Stroke Action Plan

Final Internal Audit Report

October 2023

Swansea Bay University Health Board

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Executive Summary

Purpose

To review the deployment of the Stroke Action Plan to improve stroke performance and the clinical risk mitigations put in place to prevent patient harm.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Update and produce a more robust action plan;
- Attendance at the Stroke Delivery Group Board meetings and updates to the Terms of Reference required; and
- Performance reporting to include the national standards targets.

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

Our overall assurance rating relates to the Stroke Action Plan only and does not provide assurance on the health board's performance against the national standards targets.

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A - no previous report

Assurance Summary[1]

	Objectives	Assurance
1	Approved Action Plan.	Reasonable
2	Monitoring of progress.	Reasonable
3	Performance measures and outcomes.	Reasonable
4	Progress reports and Stroke Quality Improvements.	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Stroke Action Plan	1, 2, 3	Design	Medium
2	Stroke Delivery Group Board	2	Operation	Medium
3	Reporting against national standards targets	4	Design	Low

1. Introduction

1.1 As reported by the Welsh Government "*stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors of stroke. There are currently around 70,000 stroke survivors living in Wales, and an estimated 7,400 people experience a stroke each year*".

1.2 In February 2017, the Welsh Government published its '*2017-2020 Stroke Delivery Plan – A Refreshed Delivery Plan for NHS Wales and its Partners*', which set out the expectations of all stakeholders to tackle stroke in people of all ages.

1.3 A further quality statement, describing what good quality stroke services should look like, was published by the Welsh Government in September 2021 (updated January 2022). This detailed that "*building on the work of previous Stroke Delivery Plan and acting on the recommendations of the Cross Party Group for Stroke, the next phase of service improvement for stroke survivors and their carers must drive forward change to deliver better quality, higher value and more accessible stroke services. It must take advantage of the widespread consensus on priority areas such as reconfiguration and design of services, thrombectomy, thrombolysis, imaging and rehabilitation services; further develop optimised pathways to address unwarranted variations in care whilst continuing to develop national leadership, local engagement and continued collaboration with third sector, who highlight the national voice of lived experience. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act*".

1.4 The health board participates in the King's College London's Sentinel Stroke National Audit Programme (SSNAP), a major national healthcare quality improvement programme which measures "*…how well stroke care is being delivered in the NHS in England, Wales and Northern Ireland"* and provides *"timely information to clinicians, commissioners, patients and the public so it can be used to improve the quality of care that is provided to patients*".

1.5 As reported to the Performance and Finance Committee (PFC) in May 2023, "*with ongoing investment into the Stroke workforce and the culmination of the Acute Medical Services Redesign (AMSR) programme a plan for performance recovery and improvement has been developed. As AMSR becomes more established it is anticipated this will have a positive effect on performance but new pathways and models of care are needed to establish further*". It is acknowledged that as a result of the pandemic, and the wider pressures on acute hospitals such as Morriston, access targets have been challenging to improve.

1.6 The most recent stroke dashboard, for the August 2023 reporting period, showed that the health board was outperforming the 'All Wales' performance in six of the nine Acute Stroke Quality Improvement Performance Measures relating to the 72 hours stroke pathway for 'urgent intervention' and 'urgent assessment', as shown

in the table below. However, it only meets the National Standards target for one performance measure. For a more detailed comparison of the health board's performance against other Welsh hospitals, see the extracts from the Stroke dashboard, which include the performance measures for 'Post 72 hours Pathway' and 'Post 72 hours Pathway – non routine' included in Appendix B.

Table 1 – 72 hours Stroke Pathway:

	Acute Stroke Quality Improvement Measure	National Standards Target	All Wales performance	Morriston Hospital
Urgent Intervention	Percentage of stroke patients given thrombolysis (all stroke types).	25%	13.1%	14.3%
	Thrombolysed patients door to needle time (DTN) <= 45 minutes.	95%	24.0%	83.3%
	Percentage of patients scanned within 1 hour of clock start.	95%	56.0%	38.1%
	Percentage of patients directly admitted to a stroke unit within 4 hours of clock start.	95%	30.3%	26.2%
	Percentage of applicable patients who were given a swallow screen within 4 hours of clock start.	95%	74.8%	83.3%
	Percentage of unique stroke patients given thrombectomy (all stroke types).	10%	1.6%	0.0%
Urgent Assessment	Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start.	100%	83.0%	97.6%
	Assessed by one of Occupational Therapy (OT), Physical Therapy (PT), Speech and Language Therapy (SALT) within 24 hours.	95%	78.5%	85.7%
	Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start.	100%	78.5%	100%

Source: NHS Wales Delivery Unit (NHSDU) 'Stroke Dashboard' for August 2023 reporting period.
'National Standards Targets' relevant to the Quality Improvement measures have been added to this table for reference as these are not routinely reported against (see para 2.37).

1.7 In September 2023, Healthcare Inspectorate Wales (HIW) published its report '*National Review of Patient Flow: A journey through the stroke pathway*'. This was to understand what is being done to mitigate any harm to those awaiting care, as well as to understand how the quality and safety of care is being maintained throughout the stroke pathway. Swansea Bay University Health Board (the health board) took part in this review; and as previously reported to the Quality and Safety Committee (QSC), no issues were raised at the time of the on-site inspection with the service lead. At the time of our review, the health board were reviewing the report to ascertain any recommendations for improvement.

1.8 An Urgent and Emergency Care goal in the health board's Recovery & Sustainability Plan 2022/23 – 2024/25' is to '*improve the outcomes for Stroke patients*'. The method for achievement of this goal is the implementation of a Hyper Acute Stroke Unit (HASU), in collaboration with Hywel Dda University Health Board. Our audit does not include a review of the future HASU/CRSC plans.

1.9 The risks considered during the review were:

i. Appropriate actions are not identified to improve stroke performance; and

ii. Potential significant harm to patients.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	1	2
Operating Effectiveness	-	1	-	1
Total	-	2	1	3

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: There is an approved action plan in place to improve stroke performance at the health board, which reflects the lessons learned and recommendations from external reviews/reports e.g. Welsh Government and SSNAP.

2.3 At the request of the Performance and Finance Committee (PFC) in June 2022, to provide assurance on the timescales to improve stroke performance at the health board, a Stroke Action Plan (the action plan) was produced which has been presented, and discussed, at the PFC at meetings in October 2022, February and May 2023 (for details on reporting, refer to audit objective 4). All actions were endorsed by the PFC in May 2023.

2.4 We reviewed the action plan to confirm that it included:

a. Named responsibility/ownership for actions.
b. Timeframe for implementation of each action.
c. Progress updates on current position.
d. Indication of current status e.g., completed, in progress, not started etc.
e. Costs/budget associated with the actions.
f. Current and target performance measures to demonstrate that actions are having the desired impact.
g. Tolerance level of when escalation is required when progress is off target.
h. Expected outcome following implementation of each action.
i. Initiatives that require actions to be jointly managed between organisations are appropriately communicated.

2.5 Lead responsibility for the recommended action is generally included on the plan. However, two of the recommendations / actions did not detail leads (Action 17: HASU and Action 18: AMSR). See **MA1**

2.6 The action plan includes columns for start date and due date. However, the due date column has not consistently been completed – see para 2.9.

Recommendations / actions should have a specific target date for implementation and explanations for where progress is off target. See **MA1**.

2.7 The action plan includes a column for 'Progress / Remarks'. This includes some narrative updates, some of which are very brief. This narrative could be expanded to detail the main steps required to fully implement the recommendation / action and progress against the same. See **MA1**.

2.8 The status of each action on the plan is Red, Amber, Green (RAG) rated. However, whilst the status is colour coded, it is not strictly RAG rated:

Table 2

Status per Action Plan	Status definition
Red	Highly problematic – commitment in plan not delivered/achieved and outstanding issues with ensuring delivery in subsequent quarter.
Amber/Red	Problematic – commitment in plan partially delivered/achieved and outstanding issues with ensuring full delivery in subsequent quarter.
Amber/Green	Mixed - commitment in plan not delivered/achieved but confident of achievement/delivery in subsequent quarter.
Green	Good – commitment in plan fully delivered/achieved.
Blue	Not started.

Additionally, as shown in the summary table in para 2.9, the colour coded status does not always align to the 'due date' per the plan e.g., there are actions that are colour coded yellow yet the 'timeframe' column states 'in place', which we would expect to be green per the status definition. See **MA1**.

2.9 The table below summarises the direction of travel for the 'RAG status' of the action plans presented to the PFC since October 2022 to July 2023:

Table 3

Action	Status: Oct '22	Status: Feb '23	Status: May '23	Status: July '23	Ownership of action included	Expected benefit	Due date per plan
1					✓	✓	In place
2					✓	✓	In place
3					✓	✓	In place
4					✓	✓	×
5					✓	✓	Jul-23
5					✓	✓	In place
6					✓	✓	In place
7					✓	✓	In place
8					✓	✓	Ongoing
9					✓	×	Ongoing
10					✓	Not specific	×
11					✓	Not specific	×
12					✓	✓	In place with CT pilot
13					✓	✓	×
14					✓	×	Apr-23
15					✓	×	×
16					✓	×	Apr-23
17					×	×	×
18					×	×	×

**Note* There are two separate actions, both numbered 5 on the action plan. Actions 14 – 17 relate to HASU, which is outside the scope of this audit. A separate action plan has been produced for HASU/CRSC as detailed in paragraph 1.8.*

2.10 Actions 1 – 13, which appear to be changes to current practices, did not include anything specifically in respect of costs / budget. The inclusion of a column to indicate whether there are cost or budget implications with the associated action would provide assurance that the actions are achievable and not aspirational. See **MA1**. We acknowledge that for actions 14-17 which relate to the HASU there is a separate action plan in place which includes costs.

2.11 The ability to escalate lack of progress is limited as there are no defined performance measures and targets assigned to the individual actions in the action plan. See **MA1.** However, we acknowledge that monitoring by the Stroke Delivery Board, and reporting to the PFC, included reporting of performance against the Stroke Quality Improvement Measures in addition to the action plan; and further review of the 'RAG status' as at July 2023 noted no 'red' rated actions which would require the need for escalation (see para 2.9).

2.12 The action plan includes a column for 'Expected Benefit'. These are narrative descriptions of the expected benefit rather than specific target outcomes. For four of the actions (9, 10, 11 & 18) there was insufficient information provided. See **MA1**. Actions 14-17 relate to HASU for which there is a separate action plan.

2.13 Review of the actions within the plan highlight that they look to address specific issues faced by the health board, including, for example ringfenced stroke beds in the Acute Stroke Unit (ASU). In addition, two of the initiatives (actions 5 and 13) required collaboration from Welsh Ambulance Services NHS Trust (WAST) – and related to taking pre-alert stroke patients being taken directly for a computerised tomography (CT) scan. Both of these actions have been completed. Review of both the health board and the WAST intranet site confirms that the new process has been communicated and went live on 17 July 2023.

2.14 The health board takes part in the national SSNAP audit, as detailed in para 1.4. The SSNAP audit is part of the 'National Clinical Audit and Outcome review programme'. All health boards / trusts participating in national clinical audits and outcome reviews must send completed Part A and Part B pro-forma to Welsh Government, which the health board has done. Part A draws out the national and local findings/recommendations from the review and Part B describes the actions (see Table 4) already taken or in the process of being developed to address the key findings and recommendations with timescale and details of named lead.

Table 4

Action	Timescale
Weekly stroke performance site meetings are held to review all stroke admissions from the previous week. Each admission that fails to meet the key performance indicators are assessed for lessons learned and appropriate action taken to improve performance.	Ongoing
Morriston hospital is participating in the Thrombectomy Task and Finish group led by the DU to drive the necessary agenda forward, to improve the pathway for SBUHB patients.	2023
There are plans to develop a Comprehensive Regional Stroke Centre at Morriston hospital serving the SW Wales Region.	To begin Q1 2023

Action	Timescale
Direct to CT pathway to be put in place to reduce time to CT in Q1.	January 2023

2.15 We compared the Part B pro-forma return to the health board's most recent action plan at the time of the audit fieldwork (July 2023). Whilst the action plan does not link directly to the pro-forma, it was evident that there were actions included which reflected all the responses provided within it.

2.16 As detailed in para 1.7, the health board took part in HIW's '*National Review of Patient Flow: A journey through the stroke pathway*'. As previously reported by the health board to its Quality and Safety Committee (QSC), no issues were raised at the time of the on-site inspection with the service lead. At the time of our review, the health board had recently received the report and were reviewing it to pull out any relevant recommendations for improvement. Review of the report confirmed that the recommendations made were generic for all health boards.

Conclusion:

2.17 There is an action plan in place, the content of which was endorsed by the PFC. The actions within it do look to address the specific issues the health board faces. From review of the action plan, we have identified several enhancements to make it more robust. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 2: There are appropriate mechanisms in place to monitor actual progress against the planned actions, with remedial action taken where implementation is off track.

2.18 Weekly stroke performance site meetings are held to review/scrutinise all stroke admissions from the previous week. Noting the purpose of these meetings i.e. to review the patient journey, they are not formally minuted. Each admission that fails to meet the key performance indicators are assessed for lessons learned and appropriate action taken to improve performance. Stroke consultants, site teams and managers are invited to these meetings, with members of the NHS Wales Executive also in attendance.

2.19 The health board has established a Stroke Delivery Board, its purpose is "*to support the service delivery groups in the delivery of the Health Board's Stroke Pathway and the required performance improvements through a systematic process of continuous development, improvement and monitoring*". The action plan is a standing agenda item at this forum and the performance and delivery updates provided at these meetings are used to inform the updates presented to the PFC (see audit objective 4).

2.20 The terms of reference (ToR) detail that the Stroke Delivery Board will meet every two months. However, we were informed that the meetings take place quarterly. Since April 2022, six meetings have been held in April, July and October 2022 and January, May (postponed from April) and July 2023. The next meeting is due to take place in October 2023. See **MA2**.

2.21 The ToR also details that "*the meeting will be quorate only if the Chief Operating Officer or Deputy is present together with 50% of the membership*". The ToR details that there are 21 representatives (by role), which includes the Chair. It is acknowledged, however, that the Deputy Chief Operating Officer (COO), the Vice Chair, has chaired all meetings held. From review of attendance at the meetings held since April 2022, three were not quorate. However, we acknowledge, from review of the minutes, that attendance has been raised as an issue by the Deputy COO. See **MA2**.

2.22 Review of the Stroke Delivery Board agendas, minutes and papers confirms that review of risk register entries is a standard agenda item. There are four risks currently on the Medicine Risk Register relating to stroke, being:

- *2901 - Inability to admit patients in a timely manner to the Acute Stroke Unit – current risk rating = 20;*
- *3340 - Lack of Therapies for Stroke in SBUHB – current risk rating = 16;*
- *2147 - Potential significant harm due to lack of Senior Stroke Medicine On-call rota – current risk rating = 12; and*
- *3525 - Ward F environmental / infrastructure issues may be increasing IPC issues – current risk rating = 20 (new risk).*

Review of Stroke Delivery Board meetings confirms that, at the request of Executives, the addition of risk 2901 to the health board's Corporate Risk Register is pending.

2.23 The Stroke Delivery Board ToR does not detail the route for escalation of issues. However, it does state that "*the Stroke Delivery and Development Board is a mechanism to inform and assure the Management Team and Health Board about the action on improving performance and driving forward service development in line with the latest evidence-base and best practice*". As detailed in audit objective 1 (para 2.6), due to the lack of definitive target dates (see **MA1**), it is difficult to assess from the action plan whether implementation is off track and, therefore, requires remedial action and escalation.

Conclusion:

2.24 Weekly meetings take place to scrutinise performance, with representation both internally and from the NHS Executive. The Stroke Delivery Board is in place for monitoring stroke performance - the ToR for this group requires review to reflect the intended frequency of meetings. Quoracy of these meetings has also been noted as an issue, and we recognise this has been raised within the meetings. Review of the risk register is a standard agenda item at these meetings. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 3: There are appropriate performance measures in place for monitoring of outcomes to evidence that actions have the desired effect.

2.25 As detailed in audit objective 1 (para 2.11), there are no defined performance / outcome indicators and targets assigned to the individual actions in the action plan.

However, we acknowledge that the recommendations/actions detailed on the action plan should contribute to an improvement to the stroke performance measures. See **MA1**.

2.26 As per para 2.14, the health board takes part in the SSNAP audits which have a number of performance measures. These are listed in Appendix B.

2.27 The NHS Wales Delivery Unit (NHSDU) produce the 'Stroke Dashboard', which provides NHS Wales with an overview of key performance indicators for stroke pathways based on Health Board SSNAP monthly stroke performance data returns. Extracts from the dashboard, for the period to August 2023, are included in Appendix B. These are used for reporting to the PFC, as detailed under audit objective 4. These are presented to the Stroke Delivery Board prior to Committee. Review of these reports show that Morriston Hospital is the second busiest hospital in Wales for volume of stroke patients, after the University Hospital of Wales (UHW) in Cardiff.

2.28 In addition, the following tables have been extracted from the 'Stroke Dashboard' and details the stroke performance for the 12-month period September 2022 to August 2023, comparing the health board to the All Wales average:

Table 5

72 Hours Pathway				
	Acute Stroke Quality Improvement Measure	**Swansea Bay Morriston**	**All Wales**	**Diff**
Urgent Intervention	Percentage of stroke patients given thrombolysis (all stroke types).	16.1%	13.7%	2.4%
Urgent Intervention	Thrombolysed patients door to needle time (DTN) <= 45 minutes.	12.8%	18.4%	-5.6%
Urgent Intervention	Percentage of patients scanned within 1 hour of clock start.	40.9%	52.9%	-12.0%
Urgent Intervention	Percentage of patients directly admitted to a stroke unit within 4 hours of clock start.	12.2%	22.8%	-10.6%
Urgent Intervention	Percentage of applicable patients who were given a swallow screen within 4 hours of clock start.	78.4%	68.3%	10.1%
Urgent Intervention	Percentage of unique stroke patients given thrombectomy (all stroke types).	0.5%	1.7%	-1.2%
Urgent Assessment	Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start.	93.1%	77.2%	15.9%
Urgent Assessment	Assessed by one of Occupational Therapy (OT), Physical Therapy (PT), Speech and Language Therapy (SALT) within 24 hours.	88.2%	77.0%	11.2%
Urgent Assessment	Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start.	90.7%	78.3%	12.4%

Table 6

Post 72 Hours Pathway				
	Acute Stroke Quality Improvement Measure	**Swansea Bay Morriston**	**All Wales**	**Diff**
Inpatient Rehab	Percentage of patients who spent at least 90% of their stay on stroke unit	43.6%	59.0%	-15.4%
Inpatient Rehab	Compliance with patients receiving the required minutes for OT (3 month rolling)	72.0%	56.5%	15.5%
Inpatient Rehab	Compliance with patients receiving the required minutes for physiotherapy (3 month rolling)	69.2%	54.4%	14.8%
Inpatient Rehab	Compliance with patients receiving the required minutes for SALT (3 month rolling)	45.5%	32.7%	12.8%
Discharge Standards	Percentage of applicable patients screened for nutrition and seen by dietician by discharge (exc. Palliative care pts)		93.5%	-93.5%
Discharge Standards	Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	46.0%	33.2%	12.8%
Discharge Standards	Proportion of patients assessed at 6 months	30.3%	35.0%	-4.7%

Caveat as per the dashboard: for post 72 pathway, if several months selected e.g. three months, then some measures will be 6 months (therefore may be double counting patients)

Table 7

Post 72 Hours Pathway - Non-routine				
	Acute Stroke Quality Improvement Measure	**Swansea Bay Neath Port Talbot**	**All Wales**	**Diff**
Inpatient Rehab	Percentage of patients who spent at least 90% of their stay on stroke unit			0.0%
Inpatient Rehab	Compliance with patients receiving the required minutes for OT (3 month rolling)	71.7%	97.2%	-25.5%
Inpatient Rehab	Compliance with patients receiving the required minutes for physiotherapy (3 month rolling)	96.5%	84.5%	12.0%
Inpatient Rehab	Compliance with patients receiving the required minutes for SALT (3 month rolling)	14.8%	19.5%	-4.7%
Discharge Standards	Percentage of applicable patients screened for nutrition and seen by dietician by discharge (exc. Palliative care pts)	100.0%	100.0%	0.0%
Discharge Standards	Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	20.0%	31.0%	-11.0%
Discharge Standards	Proportion of applicable patients assessed at 6 months			0.0%

2.29 As per para 2.13, actions are included for WAST pre-alert stroke patients to be taken direct to CT to speed up the process to scan the patient. The pilot, in collaboration with WAST, went 'live' on 17 July 2023. We acknowledge that it is too early to assess the impact of this pilot on performance.

2.30 Additionally, in July 2023 the health board ringfenced 18 beds in the ASU which are under the control of the Stroke team. Again, it is also too early to assess the impact of this on the performance measure of 'access to a stroke bed within 4 hours'.

Conclusion:

2.31 The action plan does not include performance measures. However, we acknowledge that the actions detailed on the action plan should contribute to an

improvement to the stroke quality performance measures. However, it is too early to assess the impact of some of the recently implemented pilots on performance and the action plan was only recently endorsed by the PFC in May 2023. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 4: Periodic reports on the progress against implementation of the action plan and Stroke Quality Improvement measures are produced and submitted to appropriate management and health board committees for review.

2.32 As noted under audit objective 1 above, at the June 2022 Performance and Finance Committee (PFC) it was requested that a Stroke Delivery Action Plan be produced to include timescales of what is being done, and being proposed, to improve the stroke performance.

2.33 Specific agenda items on Stroke Performance Reports were presented to the PFC in June 2022, October 2022 February 2023 and May 2023. The reports from October 2022 onwards included the Stroke Action Plan and graphs and charts extracted from the NHSDU dashboard, based on SSNAP Quality Improvement Measures (QIM).

2.34 There are a total of 23 Quality Improvement measures (see Appendix B). These are broken down per pathway are as follows:

Table 8

Pathway	Number of Quality Improvement measures
72 hour pathway:	
Urgent Intervention	6
Urgent Assessment	3
Post 72 hour pathway:	
Inpatient Rehab	4
Discharge Standards	3
Post 72 hour pathway – non-routine	
Inpatient Rehab	4
Discharge Standards	3
Total	**23**

2.35 Additionally, whilst not specifically relating to the Stroke Action Plan, the health board's monthly Integrated Performance Report (IPR) presented to the PFC, the QSC and Board, includes performance against four of the stroke measures relating to Urgent Intervention, being:

a. *Percentage of patients who have a direct admission to an acute stroke unit within 4 hours;*

b. *Percentage of patients who received a CT Scan within 1 hour;*

c. *Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours; and*

d. *Percentage of thrombolysed stroke patients with a door to needle time of less than or equal to 45 minutes*.

We acknowledge that these are deemed the most critical measures for better outcomes for stroke patients. As such, it is reasonable that the IPR does not include performance against all 23 measures. The PFC has received broader updates on stroke performance, as detailed in para 2.33.

2.36 The IPR includes a quadrant of harm summary which is RAG rated based on in-month movement. Stroke falls under the '*Harm from overwhelmed NHS and Social Services*' quadrant, categorised for the period since April 2022, as follows:

Table 9

Year	2022									2023								
PFC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Stroke RAG rating	Red	Amber	Amber	Red	Red	Green	Amber	Amber	Amber	Red	Amber	Green	Green	Amber	Red	Green	Amber	Amber

2.37 However, whilst review of papers to the committees included both the health board's performance against the Stroke Quality Improvement Measures and also benchmarking against the 'All Wales' performance, the National Standards target was not included within these reports. We have added such detail in Table 1 to reflect the performance for Morriston Hospital and 'All Wales' for 'Urgent Intervention' and 'Urgent Assessment'. Whilst the health board out-performs the 'All Wales' performance for 6/9 measures, it only meets the national standards target for one of these. See **MA3**.

Conclusion:

2.38 The PFC has received four specific reports on Stroke Performance, which has included the action plan and charts extracted from the NHSDU dashboard, based on SSNAP Quality Improvement Measures. Performance against the Stroke quality improvement measures relating to 'Urgent intervention' only are included in the monthly IPR report to the PFC, QSC and the Board. Whilst there is regular monitoring of stroke performance and appropriate bench-marking against other NHS Wales hospital sites, this reporting does not include the national standards target. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Stroke Action Plan (Design)	Impact
We reviewed the most recent Stroke Delivery Action Plan at the time of our review, being as at July 2023 and found the following: • Lead responsibility: not detailed for two actions (17: HASU and 18: AMSR). • Due date: not consistently completed (see para 2.9). Recommendations/actions should have a specific target date for implementation and explanations where progress is off target. • Progress/Remarks: brief narrative updates are included at this column. Such could be expanded to detail the main steps required to fully implement the recommendation/action and progress against the same. • RAG status: whilst the status is colour coded, it doesn't align with 'standard' RAG rating (see table in para 2.8). Further, the coloured status does not always align to the 'due date' as per the plan. For example, due date recorded as 'in place' we would expect the RAG status as green; however, it is yellow (see para 2.9). • Costs/budget: actions 1-13, which appear to be changes to current practices, did not include anything specifically in respect of costs/budget. The inclusion of a column to indicate whether there are such implications would provide assurance that the actions are achievable and not aspirational. • Progress escalation: the ability to escalate is limited as there are no defined performance measures/targets assigned to the individual actions. However, we acknowledge that monitoring by the Stroke Delivery Board, and reporting to the PFC, included reporting of performance against the Stroke Quality Improvement Measures in addition to the action plan; and further review of the 'RAG status' as at July 2023 noted no 'red' rated actions which would require the need for escalation (see para 2.9). • Expected benefit: insufficient information provided for four actions (9, 10, 11 and 18). Actions 14-17 relate to the HASU for which there is a separate action plan.	Potential risk of: • Confusion and lack of progress against actions; and • Unrealistic expectations.

<table>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>1.1</td><td>The Stroke Action Plan should be updated to ensure that:

a. Lead responsibility should be assigned to all actions / recommendations;
b. Actions / Recommendations should have a specific target date for implementation and explanations for where progress is off target;
c. The steps required to implement the action/recommendation could be broken down to clearly identify what actions need to be taken to fully implement the action/recommendation;
d. The colour coded status and the timeframe for implementation should be aligned;
e. The health board should consider including a column for any budget/cost implications with the identified actions;
f. It includes performance measures and targets assigned to each action;
g. Expected benefits are recorded for all actions.</td><td>Medium</td></tr>
</table>

<table>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>1.1</td><td>The Stroke Action Plan will be updated as detailed above and presented to the Stroke Delivery in January for approval and monitoring.</td><td>December 2023</td><td>Directorate Manager for Medicine</td></tr>
</table>

Matter Arising 2: Stroke Delivery Board (Operation)	Impact
The Stroke Delivery Board's purpose is "*to support the service delivery groups in the delivery of the Health Board's Stroke Pathway and the required performance improvements through a systematic process of continuous development, improvement and monitoring*". The terms of reference (ToR) detail that the Stroke Delivery Board will meet every two months. However, we were informed that the meetings take place quarterly. Since April 2022, six meetings have been held in April, July and October 2022 and January, May (postponed from April) and July 2023. The next meeting is due to take place in October 2023. The ToR for the Stroke Delivery Board details that "*the meeting will be quorate only if the Chief Operating Officer or Deputy is present together with 50% of the membership*". The ToR details that there are 21 representatives (by role), which includes the Chair. We reviewed the attendance of the meetings held since April 2022 to confirm whether the meetings included at least 10 other representatives, in addition to the Chair. The Deputy Chief Operating Officer (COO), the Vice Chair, has chaired all meetings held. From review of attendance at the meetings held since April 2022, three were not quorate. However, we acknowledge, from review of the minutes, that attendance has been raised as an issue by the Deputy COO.	Potential risk of: • Delays to approving actions to drive improvement in stroke performance; and • Lack of engagement.

Meeting	Chair /Vice Chair	Number of representatives (excluding Chair)	Quorate
April 2022	Yes	13	Yes
July 2022	Yes	9	No
October 2022	Yes	6	No
January 2023	Yes	14	Yes
May 2023	Yes	12	Yes
July 2023	Yes	9	No

Recommendations		Priority
2.1	The ToR should be updated to accurately reflect the frequency of the meetings.	**Medium**
2.2	Stroke Delivery Board representatives should send an alternative representative to ensure that the meetings are quorate.	

Agreed Management Action		Target Date	Responsible Officer
2.1	The Terms of Reference will be updated to reflect that the Stroke Delivery Board meets on a Quarterly basis.	November 2023	Deputy Chief Operating Officer
2.2	The Terms of Reference will be amended to reflect the correct membership, need for deputisation in the absence of member and review if the quoracy.	November 2023	Deputy Chief Operating Officer

<table>
<tr><th colspan="3">Matter Arising 3: Performance Reporting against national standards targets (Design)</th><th>Impact</th></tr>
<tr><td colspan="3">Review of papers to the Performance and Finance Committee confirmed that these included both the health board's performance against the SSNAP quality performance measures and also appropriately benchmarking against the 'All Wales' performance. Whilst these reports show that, for some of the measures, the health board outperforms other Welsh health boards, they did not include the National Standards targets. The table included in para 1.6 shows that for the most critical pathway, being the '72 hours Stroke Pathway', the health board only met one of the national standards targets for Urgent intervention or Urgent assessment.</td><td>Potential risk of:
• False reassurance of stroke performance.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>3.1</td><td colspan="2">The health board should include the National Standards target in its reporting against the stroke quality improvement measures.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>3.1</td><td>The performance reports presented to the Performance and Finance Committee will be amended to reflect the National Standard targets.</td><td>December 2023</td><td>Directorate Manager for Medicine</td></tr>
</table>

Appendix B:'Stroke Dashboard' performance by Welsh hospital site

Quality Measures Summary – 72 hour Pathway:

The NHS Wales Delivery Unit (NHSDU) produce the 'Stroke Dashboard' which provides NHS Wales with an overview of key performance indicators for stroke pathways based on health board SSNAP monthly stroke performance data returns. The reported performance for the reporting period August 2023 was as follows:

Acute Stroke Quality Improvement Measures Performance		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Glangwili	Prince Philip	Withybush	Morriston	
Urgent Intervention	Percentage of stroke patients given thrombolysis (all stroke types)	19.5%	10.5%	10.6%	18.9%	8.3%	8.1%	8.7%	33.3%	15.0%	8.3%	15.4%	14.3%	13.1%
	Thrombolysed patients DTN <= 45 mins	12.5%	0.0%	0.0%	57.1%	20.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	83.3%	24.0%
	Percentage of patients scanned within 1 hour of clock start	63.4%	52.6%	42.6%	64.9%	60.0%	37.8%	56.5%	91.7%	70.0%	83.3%	76.9%	38.1%	56.0%
	Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	15.0%	44.4%	8.9%	15.6%	64.8%	27.8%	0.0%	44.4%	23.5%	63.6%	50.0%	26.2%	30.3%
	Percentage of applicable patients who were given a swallow screen within 4 hour of clock start	59.0%	64.3%	64.9%	86.2%	80.0%	84.8%	61.9%	75.0%	72.2%	100.0%	81.8%	83.3%	74.8%
	Percentage of Unique stroke patients given thrombectomy (all stroke types)	2.5%	0.0%	2.2%	5.7%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.6%
Urgent Assessment	Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start	95.1%	63.2%	89.4%	86.5%	91.7%	48.6%	47.8%	100.0%	95.0%	91.7%	100.0%	97.6%	83.0%
	Assessed by one of OT, PT, SALT within 24 hours	36.6%	92.1%	89.4%	86.5%	96.7%	62.2%	60.9%	75.0%	75.0%	83.3%	84.6%	85.7%	78.5%
	Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start	82.5%	0.0%	78.9%	81.3%	95.2%	62.5%	77.8%	80.0%	100.0%	66.7%	100.0%	100.0%	78.5%

For the number of stroke patients the above percentages relate to, see table on the following page:

Acute Stroke Quality Improvement Measures Values		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Glangwili	Prince Philip	Withybush	Morriston	
Urgent Intervention Values	**Number of stroke patients given thrombolysis (all stroke types)**	8	4	5	7	5	3	2	4	3	1	2	6	50
	Total number of stroke patients (all stroke types)	41	38	47	37	60	37	23	12	20	12	13	42	382
	Number Thrombolysed patients DTN <= 45 mins	1	0	0	4	1	0	0	0	1	0	0	5	12
	Total number of Thrombolysed patients	8	4	5	7	5	3	2	4	3	1	2	6	50
	Number of patients scanned within 1 hour of clock start	26	20	20	24	36	14	13	11	14	10	10	16	214
	Total number of stroke patients (all stroke types)	41	38	47	37	60	37	23	12	20	12	13	42	382
	Number of patients directly admitted to a stroke unit within 4 hours of clock start	6	16	4	5	35	10	0	4	4	7	6	11	108
	Total number of patients applicable for direct admission to the stroke unit	40	36	45	32	54	36	23	9	17	11	12	42	357
	Number of applicable patients who were given a swallow screen within 4 hour of clock start	23	18	24	25	44	28	13	6	13	9	9	35	247
	Total number of applicable patients who required a swallow screen	39	28	37	29	55	33	21	8	18	9	11	42	330
	Number of Unique stroke patients given Thrombectomy (all stroke patients)	1	0	1	2	2	0	0	0	0	0	0	0	6
	Total number of Unique stroke patients (all stroke types)	40	38	46	35	60	37	23	12	20	12	13	42	378
Urgent Assessment	**Number of patients assessed by stroke specialist consultant physician within 24 hours of clock start**	39	24	42	32	55	18	11	12	19	11	13	41	317
	Total of patients requiring a stroke specialist consultant physician	41	38	47	37	60	37	23	12	20	12	13	42	382
	Number assessed by one of OT, PT, SALT within 24 hours	15	35	42	32	58	23	14	9	15	10	11	36	300
	Total number of patients that require being seen by one of OT, PT, SALT	41	38	47	37	60	37	23	12	20	12	13	42	382
	Number of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start	33	0	15	13	20	10	7	4	13	2	4	7	128
	Total Number of patients that require a formal swallow screen assessment	40	10	19	16	21	16	9	5	13	3	4	7	163

Quality Measures Summary – Post 72 hour Pathway:

		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
	Acute Stroke Quality Improvement Measures Performance	The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Glangwili	Prince Philip	Withybush	Morriston	
Inpatient Rehab	**Percentage of patients who spent at least 90% of their stay on stroke unit ***	68.9%	76.9%	65.1%	54.2%	71.0%	44.8%	44.7%	77.8%	33.3%	70.0%	59.6%	45.3%	58.8%
Inpatient Rehab	**Compliance with patients receiving the required minutes for OT (3-month rolling)**	24.1%	65.8%	43.1%	20.2%	76.2%	74.3%	88.3%	26.7%	57.9%	54.1%	137.8%	72.0%	56.5%
Inpatient Rehab	**Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)**	28.1%	36.8%	38.1%	45.7%	71.5%	67.6%	68.3%	55.4%	49.8%	53.7%	129.8%	69.2%	54.4%
Inpatient Rehab	**Compliance with patients receiving the required minutes for SALT (3-month rolling)**	22.7%	12.1%	48.0%	29.3%	53.0%	37.3%	26.6%	60.9%	24.9%	27.0%	33.4%	45.5%	32.7%
Discharge Standards	**Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts)**	100.0%	80.0%	100.0%	77.8%	100.0%	94.7%	100.0%	85.7%	100.0%	100.0%	100.0%		93.5%
Discharge Standards	**Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team**	54.3%	26.7%	40.0%	23.2%	34.2%	52.1%	3.8%	12.5%	0.0%	0.0%	84.6%	46.0%	33.2%
Discharge Standards	**Six month follow-up assessment for**	1.3%	0.0%	64.2%	20.8%	62.8%	85.8%	51.1%	47.4%	1.4%	100.0%	21.8%	31.9%	34.0%

For the number of stroke patients the above percentages relate to, see table on the following page:

	Acute Stroke Quality Improvement Measures Values	Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Glangwili	Prince Philip	Withybush	Morriston	
Inpatient Rehab	Number of patients who spent at least 90% of their stay on stroke unit *	102	40	69	32	125	60	38	21	9	21	31	73	621
	Total Number of patients that stayed on the stroke Unit	148	52	106	59	176	134	85	27	27	30	52	161	1057
	Compliance with patients receiving the required minutes for OT (3-month rolling)	6	17	11	5	20	19	23	7	15	14	35	19	15
	Average minutes of occupational therapy across all patients	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7
	Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	8	10	10	12	20	18	19	15	14	15	35	19	15
	Average minutes of physiotherapy across all patients	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3
	Compliance with patients receiving the required minutes for SALT (3-month rolling)	4	2	8	5	9	6	4	10	4	4	5	7	5
	Average minutes of speech and language therapy across all patients	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1
Discharge Standards	Number of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts) (Numerator)	6	4	5	14	18	18	14	6	4	9	3	0	101
	Total Number of patients who require screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts) (Denominator)	6	5	5	18	18	19	14	7	4	9	3	0	108
	Number of patients discharged with ESD/Community Therapy Multidisciplinary Team (Numerator)	38	12	10	13	26	38	3	3	0	0	22	40	205
	Total Number of patients discharged alive(Denominator)	70	45	25	56	76	73	78	24	22	36	26	87	618
	Six month follow-up assessment (Numerator)	4	0	79	25	86	103	71	18	1	22	17	38	464
	Total number of patients that require Six month follow-up assessment (Denominator)	306	90	123	120	137	120	139	38	74	22	78	119	1366

Quality Measures Summary – Post 72 hour Pathway – non routine:

	Non Routine Quality Improvement Performance	Aneurin Bevan			Betsi Cadwaladr			Cardiff & Vale			CTM	Powys			Swansea Bay	All Wales
		Nevill Hall	Royal Gwent	Ystrad Fawr	BCU-Central ESD Team	Central Rehab Unit	West Rehab Unit	CV ESD Team	Llandough	UHW NR	Ysbyty Cwm Rhondda	Brecon	Newtown	Powys_MCRT	Neath Port Talbot	
Inpatient Rehab	Percentage of patients who spent at least 90% of their stay on stroke unit *										95.2%					
	Compliance with patients receiving the required minutes for OT (3-month rolling)	44.8%	41.9%	72.1%	51.3%	27.8%	81.6%	49.2%	118.3%	41.0%	75.2%	66.4%	88.3%	150.2%	71.7%	97.2%
	Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	52.4%	51.0%	60.4%	63.6%	22.3%	91.1%	68.0%	91.9%	25.9%	71.6%	38.6%	78.5%	62.6%	96.5%	84.5%
	Compliance with patients receiving the required minutes for SALT (3-month rolling)	15.5%	23.2%	12.6%	38.7%	37.8%	74.9%	34.8%	24.8%	6.1%	66.5%	37.2%	45.4%	6.5%	14.8%	19.5%
Discharge Standards	Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	56.5%	85.7%	100.0%	0.0%	0.0%	41.7%	33.3%	70.0%	0.0%	44.1%	0.0%	44.4%	0.0%	20.0%	31.0%
	Six month follow-up assessment for										66.7%					

For the number of stroke patients the above percentages relate to, see table on the following page:

	Non Routine Quality Improvement Values	Aneurin Bevan			Betsi Cadwaladr			Cardiff & Vale			CTM	Powys			Swansea Bay	All Wales
		Nevill Hall	Royal Gwent	Ystrad Fawr	BCU-Central ESD Team	Central Rehab Unit	West Rehab Unit	CV ESD Team	Llandough	UHW NR	Ysbyty Cwm Rhondda	Brecon	Newtown	Powys_MCRT	Neath Port Talbot	
Inpatient Rehab	**Number of patients who spent at least 90% of their stay on stroke unit ***										40				0	0
	Total Number of patients that stayed on the stroke Unit										42				0	0
	Compliance with patients receiving the required minutes for OT (3-month rolling)	12	11	19	13	7	21	13	30	11	19	17	23	39	18	25
	Average minutes of occupational therapy across all patients	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7	25.7
	Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	14	14	16	17	6	25	19	25	7	20	11	21	17	26	23
	Average minutes of physiotherapy across all patients	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3	27.3
	Compliance with patients receiving the required minutes for SALT (3-month rolling)	2	4	2	6	6	12	6	4	1	11	6	7	1	2	3
	Average minutes of speech and language therapy across all patients	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1	16.1
Discharge Standards	**Number of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts) (Numerator)**	9	7	1	7	5	7	6	1	9	17	8	5	1	4	4
	Total Number of patients who require screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts) (Denominator)	9	7	1	7	5	7	7	1	9	17	8	5	1	4	4
	Number of patients discharged with ESD/Community Therapy Multidisciplinary Team (Numerator)	13	18	5	0	0	5	3	7	0	15	0	8	0	2	9
	Total Number of patients discharged alive(Denominator)	23	21	5	14	12	12	9	10	41	34	18	18	4	10	29
	Six month follow-up assessment (Numerator)										20				0	0
	Total number of patients that require Six month follow-up assessment (Denominator)										30				0	0

Appendix C: 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:

Rating	Definition
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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