Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Aneurin Bevan University Health Board

Audit year: 2019

Date issued: May 2022

Document reference: 2861A2022

This document has been prepared for the internal use of Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users. The Act comes into effect in 2023.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Aneurin Bevan University Health Board (the Health Board carried out between June and October 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

Key messages

6 Overall, we found that **the Health Board has clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety. However, there remain weaknesses at a divisional and directorate level which could impact the flow of assurance from floor to board.**

7 The Health Board has articulated its annual key areas of focus for quality and safety and there are reasonable corporate and divisional arrangements for monitoring risk with good scrutiny and challenge by the Patient Quality, Safety and Outcomes committee on quality and safety risks it has been assigned. Arrangements for monitoring mortality and morbidity and national clinical audit are developing and performance in relation to responding to complaints, and arrangements for learning lessons are improving. The Health Board has a well-established values and behaviours framework, it encourages staff to raise concerns and there is collective responsibility for quality and safety amongst Executive Leadership. Corporate quality and safety structures and processes are clearly articulated and arrangements for monitoring quality and safety information are improving.

8 However, we found some gaps in flows of assurance on healthcare standards between operational and corporate structures. This indicates a need to ensure that the quality assurance framework provides clarity around how a 'floor to board' quality and safety assurance system operates in practice. There is also a need to review the extent that operational staff and management have sufficient capacity to effectively support quality governance. At a directorate level, arrangements for monitoring and reporting on key areas of focus for quality and safety are yet to be finalised and the monitoring and escalation of risk is not always effective. Whilst there are dedicated resources for quality improvement, the capacity of the team has decreased and was further affected by COVID-19. The arrangements for Health Board-wide and local clinical audit also require improvement. The Health Boards Putting Things Right policy is out-of-date and needs reviewing. There are opportunities for the Health Board to improve how it captures and learns from patient experience in respect of services it provides and services it commissions from other providers and more to do to ensure that staff feel comfortable to report concerns, and they receive feedback on actions taken.

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Risk management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level. • ensure systems for learning and good practice from clinical audit are embedded across the organisation.

Recommendations

Values and behaviours

R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:

- they are not treated fairly or given feedback when reporting errors, near misses or incidents.
- that the Health Board does not act on concerns they raise or take action to minimise future of occurrence errors, near misses or incidents.

Patient experience

R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should:

- undertake work to understand why patient feedback updates are not regularly provided to work areas or departments.
- ensure there are systematic arrangements for collating and action upon patient experience information across the organisation and the services it commissions.

Putting Things Right

R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.

Quality and safety framework

R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:

Recommendations

- complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the framework functions as intended.
- articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide 'floor to board' assurance.

Resources to support quality governance

R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.

Coverage of quality and safety matters

R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:

- review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements.
- ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **the Health Board has articulated its annual quality and safety priorities, but it needs to improve how it monitors the delivery of these. Quality risks are appropriately managed at corporate and divisional levels but requires strengthening at directorate levels.**

Quality and patient safety priorities

12 **The Health Board has articulated its annual quality and safety priorities but there needs to be better alignment between operational quality priorities to the strategic quality aims. Monitoring and reporting on the delivery of those priorities need strengthening.**

13 The Health Board has articulated its approach to quality and safety through its Integrated Medium-Term Plan (IMTP) 2019-20 to 2021-22, Annual Plan 2021-22, and Quality Assurance Framework 2020-23. The Health Board's Annual Plan 2021-22 outlines its commitment to ensure that every individual 'has a positive experience'. To achieve this, the Experience, Quality and Safety element of the Annual Plan incorporates five key aims which replace the previous IMTP's quality priorities:

- enabling a safety culture
- a learning organisation
- a just culture
- data for quality and improvement
- a safe environment.

14 As part of its corporate planning cycle, the Health Board engages external partners, including the Community Health Council on priorities and challenges. Our discussions with staff suggest limited involvement from operational areas to help shape the Experience, Quality and Safety element of the plan.

15 The Health Board's delivery actions are designed to support achievement of its five quality aims. These delivery actions, however, lack clear target dates or milestones. Furthermore, there is no monitoring and reporting framework in place. We also found limited scrutiny and assurance by the Board and Patient Quality, Safety and Outcomes Committee (PQSO committee) on the key areas of delivery. This creates a risk that the committee might not be sighted on aspects where quality delivery aims aren't achieved or where progress is limited. Our 2021 Structured Assessment report also highlights weaknesses and made a

recommendation on the Health Board's arrangements for monitoring progress on the 2021-22 Annual Plan[1].

16 Both the General Surgery directorate and Scheduled Care division identify quality and patient safety priorities and monitor progress. The directorate and division revised their priorities in response to COVID-19. However, they haven't aligned their operational priorities with the Health Board's key delivery actions for quality and safety outlined in its Annual Plan for 2021-22.

Risk management

17 **The Health Board has defined its risk appetite for patient safety and experience and regularly reviews risks at Board, committee, and divisional levels. However, directorate level risk management arrangements need strengthening.**

18 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021. This provides a greater focus on risk escalation and how it assists in achieving the Health Board's strategic objectives. It also places additional responsibility on operational areas to take greater ownership for managing risks to the delivery of local objectives.

19 The Health Board has defined its risk appetite and tolerance for patient safety and patient and experience as level 1 indicating a low risk appetite in this area. Ten of the twelve principal risks to the Health Board relate to quality and patient safety. Quality risks in the BAF and corporate risk register are appropriately assigned to the PQSO committee designated lead Executive Director.

20 Our observations of the PQSO committee indicates good discussion and scrutiny on the quality and safety risks. The Health Board's Quality and Patient Safety Operational group is a key forum in the quality and safety assurance framework. It provides assurance and advice to the PQSO committee and coordinates the management of quality risks across the organisation. Risk is a standing item on the group's agenda. This provides a platform for each division to escalate their highest risks and concerns in relation to quality and safety. In practice however, our review found limited scrutiny, challenge, cross divisional discussion or sharing of good practice around the risks discussed.

21 At an operational level, the Health Board's Scheduled Care division maintains and actively manages its divisional risk register. Quality and safety risks at this level are clearly articulated and scored with appropriate controls and risk owners identified. However, our work found gaps in the risk management arrangements at directorate level. A risk register for the general surgery directorate was not available for review during our fieldwork. Discussions with staff suggest that completion of directorate risk registers is inconsistent. This may impact on the quality of the divisional risk

[1] audit.wales/sites/default/files/publications/aneurin_bevan_health_board_structured_assessment_2021_english_0.pdf

register because it is reliant on risks escalated from the directorate level. We understand that the Scheduled Care division has recently established a quarterly meeting to review directorate risks, to improve the quality of these arrangements (**Recommendation 1).**

Organisational culture and quality improvement

22 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, compliance with statutory and mandatory training and wider quality improvement processes.

23 We found that **the Health Board has maintained a reasonable focus on quality improvement over the course of the pandemic. However, there are a number of areas that should be strengthened including clinical audit, addressing staff concerns and approaches for capturing and sharing patient experience.**

Quality improvement

24 **The Health Board's dedicated Quality Improvement team capacity has decreased over the past three years, being further affected by COVID-19. The Health Board has worked hard to develop its arrangements for monitoring mortality and morbidity and national clinical audit. However, local, and corporate clinical audit programmes require improvement.**

Resources to support quality improvement

25 The Health Board's Aneurin Bevan Continuous Improvement team (ABCi) currently consists of 9.79 whole time equivalent (WTE) staff (12 headcount). But compared to three years ago, resources have been reduced. The pandemic further impacted the capacity of the ABCi team with some staff redeployed to other roles within the Health Board.

26 The ABCi team provides training and support to operational teams. The pandemic is limiting usual training activity, but the team has continued to deliver in virtual settings where possible. The team deliver a range of quality improvement, analytics, modelling, and leadership training, such as 'Pocket Quality Improvement' and 'PocED Quality Improvement'. The IQT training has been superseded by the Improvement Cymru Improvement Practitioner Programme. Over the past three years however, the Health Board has provided an alternative to the bronze and silver IQT. The latest Health Board figures show that 4.7% of staff to have completed its IQT equivalent training.

Clinical Audit

27 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review the Health Board was updating its Clinical Audit Strategy and Policy. This will include requirements for divisions to develop their own clinical audit plans upon which a Health Board clinical audit plan will be based. At present though the clinical audit plan is not in place.

28 Positively, the Health Board has continued to deliver all mandated national clinical audits and provide regular progress updates to the PQSO committee. These updates identify learning and actions to be taken to address issues arising from the reviews. The Health Board's Medical Directors Support team (MDS team) comprises of 7 WTE (9 headcount) staff. The team supports divisions and directorates, by facilitating data collection, on national clinical audit, outcome reviews and local clinical audit. The team also support divisions with their development of data outputs, presentations, and improvement plans. These improvement plans are then overseen by the Clinical Effectiveness and Standards Group. The Health Board is currently reviewing the effectiveness of its MDS team to maximise the support it provides to operational areas.

29 Arrangements to support sharing of clinical audit learning and good practice at an operational level are not yet effectively embedded or systematic. We also identified limited operational clinical audit resources to undertake corporate and local clinical audit work effectively and consistently.

30 In January 2020, the Health Board established the bi-monthly Clinical Effectiveness and Standards Group (CES group). This group provides a forum for senior clinicians to monitor outcome data relating to clinical effectiveness, patient safety and to monitor national and Health Board wide clinical audit activity. The CES group's multi-disciplinary membership includes all divisions and is chaired by the Assistant Medical Director for Clinical Effectiveness. However, the pandemic has meant this group has been unable to meet as planned and there is variable participation. At the meeting we observed, there were no representatives from Scheduled or Unscheduled Care.

31 In addition, at the time of our review the CES group terms of reference were draft and there was some confusion about which version was in use. We were also informed that some elements required updating to reflect changes to the group's remit **(Recommendation 2).** CES group meeting agendas are well-structured with good presentations focussing on national clinical audits and other quality and safety related issues. There are discussions on some agenda items that lead to a focus on actions and solutions to address issues. However, there are opportunities to strengthen this further by encouraging this 'actions focussed' practice across all agenda items. Where actions are identified, it is unclear if the CES group regularly seeks further assurance from divisions to understand if the actions are delivered and sustained.

Mortality and morbidity reviews

32 Mortality and morbidity meetings provide a systematic approach for peer review of adverse events, complications, or mortality to learn from and improve patient care. In November 2020, universal mortality reviews were superseded by the Medical Examiner function. The Health Board anticipates that by May 2022, all inpatient and community deaths will be subject to Medical Examiner scrutiny.

33 The Health Board established a Mortality Review Screening panel in July 2021. This has multi-disciplinary and cross-division representation. The panel considers the need for further investigation to Medical Examiner referrals. If needed, the panel determines an investigation terms of reference and appoints an investigating officer. The panel reports investigation outcomes to the Health Board's Mortality Review Group and has recently published its first bi-annual Learning from Death report.

34 Shared learning is a crucial element of the five levels of mortality management. The Health Board's Learning from Death report demonstrates how the organisation is learning and improving its arrangements following investigation.
The improvements in prevention of COVID-19 nosocomial infection using a Rapid Assessment Tool provides a good example of this. Other learning following investigations include lessons from inter-site transfers, steroid prescribing, and advanced care planning. The Learning from Death report identifies communication as a commonly recurring theme and outlines several improvement actions. The Health Board now intends to introduce a systematic process for reporting outcomes of mortality and morbidity reviews to different Health Board forums.

35 The Health Board is planning on developing a Learning from Death Framework during 2022. This will bring together information from numerous sources including inquests, mortality and morbidity reviews, Putting Things Right complaints processes, and Medical Examiner scrutiny. It will focus on outcomes and improvements and further strengthen the assurance provided to PQSO committee.

36 Together, the Mortality Review Group, CES group and Deteriorating Patient and Resuscitation Group prepare a joint annual report. The aim of this is to provide collective assurance to the Quality and Patient Safety Operational group and PQSO committee on the arrangements for safe and clinically effective care.
Our review of the report found it to provide sufficient information for assurance and decision-making, demonstrating levels of compliance with healthcare standards and improvement actions for the next 12 months.

Values and behaviours

37 **While there is a well-established values and behaviours framework, the Health Board needs to ensure that staff feel listened to when they report errors or concerns.**

38 The Health Board's values and behaviours framework sets out its vision of a quality and patient-safety-focussed culture. It focuses on continuous improvement, openness, transparency and learning when things go wrong. Values and behaviours are embedded in workforce processes, such as recruitment, induction and performance appraisal and development reviews. They are also regularly publicised and referenced during meetings.

39 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. We undertook a survey of operational staff working across the Scheduled Care Division[2] (see results in **Appendix 2).** Of those responding, we found that 58 out of 83 staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, 39 out of 83 staff agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (**Recommendation 3**).

40 The most recent NHS Wales Staff Survey[3] showed a minority but significant proportion of concerns relating to bullying, harassment, or abuse over the past year (16.6%, 15.2% and 9.6% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (42.2%).

41 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show a 76%[4] overall organisation compliance with mandatory training requirements. This level has remained consistent since November 2020. Our survey of staff in the Scheduled Care division found that 42 out of 83 staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training. The Scheduled Care division and General Surgery directorate have indicated that they are developing plans to ensure staff have access to training and time to

[2] We invited operational staff working across the Scheduled Care division to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. We had a response rate of 83 staff. Although the findings are unlikely to be representative of the views of all staff across the Scheduled Care division, we have used them to illustrate particular issues.

[3] The NHS Wales staff survey ran during February 2021 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 19%, compared to an all-Wales average of 20%.

[4] The Health Board is required to report compliance to the Welsh Government on a monthly basis. The target for compliance for all health boards is 85%.

complete online modules. Despite this, the Health Board remains concerned and is establishing a working group to further support mandatory training compliance.

42 Performance appraisal and development reviews aim to help staff understand what is expected of them and take responsibility of their own performance and development. Against a national target of 85%, the Health Board's compliance rate for appraisals in November 2021 was 59%. This is also broadly consistent with the compliance rate reported by the Scheduled Care division during our fieldwork of 50%. The Health Board is seeking to improve through its PADR strategic meetings and shared learning. The pressure on services may continue to affect PADR rates for some time.

Listening and learning from feedback

43 **Building on the lessons learnt from the pandemic, the Health Board now needs to reinvigorate its efforts to capture and learn from patient experience, staff feedback and independent review.**

Patient experience

44 Information on patient experience can provide a valuable insight into the quality of services received. Our work has found that the arrangements for obtaining feedback have been impacted by the pandemic.

45 It has not been possible for the Health Board's Person-Centred Care team to support divisions in capturing patient experience in the same way they would have prior to the pandemic. The Health Board has instead relied on patient experience surveys and third-party feedback. In August 2020, 96 patients provided feedback through a pilot scheme. While small in terms of numbers contacted, this innovative scheme enabled virtual inpatient 'buddying', where two members of the Person-Centred Care team would attend wards and connect patients to Community Health Council officers.

46 The Scheduled Care division and General Surgery directorate use questionnaires, complaints, and compliments, critical care follow-up clinics and patient stories to capture information. The division and directorate indicated to us that they seek feedback from patients and share learning. However, our survey found that 38 out of 83 staff disagreed or strongly disagreed that they receive regular updates on patient feedback for their work area or department.

47 The Health Board has arrangements for collating and acting upon patient experience information. However, our discussions with Health Board staff reveal that these arrangements are not systematic across the organisation or the services it commissions. A business case is being developed for the Health Board to procure the Once for Wales Concerns Management System. Its aim is to provide real-time feedback and 'ward to board' reporting functionality **(Recommendation 4)**.

48 At a corporate level, reports provided to both the Quality and Patient Safety Operational group and PQSO committee provide a good overview of patient experience activity alongside areas for improvement. The Health Board does not intend to update its Patient, Family and Carer Experience Strategic Framework which expired in 2019. However, it uses the 'what matters' principles and is awaiting the refreshed national approach to patient experience which aligns to the Quality and Engagement Act.

Concerns and complaints

49 The Health Board's Putting Things Right Policy outlines its arrangements for complaints, claims and patient safety incidents. The policy applies to all staff employed by or working with the Health Board and outlines their roles and responsibilities for dealing with concerns. The policy was due to be reviewed in 2018 and now contains out of date information **(Recommendation 5)**.

50 Against a national target of 75% of complaints responded to within 30 days, the Health Board achieved 69% compliance during 2020-21. This represents a year-on-year improvement from 2018 to 2021 and we understand that performance is continuing to improve. We were told, however, that the impact of the pandemic is resulting in growing complaints within the Scheduled Care division. The numbers of complaints are steadily rising due to service pressures and lengthy waits.

51 Staff training on 'putting things right' is well attended and receives positive feedback. The Health Board has also introduced a Complaints Co-ordinator Network meeting and a tracking system to monitor progress with corporate complaints. The Health Board uses learning from concerns, complaints, incidents, and redress to identify required improvements. These are reported in the annual Putting Things Right and Patient Quality Safety and Outcomes reports. For example, the latest report highlights aspects of clinical treatment, assessment, communication issues, and timeliness of appointments as the main themes arising from concerns and complaints.

Listening to staff concerns

52 The Health Board uses the all-Wales incident reporting policy, procedure and the Datix system for staff to raise concerns and support learning from staff experiences. This includes guidance on the responsibilities of all staff and the process for raising concerns, including whistleblowing. All staff have access to the system, however there are inconsistencies at corporate and operational levels around the levels of training provided on reporting concerns or near misses.

53 Our review found that there was an 'open door' policy amongst senior Health Board staff where staff concerns are confidentially brought to their attention. We were also informed of various other methods to understand staff concerns such as bespoke surveys, exit meetings, staff forums and the 'ask the Chief Executive' on the intranet. But our work suggests there is more to do to address staff

concerns and demonstrate where improvement action has been taken, or act to minimise future occurrence of errors, near misses or incidents. Our survey found that only 30 out of 83 staff agreed or strongly agreed that the organisation acts on concerns raised by staff and just over half of respondents (44 out of 83) agreed or strongly agreed that the organisation acts to minimise future occurrence of errors, near misses or incidents **(Recommendation 3)**.

Patient stories

54 Patient stories are used by the organisation at Board meetings, PQSO committee and various learning events. Patient stories featured regularly at Board prior to the pandemic. Since April 2021, patient experience and public engagement is a standing agenda item. While there have been difficulties in collating patient experience information needed over the last two years, there is an opportunity to return the frequency of patient story use to pre-pandemic levels. When used, patient stories are linked to agenda items.

55 The PQSO committee receives specific examples of patient stories as part of its assurance reporting in relation to listening and learning from feedback. Health Board staff have completed several digital patient stories. These include a patient's experience of COVID-19 in the Intensive Care Unit, and the experience of a patient within cancer services. However, it is unclear where these stories are presented. We also found limited evidence to indicate if patient stories are considered at divisional and directorate Patient Safety and Quality group meetings.

Patient safety walkarounds

56 Patient safety walkarounds provide independent members with an understanding of the reality for staff and patients, making data more meaningful and provide assurance from more than one source. The Health Board has recommenced the programme of walkarounds having paused them due to the pandemic. Independent Members commented positively on the walkarounds. They indicate that the walkarounds help to triangulate information, gain a sense of staff morale and an understanding of the day-to-day issues affecting staff.

Internal and external inspections

57 Our work indicates that the number of outstanding HIW recommendations has reduced over the last three years. The Health Board has made good progress in developing its arrangements for monitoring and disseminating findings and recommendations from Health Inspectorate Wales (HIW) reports. It maintains a detailed tracker which it uses to monitor progress in implementing the required improvements arising from HIW inspections across the organisation.

58 The Executive Team reviews the tracker quarterly prior to the PQSO committee meeting. The detailed tracker is not shared with the PQSO committee but doing so might help provide a greater level of assurance. The committee does however

receive updates on HIW inspections as part of its assurance reporting. Updates provide details of HIW inspections completed during the year, and both positive findings and areas for improvement.

59 The PQSO committee receives quality and safety related reports which may reference findings from Internal Audit reviews where these are relevant. At present though, Internal Audit reports that focus on quality and safety issues are not included on the committee agenda in their own right. This could leave some members less than fully sighted on quality and safety risks and limits opportunities to provide scrutiny and assurance.

Governance structures and processes

60 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

61 We found **collective responsibility for quality governance amongst the Executive Leadership of the Health Board and corporate structures and processes are working well. However, there are gaps in flows of assurance with a need to strengthen 'floor to board' quality and safety assurance.**

Organisational design to support effective governance

62 There is collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. The Health Board's Clinical Executives have a collegiate and robust approach to quality and safety supported by the Assistant Director of Nursing for Quality and Safety, Assistant Director for Quality and Patient Safety and Assistant Director for Person-Centred Care. Together they provide additional senior capacity and focus from medical, nursing, and patient perspectives. The Health Boards' Director of Nursing will be retiring in July 2022 and therefore the Health Board will need to recruit to this role.

63 The Health Board's clinical executives and their teams attend weekly 'clinical huddle' meetings to discuss quality and patient safety matters. The executive team receive regular reports identifying issues and risks from these huddle meetings during its standing agenda item on quality and patient safety.

Quality and safety framework

64 In March 2020, the Board approved the Health Board's quality assurance framework. The purpose of the framework is to inform and support the Board and the PQSO committee in its focus on quality and quality improvement. The framework is mapped to Health and Care Standards and outlines the Health Board's quality assurance structure. The approval and implementation of the framework coincided with the COVID-19 pandemic which had an impact on progress to embed the approach across the Health Board.

65 The quality assurance framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. For example, the Health and Care Standard for 'safe care' structure includes overarching committees, such as the Health and Safety Committee supported by sub-groups including the Strategic Fire Safety Committee and Manual Handling Group. Each group is required to provide assurance to the Quality and Patient Safety Operational group and ultimately the PQSO committee and Board. The framework helpfully identifies areas which previously had not provided assurance. However, there are gaps in the flows of assurance from some sub-groups and in relation to some elements of the Health and Care Standards, for example, Communicating Effectively (Health and Care Standard 3.2).

66 The framework is reasonably comprehensive at a corporate level. But it doesn't fully articulate the operational structure and processes for quality and safety and how those align with the corporate structures to provide 'floor to board' quality and safety assurance. The Health Board recognises that elements of the framework and structure are not functioning as intended and have identified this as a key area for delivery in its annual plan **(Recommendation 6)**.

Patient Quality, Safety and Outcomes Committee

67 The Health Board's PQSO committee is responsible for providing assurance and advice to the Board in relation to quality and safety. The terms of reference for the PQSO committee were revised in April 2021 in response to changes made to the Health Board's governance structure. The changes aim to achieve a person-centred approach to care and recognise the need to become more outcomes focussed.

68 Our work found the committee is becoming more effective. We noted clear and concise papers and an increased focus on risk and outcomes. Independent Members commented positively on the quality of the committee meetings and were generally satisfied with the level and quality of assurance they receive. As part of our audit, we observed the committee on several occasions. We found good quality discussion, scrutiny, and challenge from independent members. There is multi-disciplinary involvement at agenda setting meetings ensuring transparency and balance in the coverage of quality and safety matters at the meeting.

Quality and Patient Safety Operational Group

69 The Health Board's Quality and Patient Safety Operational group is responsible for providing assurance and advice to the PQSO committee in relation to quality and safety. The group's bi-monthly meetings precede the PQSO committee. The group is chaired by the Director for Families and Therapies with representation from across all Health Board operational divisions and corporate departments. Health Board staff informed us that operational participation at the meeting has improved following the introduction of virtual meeting arrangements during the pandemic.

The Health Board intends to review the role of the Quality and Patient Safety Operational group within the Health Boards quality assurance structure to ensure that it is receiving and providing appropriate quality and safety assurance.

Divisional / Directorate Patient Safety and Quality Group(s)

70 The Scheduled Care Divisional Patient Safety and Quality group (DPSQ group) terms of reference indicates a responsibility to provide assurance on quality and safety to the Health Board's corporate groups and committees. However, our work found that the group does not provide a dedicated assurance report and there is a lack of clarity around the flows of assurance from divisional to corporate levels.

71 The DPSQ group meets monthly and is chaired by the Divisional Director for Scheduled Care. The groups terms of reference outline a multi-disciplinary membership. This includes both the divisional director and divisional nurse, medical and nursing leads for patient safety and quality, and senior representatives for Putting Things Right, Health and Safety. Whilst the proposed membership is appropriate, our work identified instances where certain members, for example a Health and Safety representative had not attended a meeting or provided an update for some time, leaving a gap in assurance. It was also unclear whether representatives from all directorates attend this meeting. Health Board staff indicate that meeting dates for the group are being revised to align with directorate audit days to improve attendance.

Resources and expertise to support quality governance

72 Corporately there are several teams working to support quality and safety issues in the Health Board. The Person-Centred Care Team and Putting Things Right Team, report to the Assistant Directors of Nursing for Person-Centred Care and Quality and Safety respectively. This is in addition to ABCi, Medical Director's Support Team, and Infection Prevention and Control Teams referred to earlier this report.

73 The Person-Centred Care Team (9.8 WTE, 12 headcount) provides a range of training and support to operational areas on patient surveys, developing patient experience metrics and digital patient stories. The team has expanded over the last three years through recruitment of an End-of-Life Companion Co-ordinator and Clinical Skills Trainer on fixed term contracts.

74 The Putting Things Right Team (11.9 WTE staff, 14 headcount) role is to provide training and support to operational staff, for example effective complaints handling and investigating officer training. The Health Board informed us that 150 staff are trained to investigate complaints and 101 staff trained to investigate incidents across the Health Board. There are currently no vacancies within the team and its size and composition has remained relatively constant over the last three years. However, there have been some changes to its structure resulting in recruitment and changes in personnel.

75 There is a dedicated team for Infection Prevention and Control (14.8 WTE staff, 17 headcount). They provide training and support to operational staff in line with the Health Board's infection prevention training strategy and has adapted in response to the COVID-19 pandemic. Recently, the Infection Prevention and Control Team has received funding to enhance the primary care aspect of its role. The pandemic has placed significant additional demands on the team, and this limits the amount of proactive infection and prevention control work it undertakes.

76 At an operational level, the Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. This includes managing concerns, risk management, infection prevention and control, quality improvement, Datix and health and safety. They also have designated leads for quality and safety. They assist with serious incidents investigations, support wards and departments in relation to the Datix system, attend quality improvement meetings and represent the division at meetings where there is a quality and safety focus. However, we found that some designated leads do not have protected time to fulfil several of these roles. **(Recommendation 7)**. In addition, the Health Board does not have designated leads for patient experience or a dedicated patient experience team such as a Patient Advice and Liaison Service (PALS). This contrasts with some other Health Boards in Wales. However, we understand that the Health Board is currently considering a model for the introduction of this service.

Arrangements for monitoring and reporting

77 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

78 We found that **the Health Board arrangements for monitoring quality and safety at a corporate level are improving, but the Health Board needs to review arrangements at an operational level to ensure it is receiving appropriate assurance on the quality and safety of its services**.

Information for scrutiny and assurance

79 The Board performance report and integrated performance dashboard provides performance information against the NHS Wales Delivery Framework measures including complaints and healthcare acquired infections. The redesigned Patient Quality, Safety and Outcomes report is more succinct, and outcome focussed. It includes quality metrics, including healthcare-associated infections, COVID-19, pressure damage and inpatient falls. It also provides greater clarity around emerging themes, areas of concern, mitigation, and good practice. Whilst the report is predominantly secondary care focussed, it includes wider areas of the Health Board's business such as Child and Adult Mental Health Services (CAMHS)

and Primary Care Mental Health. However, opportunities exist to strengthen reporting on the services the Health Board directly commissions.

80 At an operational level, the Divisional Patient Safety and Quality group receives presentations and reviews performance reports and dashboards with infection control, incident reports, concerns data and health and safety information. Some supporting papers are available in advance and attached to meeting agendas, but several are not. This may limit opportunity for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

81 The four harms associated with COVID-19 remain a key consideration on the Health Board's BAF and information is routinely reported and escalated via a safety dashboard report to the PQSO committee. Whilst COVID-19 issues are included in various reports and papers for the Board, the removal of COVID-19 updates as a standing item on the Board agenda may limit opportunities to provide assurance.

82 The Health Board's annual plan includes requirements to refine its quality and safety dashboard quality indicators and increase the capacity and capability of divisions and its corporate teams to utilise data to support quality and safety.

Coverage of quality and patient safety matters

83 The PQSO committee's remit is clear in relation to oversight for quality and safety and its agendas are aligned to the main quality and safety risks within the Health Board. Agenda includes regular information around patient feedback within services and reports on external inspections and reviews. Health Board senior leadership are responsive to requests from the committee for additional information resulting from concerns identified at previous meetings. The chair of the Quality and Patient Safety Operational group presents assurances to the PQSO committee on the group's activities. Our review of the update reports found them to provide information on divisional quality and safety risks, and a summary of key matters arising from other items considered during the meeting. This is supplemented with additional information by the Quality and Patient Safety Operational group chair and senior Health Board officers as part of its presentation and discussion during committee meetings.

84 Operationally, the Divisional Patient Safety and Quality group uses a standardised agenda which covers key aspects of quality and safety. This includes infection prevention and control, serious incidents, safety alerts, complaints and concerns, divisional risks and Datix feedback to staff. The group also focuses on wider quality improvements. An example of this is its regular oversight of the theatre improvement programme which was established in response to 'never events' occurring within the General Surgery directorate. The Divisional Patient Safety and Quality group actively manages its action log which provides details on actions, completion dates, lead officers and progress updates.

85 The General Surgery directorate has recently established its own Patient Safety and Quality group, but it is in the early stages. At the time of our review, the group

did not have a terms of reference, standardised agenda, or report templates and whilst an action log is maintained, minutes of meetings are not taken.
The Divisional Patient Safety and Quality group is considering the introduction of standardised agendas, reporting templates and patient safety and quality plans and gaps in the flow of quality and safety information across its directorates. This should help to address some the inconsistencies in directorate approaches.

86 Our review of agendas and papers for the monthly assurance meetings with the Director of Operations indicate a focus on quality and safety, particularly around concerns, serious incidents, and infection control. However, these meetings stopped in March 2021 and have not resumed. We also note a focus on quality and safety at bi-annual reviews with the Executive Team. However, we found limited focus on quality and safety at the Scheduled Care divisional management team meetings with some meetings mainly focussing on finance, performance, and operational matters **(Recommendation 8)**.

Appendix 1

Management response to audit recommendations

Exhibit 1: management response

Recommendation	Management response	Completion date	Responsible officer
Risk Management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross			

Recommendation	Management response	Completion date	Responsible officer
divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.	The form and function of Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes. The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	June 2022 October 2022 May 2022	Executive Director of Therapies and Health Sciences Director of Clinical Governance Director of Clinical Governance

Recommendation	Management response	Completion date	Responsible officer
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This	The Clinical Audit strategy and policy are currently under review and will be ratified by June 2022. A Digital Clinical Audit Platform has been procured to support the delivery of Divisional, Directorate and Corporate Clinical audit plans designed to provide assurance around areas of high priority.	June 2022	Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level • ensure systems for learning and good practice from clinical audit are embedded across the organisation.	Complete ABUHB will undertake a review of resources and capacity available to support the completion of the National Clinical Audit programme. The Clinical Standards and Effectiveness Group is the forum where Clinical audit is discussed and presented to ensure scrutiny and assurance. Bi-annual reporting to the PQSOC takes place to provide assurance of clinical performance and the development of action plans to address requisite improvements. A review of the	N/A August 2022 June 2022	N/A Executive Medical Director Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
	membership of the group will be undertaken to support improved Divisional representation.		

Recommendation	Management response	Completion date	Responsible officer
Values and behaviours R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel: • they are not treated fairly or given feedback when reporting errors, near misses or incidents.	The ABUHB Value Framework has been refreshed recently. There is clearly a need to remind managers and leaders to ensure feedback to staff who have raised concerns and this will be reinforced through Divisional Triumvirates for cascade.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
• that the Health Board does not act on concerns they raise or take action to minimise future occurrence of errors, near misses or incidents	A review of concerns raised by staff and the actions taken will be conducted to provide assurance.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
Patient experience R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should: • undertake work to understand why patient feedback updates are not regularly provided to work areas or departments. • ensure there are systematic arrangements for collating and acting upon patient experience	A business case is in-development for the procurement of 'Civica' as part of the OFWCMS. If supported this will strengthen the ability to capture live patient experience which Divisions and Directorates will own, strengthening feedback. (As per response above)	September 2022	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
information across the organisation and the services it commissions.			

Recommendation	Management response	Completion date	Responsible officer
Putting Things Right R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.	The PTR policy will be updated with an extension to the date in light Welsh Government are reviewing the PTR policy aligned to the Quality & Engagement Act implementation.	June 2022	Executive Director of Nursing

Quality and safety framework R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should: • complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
• framework functions as intended. • articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide a 'floor to board' assurance.	The revised Quality Assurance Framework will include the operational structures and processes.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Resources to support quality governance R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.	A review of roles for QPS across Divisions will be undertaken with the aim of implementing a consistent approach (this will include time for leads to undertake their role effectively).	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Coverage of quality and safety matters R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional			

Recommendation	Management response	Completion date	Responsible officer
Management Team meetings. The Health Board should: • review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements. • ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6). Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	October 2022 May 2022	Clinical Executives Clinical Executives

Appendix 2

Staff survey findings

Exhibit 2: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	19	32	12	11	8	-	82
2. I am satisfied with the quality of care I give to patients	25	28	10	12	6	2	83
3. There are enough staff within my work area/department to support the delivery of safe and effective care	5	17	16	18	27	-	83
4. My working environment supports safe and effective care	15	25	11	16	15	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	11	21	13	18	17	3	83
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	14	35	18	4	5	7	83
7. My organisation acts on concerns raised by staff	7	23	16	16	17	4	83
8. My organisation encourages staff to report errors, near misses or incidents	18	40	13	6	5	1	83
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	11	28	24	9	4	7	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	11	33	20	10	5	4	83
11. We are given feedback about changes made in response to reported errors, near misses and incidents	8	26	17	18	10	4	83
12. I would feel confident raising concerns about unsafe clinical practice	18	31	15	10	7	2	83
13. I am confident that my organisation acts on concerns about unsafe clinical practice	12	32	21	11	6	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Working in my organisation							
14. Communication between senior management and staff is effective	2	27	16	18	20	-	83
15. My organisation encourages teamwork	7	35	22	11	8	-	83
16. I have enough time at work to complete any statutory and mandatory training	4	25	12	25	17	-	83
17. Induction arrangements for new and temporary staff (e.g. agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	7	31	23	5	10	7	83

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail:
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.