolkit developed to support ward to Board reporting through multi-disciplinary unannounced inspection. A number of enhancements have been made to the toolkit in recent months, including the creation of an unscheduled care assurance toolkit which incorporated Healthcare Inspectorate Wales practice from its review of Ysbyty Glan Clwyd.

2.52 A remote/digital assurance toolkit has also been developed which can be used where circumstances do not allow an on-site audit, and has been used for a review of Gorseinon Hospital in January 2023. We are also informed there is work underway to develop toolkits for other non-ward services including HMP Swansea, and maternity services.

2.53 The PSCG includes ward assurance visits as a standing agenda item, and we note in March 2023 it received an update summary on action status from the nine assurance visits undertaken in 2022/23. The update indicated further information on action completion was required for seven, but note that three of the outstanding areas were impacted by service changes. We also note the SOP and guidance document relating to the QAF dates from 2019, and so there is scope to update this to reflect recent changes and clarify requirements for reporting on action completeness. **See MA6**

2.54 A Duty of Quality intranet page was launched at the end of March 2023, providing information for staff on the duty including videos introducing the duty and links to external guidance.

Duties of Quality and Candour

2.55 As part of engagement with the national groups overseeing implementation of the two duties, the health board has returned status updates which RAG rates readiness against a set of road map milestones. We reviewed the March 2023 return, and were able to verify updates provided for key areas. Overall, the return indicated a good level of preparedness, 13 of 18 Duty of Candour indicators were reported as confident of delivery, the Duty of Quality included six of 14 as confident of delivery, with those remaining listed as at risk but within tolerance to meet the April 2023 implementation target date. Within the review of Duty of Quality indicators we note there has been delay in development of a communications plan to support the sharing of progress internally and externally. **See MA7**

Conclusion:

2.56 There is evidence that the requirements of the duties have been assessed and action has been progressed, and amendments made where appropriate. There are a small number of areas where enhancements could be considered to support the effectiveness of actions. We assign this objective **reasonable** assurance.

Audit objective 4: Key indicators have been identified to support the monitoring of the quality of services and patient outcomes.

2.57 An outstanding action from the 2021/22 Board Effectiveness Action Plan is the development of a quality dashboard. Audit Wales's Quality Governance review also highlighted that whilst a number of performance systems and dashboards are available within the health board, there was no single location where quality and safety metrics are available, also noting *'no ability to drill down to ward or departmental level*'.

2.58 In April 2022 a Quality & Safety Informatics group was established to oversee development of a dashboard, ensuring that the metrics selected were fit for purpose. There has also been consideration of dashboards in place at other NHS-Wales organisations to ensure good practice is applied at the health board, and we note discussions held with the NHS Delivery Unit which is developing its own quality dashboard. The group approved its ToR at the May 2022 meeting which included that the group would be a task and finish group for a period of 12 months. We could not identify presentation or approval of the ToR outside of the group. **See MA8**

2.59 The aim of the dashboard is to support the quality management system allowing triangulation of performance, but also to evidence the use of information and data in decision making. Phase one of the dashboard development has focused on indicators which link to the health boards quality priorities.

2.60 There has also been a larger scoping exercise involving Quality & Safety Informatics group members, to collate as wide a range of indicators as possible. A specification document was issued to the group members which sought to capture measure, description, data source, target/trajectory, level of data (ward/service), update frequency, and priority level. The specification also asked for information on common data issues, or any data quality comments or concerns.

2.61 Specification returns have been collated into a master spreadsheet to support the later phases of dashboard development. Indicators are also being mapped to four quadrants, quality, patient safety, patient experience, and assurance and compliance. At the February 2023 meeting, discussion of the document identified that some returns remained outstanding. **See MA8**

2.62 Review of the Quality & Safety Informatics Task and Finish Group agendas and minutes noted that the early work plan aligned to the groups objectives was suspended in October, as there was desire for a more action-based approach. However, we were not able to identify a replacement within the subsequent meetings (November 2022 and February 2023). **See MA8**

2.63 Reporting from Quality & Safety Informatics Task and Finish Group to the QSG has been primarily through verbal updates, alongside the sharing of an early draft of the dashboard in September. We could not identify further updates being provided from November onwards. **See MA8**

2.64 A presentation of phase one indicators was provided to the Quality Management System Task and Finish Group (see para 2.30) at its February 2023 meeting. User acceptance testing with quality priority leads was being progressed at the time of fieldwork, ahead of the anticipated launch in April 2023.

Conclusion:

2.65 A quality dashboard is under development and phase one indicators are linked to the health board's quality priorities. We note there is ambition to develop a wider range of indicators for later phases, but enhancements are needed to the governance arrangements in order to support this ambition. We assign this objective **reasonable assurance.**

Appendix A: Management Action Plan

Matter arising 1: Quality Safety Process Framework (Design)	Impact
The purpose of the Quality and Safety Process Framework (QSPF) is to describe processes for ensuring the quality and safety of services, and it outlines mechanisms to support this, alongside roles, responsibilities and the health boards quality and safety governance structure. The Quality and Safety Process Framework (QSPF) has been revised following recommendations from previous quality governance reports, however it was noted that further refinement would be needed to reflect the development of the quality strategy and its implementation plan, the final duty of quality and candour guidance, and further development of the quality management system. Whilst the QSPF contains important detail on the above, retaining the framework may result in duplication with the crossover content of the strategy; and it may be beneficial to streamline and combine the documents for ease of access and understanding.	Potential risk of: • Duplication of content. • Confusion or lack of clarity on key documents.

Recommendations	Priority
1.1 The health board should consider including key content from the quality and safety process framework such as roles, responsibilities, and final quality structures as an addendum to the Quality Strategy.	Low

Management response	Target Date	Responsible Officer
1.1 Agreed. Revised Quality and Safety Process Framework to be presented to Quality Management Board for approval, the revised document will reflect the Quality Strategy and the Duty of Quality.	September 2023	Head of Quality and Safety

Matter arising 2: Quality Groups Terms of Reference (Design)	Impact

Terms of reference (ToR) have been developed for QSG, PSCG, and PSEG, and after a period of updating and amendment, were approved by QSG in January 2023. Review of all ToR confirms that they are consistent in composition and format.
 	
We've highlighted further amendments which could enhance consistency
 	
• Quorum requirements: currently for the QSG, it includes a requirement for three Service Group representatives. For PSCG and PSEG, quorum requirements for both are the Chair and two Service Group representatives. Attendance has generally been consistent with some minor gaps identified;
  ○ QSG – one meeting stood down due to industrial action, all meetings quorate, two meetings where not all Service Groups were represented (Morriston - July and August 2022)
  ○ PSCG - one meeting cancelled (July 2022), one not quorate (August 2022); and two further meetings where not all Service Groups were represented (September PCT, January MHLD).
  ○ PSEG - two meetings cancelled (August and November), all quorate, two meetings where not all Service Groups were represented (July & January MHLD).
• Current structure:
  ○ Quality Priorities Programme Board ToR - ToR was last reviewed in 2021, we were informed that they will be reviewed and updated to reflect the inclusion of Safe Care Collaborative within the groups remit.
  ○ Clinical Outcomes and Effectiveness Group – ToR references Quality & Safety Governance Group and not the new Quality and Safety Group.
  ○ PSEG ToR includes '*Assure there are processes in place to safeguard children and adults.*' Information on safeguarding is provided in a monthly report to QSG, and we did not identify safeguarding reports submitted to the PSEG.
• Alignment of subgroups: In establishing the subgroups there has been a need to develop supporting structures, and whilst this detail is not included within structure diagrams, we were provided with a mapping document to support alignment of groups. It may be beneficial to capture updated arrangements within respective groups within their next review of ToR.
  ○ Currently the Safeguarding Committee is not listed within the quality and safety governance structure.
  ○ Any refinement of reporting such as PSCG combining Point of Care Testing and Ultrasound Clinical Governance within the Medical Devices Committee report.
  ○ Movement of groups as a result of new quality priorities, e.g. Pressure Ulcer Prevention Strategic Group.
	Potential risk of:
	
	• Required attendance may not be explicit.
	• Reporting groups and structures may not be fully documented.

Recommendations		Priority
2.1	Quorum requirements should be standardised across quality and safety groups, and these should include representation from all Service Groups.	Medium
2.2	Terms of reference for the Quality Priorities Programme Board and Clinical Outcomes and Effectiveness Group should be refreshed to ensure alignment of format and content with other quality and safety subgroups.	
2.3	Terms of reference and associated structure maps be updated to reflect updated or revised arrangements.	

Management response		Target Date	Responsible Officer
2.1-3	Agreed. Terms of reference to be revised to incorporate the above, and presented to Management Board for approval.	August 2023	Head of Quality and Safety in conjunction with Deputy Medical Director

Matter arising 3: Subgroup reporting and escalation (Operation)	Impact
Terms of Reference for the two newly established subgroups (PSEG & PSCG) to the QSG include that each will provide a monthly report. Review of papers identified that reporting from PSEG has been through verbal updates or sharing of group minutes; and PSCG submitted two reports in September 2022 and February 2023. Review of the February 2023 escalation report from the PSCG noted this was limited to list format, and did not include detail on associated mitigating actions, specific requests, or requirements needed to support the escalated area. Review of QSG highlight reports submitted to Management Board noted that issues raised have been consistently captured, however not all have included narrative detail relating to any action taken, links to risk register entries, or supporting requests. Within the February report we noted: • Safeguarding team capacity concerns; • Service Group concerns on delivery of Duty of Candour resourcing; and • Provision of an emergency CAMHS bed on an adult mental health ward. Within the highlight report it is noted there are a number of areas where issues can be raised, including through subgroup updates, QSG or Service Group updates, or within a 'challenges, risks, and mitigations' heading.	Potential risk of: • Ineffective reporting and escalation arrangements.

Recommendations	Priority
3.1a The format of reporting provided from subgroups to QSG should be reviewed and consideration given to ensuring any risks or issues escalated include mitigating actions, detail of any support required, and details of any related risk register entries. 3.1b Management should consider development of an escalation log to support the ongoing monitoring of issues, risks and actions for areas raised.	Medium

Management response	Target Date	Responsible Officer
3.1a Agreed. Standard template for use by sub-groups to be presented to QSG for approval.	June 2023	Head of Quality and Safety
3.1b Agreed. Record of escalation to be added to existing safety log.	June 2023	Head of Quality and Safety

Matter arising 4: Service Group Quality & Safety arrangements (Design)	Impact
The Quality Management System Task and Finish Group agenda for November 2022 included *Deep Dive Area: Service Group Quality Governance Arrangements,* alongside a presentation document setting out the revised corporate quality and safety group structure. Minutes of the November and December 2022 group meetings include discussion of Service Group quality governance arrangements, and the need for alignment. At the final task and finish group meeting held in March 2023, each Service Group provided a progress update, and meeting minutes reflect that there remained some inconsistencies in approach across Service Groups. An action was raised that structures be mapped in a consistent format, and a 'house style' reporting format be considered.	Potential risk of: • Inconsistent governance arrangements.

Recommendations	Priority
4.1 Noting the Quality Management System Task and Finish Group has now been stood down, a further presentation of Service Group quality management arrangements should be added to the Quality and Safety Group work programme to confirm consistent mapping has taken place.	Medium

Management response	Target Date	Responsible Officer
4.1 Agreed. Presentation to confirm mirroring arrangements within service groups to be presented to Quality Management Board.	August 2023	Director of Corporate Governance, in conjunction with Service Group Directors.

Matter arising 5: Duty of Candour: Service Group processes (Design)	Impact
The Duty of Candour requires the health board to follow a designated process when a patient or service user suffers and adverse outcome, which has, or could result in, unexpected or unintended harm. A policy has been drafted which contains guidance on where the duty may be triggered, definitions of key terminology, and outline of roles and responsibilities. Section 11 of the draft Duty of Candour policy includes – Roles and responsibilities states that *each service group must have an agreed Standard Operating Procedure in place for the management and investigation of incidents*. These SOP documents will outline how Service Group quality and safety teams will support staff in meeting the requirements of the duty where triggered. At the close of fieldwork, only one Service Group had provided a finalised process to the Assistant Head of Concerns, draft SOPs were available for the three remaining Service Groups but timings for final versions remained unclear.	Potential risk of: • Gap in operational process documents and guidance.

Recommendations	Priority
5.1 The status and approval of Duty of Candour standard operating procedures, for each Service Group, should be included within any further Duty of Candour reports to the appropriate forums.	Medium

Management response	Target Date	Responsible Officer
5.1 Agreed. As of 17th May 2023, Primary, Community and Therapies SOP has been ratified at their Safety and Compliance Group and requires final ratification at QSAG on 23rd May 2023. MH&LD SOP is being taken to the Health Board's Quality & Safety Committee on 23rd May 2023 for ratification. NPTSSG SOP will be included in the Quality and Safety Group agenda for ratification on 8th June 2023. An update on the status and approval of SOPs will feature within a future Duty of Candour report.	June 2023	Assistant Head of Concerns Management

Matter arising 6: Quality Assurance Framework (Design)	Impact
The PSCG includes ward assurance visits as a standing agenda item, and we note in March 2023 it received an update summary on action status from assurance visits undertaken in 2022. The update indicated further information on action completion was required for the majority of visits undertaken, a number of which have been impacted by organisational changes. Toolkits to expand the quality assurance framework, beyond the original ward-based audit, have been developed and used for unscheduled care and remote audits. We were informed further toolkits are being developed for paediatric, HMP Swansea and maternity services. We also note the SOP and guidance document relating to the QAF dates from 2019, and so there could be scope to update this to reflect recent changes and clarify requirements for reporting on action completeness.	Potential risk of: • Completeness of actions may not be captured.

Recommendations	Priority
6.1a Whilst ward assurance visits are included as a standing item on the PSCG agenda, there should be an assurance programme implemented to effectively manage completeness of agreed actions. 6.1b The QAF SOP and guidance document should be updated to reflect the new toolkits, and include detail on organisational reporting and follow up requirements.	Medium

Management response	Target Date	Responsible Officer
6.1a Agreed. Tracking system for assurance visits to be approved by the PSCG.	August 2023	Deputy Head of Quality and Safety
6.1b Agreed. Revised guidance to be presented to the QSG following approval by the PSCG.	August 2023	Deputy Head of Quality and Safety

Matter arising 7: Duty of Quality Communications Plan (Design)	Impact
As part of engagement with the national groups overseeing implementation of the two duties, the health board has returned status updates which RAG rates readiness against a set of road map milestones. We reviewed the road map update returned in March 2023, and were able to verify updates provided for key areas, with the exception of the development of a communications plan. The road map outlines expectation that there should be a '*Mechanism and publication schedule / plan in place for sharing Duty of Quality progress information externally'* and '*All staff are aware of key Duty of Quality messages tailored to their organisation*' The accompanying paper to the Quality Strategy, presented to the board in January 2023, included a target date of 31 March 2023 for the development of the communications plan. The quality management system 'stock take' paper in March noted a plan had been developed, but no copy could be provided when requested. We note that this period includes the departure of the interim Director of Insight, Communications, and Engagement, and the arrival of a substantive Director. The health board has launched an intranet site for the Duty of Quality for staff which includes key aspects relating to the Duty of Quality, alongside links to statutory guidance.	Potential risk of: • Opportunities to raise internal and external awareness may be missed.

Recommendations	Priority
7.1 The health board should develop a Duty of Quality communications plan to ensure there is a structured approach to raising awareness both internally and externally of key actions and impacts from the implementation of the duty. Following development, the plan should be shared at an appropriate forum.	Medium

Management response	Target Date	Responsible Officer
7.1 Agreed. Development of a Duty of Quality communication plan, to include the requirements of 'Always on' reporting.	September 2023	Director of Insight, Communications and Engagement

Matter arising 8: Quality and Safety Informatics Group (Operation)	Impact
In April 2022 a Quality & Safety Informatics group was established to oversee development of a Quality dashboard to assist in displaying key quality and safety metrics which would allow the ability to triangulate data at multiple levels, The group approved its ToR at the May 2022 meeting which included that the group would be a task and finish group for a period of 12 months. We could not identify presentation or approval of the ToR outside of the group. Review of the Quality & Safety Informatics Task and Finish Group agendas and minutes, noted that an early work plan aligned to the groups objectives was stood down in October 2022 as there was desire for a more action-based approach. Review of subsequent meeting agendas did not identify a replacement workplan being shared. There has been widespread engagement across the organisation to develop a comprehensive selection of future indicators to be included within later phases/versions of the Quality dashboard. Those received to date have been collated within a master spreadsheet. Review of the most recent version shared at the February 2023 Quality & Safety Informatics Task and Finish Group meeting identified returns had not been received from the following Service Groups / Directorate: Neath Port Talbot Service Group, Primary Community and Therapies Service Group, Children and Young Peoples Services, Estates, Health and Safety, and the Directorate of Insight, Communication and Engagement (DICE). Additionally, we note reporting from the group to the QSG has been primarily through verbal updates, alongside sharing an early draft of the dashboard in September, but we could not identify further updates from November onwards. The Quality Management System Task and Finish Group received a demonstration of phase one indicators in February 2023.	Potential risk of: • Unclear governance and reporting arrangements

Recommendations	Priority
8.1 If the Quality and Safety Informatics group extends its operation beyond the initial 12 months indicated, then its terms of reference should be reviewed, and approved by the QSG. 8.2 An updated Informatics Work Plan and content should be developed to capture future phases of dashboard development. 8.3 The ongoing development and delivery of the dashboard should be regularly reported to the QSG. This should include status updates against indicator returns.	Medium

	Management response	Target Date	Responsible Officer
8.1	Agreed. Proposal on the future direction of the Quality and Safety Informatics Group to be presented to the Quality and Safety Group.	July 2023	Associate Nurse Director
8.2	Agreed. The Workplan and launch date is to be confirmed and reported to the Quality and Safety Group.	July 2023	Associate Nurse Director
8.3	Agreed. Quarterly reports to be received by the Quality and Safety Group.	July 2023	Associate Nurse Director

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.
 **No 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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