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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 (the 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.

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 Swansea Bay University Health Board (the Health Board) carried out between March and October 2021. To test the 'floor to board' perspective, we examined the arrangements for the Integrated Surgical Services Division which sits within the

Morriston Hospital Service Group. We also undertook a staff survey within this division.

6 Whilst this is not a joint review, we have engaged closely with Healthcare Inspectorate Wales (HIW) in the design and rollout of this work. HIW colleagues have been variously involved in activities aimed at sharing information and intelligence arising from this work and other related external review activities. In accordance with COVID legislative requirements at the time of fieldwork, all audit work was undertaken remotely.

Key messages

7 Overall, we found that **whilst the Health Board's corporate quality governance arrangements demonstrate a number of strengths, there are significant weaknesses in arrangements both corporately and within operational teams, which limits the Health Board's ability to know whether the services it provides are safe and effective.**

8 The Health Board has articulated its annual quality and safety priorities and there are good corporate arrangements for monitoring risk. There are dedicated resources for quality improvement and there is good use of local teams at an operational level to capture patient experience. The values and behaviours of the Health Board are well established, encouraging an open and learning culture, and a quality and safety framework sets out the processes for assurance. There is ownership of quality and safety at the executive and operational levels, and well-established committee arrangements are in place to provide scrutiny and assurance.

9 However, arrangements for monitoring quality priorities are yet to be finalised. Resources to support quality governance corporately are limited. Additional resources are embedded within the service groups, but these are working in isolation and have the risk of diluting ownership within the divisions. The visibility and frequency of clinical audit and mortality at a committee level need to be increased, and there is a lack of a co-ordinated and strategic approach to capturing patient experience. Despite good corporate risk arrangements, there are issues with the operational risk registers and flows of information. Awareness of the values and behaviours is mixed, and an open and learning culture is not always recognised by staff, with concerns that the Health Board will not always act in response to concerns. Compliance with appraisal is low and more could be done to promote and embed learning across the organisation.

10 Delivery of the quality and safety agenda largely rests with the nursing leads, and a number of changes in personnel at executive and operational level have presented challenges. Despite the development of the framework, it has not been implemented and weaknesses in approaches to quality governance at an operational level are resulting in quality concerns being missed, such as those highlighted in the recent report on cardiac services. A lack of data analytics

support, clear quality dashboards and understanding of data is impacting on operational ownership and performance monitoring. The Health Board is aware of the weaknesses and has been undertaking its own internal governance review.

Recommendations

11 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 The approach taken by operational managers to risk management is inconsistent and risk registers are often incomplete and missing robust mitigating actions. The Health Board should strengthen its management of risks at an operational level by: a) providing training to managers across the operational structure to enable them to clearly identify the risks for which they are responsible and update risk registers in line with corporate policy; and b) ensuring risks registers are receiving sufficient scrutiny at the operational level and the risk management group.
Develop a clinical audit plan R2 During our review we were unable to obtain a copy of the Health Board's most recent clinical audit plan. The Health Board should develop a clinical audit plan for 2021-22 which covers both mandated national audits and local audits which are informed by areas of risk. This plan should be approved by the Audit Committee and progress of its delivery monitored routinely.

Recommendations

Frequency of reporting of clinical audit and mortality

R3 The Health Board has set up a Clinical Outcomes and Effectiveness Group which provides assurance on clinical audit and mortality outcomes, but this information is currently fed through the Quality and Safety Governance Group and is only reported in its own right to the Quality and Safety Committee once a year. The Health Board should review this frequency so updates on progress delivering the clinical audit plan, and associated learning from mortality reviews are reported to the Quality and Safety Committee more frequently.

Values and behaviours

R4 The Health Board has a well-established values and behaviour framework which promotes an open and learning culture, but staff are not always aware of the values and behaviours, and some staff do not always recognise a culture that promotes learning from errors. The Health Board should:

a) refresh organisational awareness of the values and behaviours framework, so the values are at the forefront of everything staff do in the Health Board; and

b) undertake work to understand why some staff feel that the Health Board does not encourage reporting of errors, near misses or incidents, and does not act in response to concerns.

Performance Appraisal and Development Review (PADR)

R5 Our work found that compliance with Performance Appraisal and Development Reviews (PADR) within the operational groups we examined was low. Whilst we recognise the pressures of COVID-19 on the ability of the Health Board to improve performance in this area, these reviews are an important aspect of staff development. The Health Board should put in place a plan to improve performance which sets out when full compliance can be achieved. This plan needs to be monitored at an Executive and committee level.

Recommendations

Operational design to support effective governance

R6 Despite the development of a Quality and Safety Framework in January 2021 it is yet to be rolled out across the Health Board. The framework sets out the process by which the Health Board assures itself that services are of a high quality and safe for all. The Health Board should:

a) refresh the framework in light of learning from the COVID-19 pandemic;
b) relaunch the framework, and provide clarity on the quality governance arrangements expected within the Health Board; and
c) monitor compliance with the implementation of the framework across the organisation.

Ensure collective ownership of the quality and safety agenda

R7 Our work found that whilst there was collective responsibility for quality and safety amongst the executive team, there was an overreliance on nursing leads to take forward the quality agenda within divisions. The Health Board should look to ensure that other clinical professionals within the operational teams take an active role in quality governance arrangements.

Resources to support quality governance

R8 There are limited corporate resources to support quality governance and operational resources are working in isolation. The Health Board should:

a) review current resources and requirements to support quality improvement at a corporate, service group and divisional level; and
b) seek to maximise the potential of the operational resources by developing opportunities to bring resources together either through network arrangements or changes in lines of accountability.

Detailed report

Organisational strategy for quality and patient safety

12 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.

13 We found that **the Health Board has articulated its annual quality and safety priorities, but the monitoring arrangements are yet to be finalised, making scrutiny of delivery difficult. The Health Board has good arrangements for reviewing risk at a corporate level but management of risk at an operational level is inconsistent.**

Quality and patient safety priorities

14 **The Health Board has articulated its annual quality and safety priorities and is fully committed to improvement and achieving impact in these key areas, although monitoring arrangements are yet to be finalised.**

15 As part of the Health Board's Annual Plan 2021-22, the following five quality and safety priorities were identified along with their deliverables, the method of achieving the goal and the intended outcome.

- **Sepsis** – Increase number of patients being recognised, assessed, and treated for Sepsis.
- **End of Life Care –** All patients to be recognised and receive End of Life Care wherever they are being cared for/treated within the Health Board.
- **Suicide prevention –** An overall reduction in the numbers of suicides across the Health Board. A service which takes suicide seriously and embeds the knowledge of recognising and managing suicide and self-harm across the Health Board.
- **Infection prevention and control –** Reduction of Healthcare Acquired Infections across the Health Board. A reduction in antimicrobial medications in line with the Welsh Government requirement and the All-Wales Medicines Strategy Group (AWMSG).
- **Falls –** Reduce injurious falls and mortality levels, associated with injurious falls, across the Health Board (including within Primary, Community and Secondary Care).

16 Whilst there are clearly many more areas that could have been identified, the Health Board has decided to focus on a smaller number than previous years to ensure deliverability. The Health Board has made assurances that other programmes of work will still be developed through existing processes such as the Health and Care standards.

17 Key internal stakeholders were involved in identifying these priorities. Initially scoped by executive directors, the priorities were presented and discussed at a virtual workshop with representation from across the Health Board. This gave an

opportunity for executive directors, members of the service group triumvirates, service group quality/governance mangers, corporate teams and the Chair of the Quality and Safety Committee to inform the priorities. Following this work, the rationale for each quality priority was clearly set out in a document that was received by the Quality and Safety Committee in March 2021 and subsequently approved by the Board as part of the Health Board's Annual Plan 2021-22 in June 2021. Whilst external stakeholders such as the Community Health Council (CHC) were not involved in the formation of the priorities, they were consulted on the annual plan in its entirety.

18 However, although these quality priorities are subject to the Health Board's 100-day planning and implementation process[1] to ensure deliverability, the arrangements for monitoring achievement of these was yet to be finalised. At the time of our review, the arrangements at the Quality and Safety Committee and the operational level arrangements within the Morriston Hospital Service Group and Integrated Surgical Services division were yet to be agreed. This raises the question on how the Health Board is seeking assurance on the delivery of the plan and poses the risk that the priorities may not be achieved.

19 The Health Board has a well-established Quality Impact Assessment process. The process considers the impact on quality and safety of any potential service changes and redesigns. The Quality Impact Assessment screening tools are completed by service groups and assessed by the Quality Impact Assessment Panel who meet monthly.

Risk management

20 **The Health Board has kept its corporate risk appetite under review, and the risk register is regularly monitored at Board and committee level. There is a risk management policy and a group which sets out the approach for operational teams, but risk management at an operational level needs improvement.**

21 In previous structured assessment reviews, we highlighted the absence of a Board Assurance Framework (BAF) as it had been in draft for quite some time. This has now been addressed. In July 2021 the Audit Committee and Board received the new Board Assurance Framework. The BAF contains seven principal risks to achieving the Health Board's strategic objectives. An assurance rating identifies which strategic objectives are at risk because of inadequacies in controls or insufficient assurance about them. The Audit Committee monitors the BAF, which is an iterative document which will be continually updated.

22 The Health Board has a dedicated risk management team (6.4 WTE, one vacancy) which is responsible for managing the framework and facilitating and supporting service group managers to monitor and report on risk. They provide support on the

[1] Quarterly planning cycle adopted by the Health Board.

management of the Health Board Risk Register (HBRR) and support the management of the Datix system where risks are recorded, including providing some training. The Health Board has recently appointed an Assistant Head of Risk and Assurance to help strengthen the corporate team support for risk management within the organisation. The risk management team provide training to the Board as well as operational and corporate staff and have recently rolled out training to service groups. At the time of our review, our tracer area, Morriston Hospital Service Group, had not received the training.

23 During 2021 and in response to COVID-19 the Health Board reviewed its corporate risk appetite. Following the onset of the COVID-19 pandemic, members of the Board agreed that the risk appetite score would increase to 20 and above for an initial period of three months. The risk appetite of 20 and above has remained in place since the start of the pandemic. These arrangements are reviewed regularly by the Executive Team, Audit Committee, and the Board.

24 Health Board Risk Register entries are assigned a lead executive and the risk is also assigned to either the Board or a specified oversight committee. Executive directors were recently tasked with reviewing and refreshing all entries on the HBRR that exceed the risk appetite and reviewing the mitigating action. As of September 2021, the HBRR had 39 risks of which 21 had risk scores of 20 and above.

25 At the time of our work, 15 out of 39 (38%) risks on the corporate risk register were related to quality and were assigned to the Quality and Safety Committee for scrutiny and assurance. The committee receives a risk report and the register of risks that have been assigned to them bi-monthly. There is good scrutiny from independent members of the risks, although there may be some refresher training needed in respect to the risk escalation process.

26 Corporately, a Risk Management Group (RMG) meets quarterly to ensure there is an appropriate and robust risk management system in place and working through the organisation. This group is chaired by the Director of Corporate Governance with representation from across all service groups. It reports to the Audit Committee and the Management Board on a quarterly basis. In addition, a Risk Scrutiny Panel meets monthly and is responsible for advising the Management Board on moderating new risks and escalation and de-escalation of risks on the HBRR and Board Assurance Framework. The Director of Corporate Governance also chairs these meetings.

27 As part of our work, we reviewed the risk registers and processes in place at the service group and divisional level. At a service group level, the risks from the divisional registers are compiled into a Service Level Risk Register. However, our review found that due to its size, the service group struggles to review all the risks, assurances, and mitigating actions. Risks are therefore grouped together and form an exception report for escalation purposes which is considered at the Risk Management Group. This leads to the potential that risks could not be receiving sufficient scrutiny. **(Recommendation 1)**

28 At a divisional level (Integrated Surgical Services), our risk register review found a number of issues. Some risks had been on the register for a significant period of time. We also found issues with the quality of mitigating actions and inconsistent application of risk ratings. We were informed that due to COVID-19, a number of divisional meetings where risk would have been discussed had been paused between March and June 2020, which has affected the ability of the teams to review the registers. This therefore leads to concerns about the quality of the risk registers at each level of the organisation. **(See Recommendation 2)**

Organisational culture and quality improvement

29 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, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

30 **The Health Board has a dedicated Quality Improvement Team, although its capacity has been affected by COVID-19. Operational capacity for capturing patient experience is good, but the Health Board could use this resource more effectively. A well-established values and behaviours framework is in place, but a refresh is needed to raise awareness. Although there are different ways for staff to report concerns, an open culture is not always recognised, the process is not always clear, and some staff are concerned lessons are not being learnt. Compliance with performance reviews is low within service groups.**

Quality improvement

31 **The Health Board has a dedicated Quality Improvement Team; however, its capacity is small and has been further affected by COVID- 19. Arrangements for monitoring clinical audit and mortality are in place but the visibility and frequency of reporting to Quality and Safety Committee for scrutiny could be increased.**

Resources to support quality improvement

32 There is a dedicated Quality Improvement Team of seven WTE (nine headcount) and one vacancy. The capacity of this team has remained consistent over the past three years. The team provides training and support to operational teams by delivering Improving Quality Together (IQT), the national quality improvement training programme for NHS staff in Wales. The goal of the programme is to develop quality improvement capability within NHS Wales using a common

language for quality improvement. The latest figures show that within the Health Board, the proportion of staff to have completed the bronze IQT was low at 4% and silver at 2%.

33 The capacity of the Quality Improvement Team was reduced during COVID-19 as staff were seconded to other roles within the Health Board. This affected the ability of the team to undertake its usual training activities, although this has now been addressed and the team are now operating as before.

34 At an operational level, Morriston Hospital Service Group and the Integrated Surgical Services division have their own designated lead for quality improvement with protected time to fulfil their role. The operational teams reported that they rarely receive any corporate support for quality improvement due to limited resources within the central team.

Clinical Audit

35 Clinical audit is an important way of providing assurance about the quality and safety of services. The Health Board has recently updated its Clinical Audit and Effectiveness Policy which sets out the local framework for the prioritisation, conduct, delivery, and governance of clinical audit in line with best practice guidance and the requirements of the Health and Care Standards. It identifies the structures, roles, and processes in place to support the Health Board, doctors in training and other healthcare professionals and sets out a hierarchy for delivery of clinical audit priorities. The Executive Medical Director is responsible for ensuring that the Health Board makes adequate provision to support clinicians and managers who are undertaking clinical audits.

36 The Health Board has a dedicated clinical audit team of 9.8 WTE (11 headcount). As with other health boards, COVID-19 affected the Health Board's ability to deliver clinical audit. In March 2020, all local clinical audits were suspended but these restarted in July 2020. During the pandemic, social distancing rules affected the ability of the team to undertake their normal activities as staff were not permitted to leave their office to retrieve records from wards which caused some delays with national and priority audits.

37 The clinical audit team has a wide range of responsibilities, these include.

- supporting national clinical audits and outcome reviews;
- undertaking organisation-wide audits;
- supporting other clinical audits by providing project design, records retrieval, records/systems review and extraction of information, data entry and analysis, data outputs and presentation materials and general advice;
- providing training to operational staff to design and undertake audits (although they have not been requested by teams to provide training for many years);
- facilitating the Health Board mortality reviews, medical examiner system feedback system; and

- supporting the work of the Clinical Outcomes and Effectiveness Group.

38 As part of our work, we were unable to obtain a copy of the Health Board's most recent clinical audit plan. We did however see a document which set out the mandated national clinical audits which the Health Board is required to deliver. The document was considered by Audit Committee in September 2021. We would expect to see a standalone clinical audit plan which encompasses both national and local clinical audits. **(Recommendation 2)**

39 The Clinical Outcomes and Effectiveness Group (COEG) which meets monthly was established in September 2020 and has multi-disciplinary membership. The group provides assurance to the Quality and Safety Committee via the Quality and Safety Governance Group that there are appropriate systems in place for the development and monitoring of policy and standards relating to national and local clinical audits and mortality reviews. The COEG's standard agenda items for clinical audit include national clinical audits, the status of audit data tools and the status of local clinical audits.

40 While it is positive that the COEG's purpose is to provide assurance on the systems, clinical audit is only considered once a year on the Quality and Safety Committee work programme. There is a risk that these important measures of quality could be subsumed within the Quality and Safety Governance Group updates to Quality and Safety Committee[2] and not receive sufficient scrutiny from independent members. **(Recommendation 3)**

Mortality and morbidity reviews

41 Mortality and morbidity review meetings provide a systematic approach for the peer review of adverse events, complications, or mortality to reflect, learn and improve patient care. At the time of our work, the Medical Examiner Service was being rolled out across Wales with an expectation that this will become a statutory function from April 2022.

42 The Quality and Safety Committee receives updates on Health Board mortality reviews; however, the Health Board has recognised that the frequency of reporting needs to be increased. The reports to the Quality and Safety Committee we reviewed did identify areas of learning and themes, which is positive.

43 The Health Board is in the process of developing a Mortality Review Framework document, based around the National Learning from Deaths Framework. Following this, it is looking to amend the content of future reports to the Quality and Safety Committee to provide further assurance.

44 Currently the COEG receives the performance data in relation to mortality reviews. The COEG is responsible for scrutinising the trends arising from mortality reviews

[2] The Clinical Outcomes and Effectiveness Group has been reporting via Quality and Safety Governance Group update papers to the Quality and Safety Committee since July 2021.

and mortality statistics, monitoring progress against any agreed actions and providing assurance to the Quality and Safety Governance Group that lessons are learned from these reviews. Learning from mortality is a key part of the COEG agenda. The COEG receives an update report from the Deaths Scrutiny Panel which is a panel to screen and review referrals from the medical examiner with a view to promoting learning across the Health Board. The COEG also receives presentations from service groups on their arrangements and what they have learnt in relation to mortality.

Values and behaviour

45 **The Health Board has a well-established values and behaviour framework in place which encourages an open and learning culture, although this is not always recognised by staff, and compliance with performance appraisal is low within service groups.**

46 The Health Board's Values and Behaviours Framework was published in 2015 and sets out its vision for a quality and patient-safety-focused culture with a focus on continuous improvement, openness, transparency and learning when things go wrong. Whilst there has been previous work to publicise the values, there has not been any recent initiatives to refresh staff's awareness of the values and behaviours. **(Recommendation 5)**

47 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. Our survey of operational staff working across Integrated Surgical Services Division[3] (see results in **Appendix 2**) found that 53 out of 80 staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However only 29 out of 80 agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation.

48 The results of the NHS Wales Staff Survey which was undertaken in November 2020[4] also showed that some staff responding continued to experience bullying, harassment, or abuse by another colleague, member of the public or line manager over the past year (9%, 16% and 15% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff (41%) or a member of the public (41%).

[3] We invited operational staff working across the Integrated Surgical Services Division to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. The estimated response rate is 16%. Although the findings are unlikely to be representative of the views of all staff across Integrated Surgical Services, we have used them to illustrate particular issues.

[4] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 18%, compared to an all-Wales average of 20%.

49 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. The Health Board is required to report compliance to the Welsh Government on a monthly basis and the target for compliance for all health boards is 85%. Figures from April 2021 show an overall organisation compliance of 80.20%, a drop from April 2020 of 2.29%. It was noted however that the total number of staff had risen during COVID-19 by 403 staff. Morriston Hospital Service Group reported 75.40% compliance. Compliance has improved and in October 2021, it was reported that compliance at an overall organisation level was now 80.98%, a 0.78% increase from April 2021.

50 Our survey of staff in the Integrated Surgical Services Division found that 37 out of 80 staff disagreed that they had enough time at work to complete any statutory or mandatory training. The Health Board has recently identified some strategies to improve compliance, including restarting the Mandatory Training Group, which was paused during the pandemic, looking at certain job roles to explore raising compliance and providing support sessions for those who have issues with IT literacy, accessing equipment and time to attend sessions.

51 Personal Appraisal and Development Reviews (PADR) is a two-way discussion which helps staff understand what is expected of them in their role, become more engaged and take responsibility for their own performance and development. Compliance with PADR is a Tier 1 Target set by the Welsh Government, requiring all health boards to achieve an annual compliance rate of 85%. The overall Health Board compliance is currently 60.04%. However, there is significant variation within service groups with Morriston Hospital Service Group reporting only 36% compliance and Integrated Surgical Services Division only 25% compliance. Service pressures and time were cited as the biggest challenges for staff undertaking PADRs, especially with the impact of COVID-19. **(Recommendation 5)**

Listening and learning from feedback

52 **The Health Board has dedicated resources to capture patient experience but lacks an overall coordinated approach and patient experience strategy. Staff are concerned that the Health Board will not act in response to concerns and more could be done to promote and embed learning across the organisation.**

Patient experience

53 At the time of our work there was no Patient Experience Strategy in place. The Health Board is engaged at a national level in the development of the national patient experience strategy. However, the timescales of this are unknown, and the Health Board needs to consider if it needs a short-term plan to manage its patient experience work in the interim period.

54 At a corporate level, the Health Board has a dedicated Patient Experience team of three WTE staff who report to the Head of Patient Experience, Legal and Risk who

reports to the Director of Corporate Governance. As part of their role, they provide training to operational staff on how to use the patient experience system and on producing reports.

55 At an operational level, the Morriston Hospital Service Group has a dedicated Patient Advice and Liaison Service (PALS) that sits under the remit of the Head of Quality and Safety for the Service Group. They help collect patient experience and friends and family feedback via paper and digital systems, provide direct patient contact and are trained in patient story telling. The PALS team is available seven days a week. The PALS teams were used extensively during the pandemic to provide an interface between patients and their families and friends with visiting restrictions in place. Information from PALS is fed up the organisation by the Service Group Head of Quality and Safety to the Quality and Safety Governance Group, although it was not clear whether the corporate patient experience team interact and learn from the experiences of the PALS team.

56 Our observation is that the corporate patient experience team seems disengaged from the PALS teams in the service groups which sit under the Group Head of Quality and Safety, and may be missing out on useful intelligence, as the PALS are with patients on a day-to-day basis and help patients complete the feedback surveys. It was clear through interviews with staff that they felt that more could be done in relation to patient experience in the Health Board and how the information is used.

57 We were told that the opportunity to provide patient experience feedback is available 24/7 via digital feedback systems. For the month of August 2021, there were 2,025 friends and family surveys completed across the organisation of which 92% said they would highly recommend the Health Board to friends and family. Morriston Hospital Service Group recorded 642 responses with 92% rating their overall experience of the service as good or very good. During the same period, the Health Board received 150 complaints of which 77 were related to Morriston Hospital Service Group. The top four complaints related to communication issues, clinical treatment/assessment, admissions, and appointments.

58 Integrated Surgical Services use the same feedback form process as the rest of the service group divisions. We were told that outcomes from these are provided to ward and departmental leaders, but it is not clear how the wider operational staff have access to the feedback. Prior to the pandemic we were told this was disseminated via the ‘How are we doing’ information displayed at the entrance of individual wards and departments. The Health Board plans to relaunch this when restrictions are eased and with the implementation of the new patient experience system. We found that only 30 out of 80 staff responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area.

59 The Welsh Government target for timely response to complaints is 75% within the 30-day target. In August 2021, the Health Board’s performance was 83%. The Health Board has a Concerns Redress Assurance Group (CRAG) which reviews

responses to complaints and carries out ‘deep dive’ reviews within service groups to ensure the learning is shared and assurance can be taken. During the pandemic the concerns team did move to a seven-day rota as their volume of work increased, but within the Service Groups, there were decreases in the timeliness of responses to complaints as some staff trained to respond to concerns were redeployed.

60 The concerns and complaints information is being used to identify themes and trends. Communication is a common theme for complaints, which is recognised by the Health Board. A task and finish group has been recently established to address this issue, and the Health Board is reviewing the training provision for communicating effectively with patients in direct response to issues arising from complaints.

Listening to staff concerns

61 The Health Board is committed to listening to and learning from staff experiences and concerns. The Health Board launched a Guardian Service for staff in May 2019 which is an external independent service offering staff a safe, confidential way of raising any concern or risk in the workplace. This includes concerns around patient safety. This does not replace the existing support systems within the Health Board but was implemented as a direct result of feedback provided through the NHS staff survey. The Health Board is the only health board in Wales to provide this service.

62 The Guardian Service reported that during the period 1 April 2020 to 31 March 2021, a total of 66 (96 previous year) concerns were raised by staff, of which there were no patient safety concerns raised compared to six in the previous reporting period. Of the 66 that reported concerns, 29 believed they would not be listened to and 21 believed the organisation would not act. This is similar to the results of our staff survey which found that only 36 out of 80 agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again. The majority of concerns raised in the Guardian Service report were around management concerns (30). Out of the Service Groups, Morriston had the highest number of contacts (25). This is higher than Neath Port Talbot (5) and Singleton (11). It is unclear as to whether the higher rate reflects the pressures on the services within the service group, or is because of an increased awareness of, and willingness to use, the Guardian Service.

63 The Health Board senior team has worked extensively with the Kings Fund to embed compassionate leadership into the way the organisation leads and communicates with staff and service users. In 2019, the Health Board committed to working with Mersey Care NHS Foundation Trust to develop a Just and Learning

Culture[5]. Training of 30 key stakeholders including trade union partners, managers, and staff from the HR, Learning and OD team was completed during early May 2021 to align with the national Healthy Working Relationships programme of work.

64 If there are concerns which are escalated about a ward or area, then the Director of Nursing and Patient Experience can organise an unannounced visit to that area using the Quality Assurance Framework Ward Toolkit. The visits comprise a multi-disciplinary team which is drawn from across the organisation. Although the visits were largely suspended during the pandemic, there was a recent review of a ward area. This review deemed the area safe for patient care but did identify a number of areas which required improvement, including issues relating to infection control, documentation relating to nutrition and hydration, ward signage and the general ward environment.

Patient stories

65 Patient stories are used throughout the organisation from Board meetings through to service group Quality and Safety meetings and are typically at the start of the meeting/committee to set the tone of the meeting from a patient's perspective. Every meeting of the Board and the Quality and Safety Committee has a patient story at the start. The stories set out the personal experience of someone who has used one of the Health Board's services and are a mix of learning from something that has not gone so well and stories that reflect a positive patient experience. The patient stories we observed were often emotive as the patient or family member is usually interviewed as part of the story. Patient stories are well received by independent members and encourage discussion and challenge on what lessons have been learnt and how the learning is being shared.

Patient safety WalkRounds

66 Patient safety WalkRounds provide independent members with an understanding of the reality for staff and patients, help to make data more meaningful, and provide assurance from more than one source of information. At the time of our audit, the Health Board had paused the programme of WalkRounds due to the pandemic, but restarted these in September 2021 albeit on a lesser scale as some COVID-19 restrictions and considerations still need to be factored in. Prior to the pandemic, the Health Board had a programme of regular independent member and executive director WalkRounds in which they fed back findings via a standardised template. All those interviewed at an operational level found these visits beneficial. Independent members also find these visits crucial to their ability to carry out the

[5] Just and Learning Culture is a programme developed by Mersey Care NHS Foundation Trust to fundamentally change the way it responded to incidents, patient harm and complaints against staff.

role effectively as it provides triangularity of information, helps them gain a sense of staff morale and an understanding of the day-to-day issues affecting staff.

Governance structures and processes

67 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.

68 We found that **although Board committees are providing appropriate oversight and corporate responsibility for quality and patient safety is clear, delivery of the quality and safety agenda largely rests with nursing leads. The lack of implementation of the quality and safety framework has been a missed opportunity to provide clarity on quality governance arrangements. There are limited corporate resources to support quality governance and resources within operational service groups are fragmented and inconsistent, and not delivering their full potential.**

Organisational design to support effective governance

69 **Board committees are providing appropriate oversight and corporate responsibility for quality and patient safety is clear. However, delivery of the quality and safety agenda largely rests with the nursing leads and a number of changes in personnel at executive and operational level have presented challenges. The Health Board has developed a quality and safety framework, but it has not been implemented and weaknesses in approaches to quality governance amongst the operational teams are resulting in quality concerns being missed. The Health Board is aware of the weaknesses and has been undertaking its own internal governance review.**

Quality and Safety Framework

70 In January 2021, the Board approved a Quality and Safety Framework. This framework sets out the processes by which the Health Board assures itself that their services are of high quality and safe for all. However, the framework has not been adopted across the organisation and therefore is not delivering its intended benefits or providing clarity on quality governance arrangements within the Health Board. **(Recommendation 6)**

Corporate responsibility and leadership

71 While there is collective responsibility for quality and safety amongst the Executive team with the Clinical Directors taking ownership to ensure the quality and safety of clinical services, it is the Director of Nursing and Patient Experience who is largely taking responsibility for quality and safety. **(Recommendation 7)**

72 The Director of Nursing and Patient Experience has delegated responsibility for the overall strategic direction and policy and professional lead for Concerns and Putting things Right. The Director of Nursing and Patient Experience also chairs the Quality and Safety Governance Group supported by the Head of Quality and Safety. At time of our fieldwork, the Assistant Director of Nursing was acting as Interim Director. In October 2021, the former Director of Nursing and Patient Experience was seconded back into the Health Board from the Welsh Government for a period of two years.

73 The Medical Director has responsibility for clinical audit and effectiveness along with quality improvement, the deputy Medical Director is responsible for the Clinical Outcomes and Effectiveness Group. The Director of Therapies and Health Sciences has responsibility for ensuring that all Healthcare Professionals Council registered staff are fit for purpose to ensure the provision of high quality safe therapeutic intervention.

74 Since a change in portfolio, the Director of Corporate Governance has responsibility for risk management, legal services, the serious incident team, the patient experience team, and the concerns assurance team. The Director left the Health Board at the end of November 2021 with an interim arrangement due to be put in place.

75 Within the service groups and divisions, the Group Head of Quality and Safety for Morriston is responsible for providing day to day performance management and quality governance support, reporting to the Nursing Director within the Service Group triumvirate[6]. The Group Head of Quality and Safety works closely with the lead nurse within each of the divisions, although in a number of divisions in the Morriston Hospital Service Group, the lead nurse role was vacant. The vacancy at lead nurse role compromises the extent to which there is oversight of quality governance at a divisional level. During 2021, following the service group restructure, there has been significant turnover at both the service group and division levels.

Health Board Quality and Safety Committee

76 The Health Board Quality and Safety Committee is responsible for providing assurance and advice to the Board in respect of quality and safety. The Quality and Safety Committee meets on a monthly basis and continued to meet throughout the pandemic albeit a slightly shortened meeting. As part of our audit, we observed the committee on several occasions, and found that there was a good degree of challenge from independent members. Independent Members have, however, expressed frustration about the lack of progress in certain areas especially infection, prevention, and control. This is a longstanding item on the Quality and

[6] The Service Group triumvirate team consists of a Service Group Director, Nurse Director and Medical Director. A similar leadership arrangement is also in place within the divisions.

Safety Committee agenda, although the Health Board continues to have some of the highest rates of infections monitored under the NHS Wales performance delivery framework.

77 A summary of the discussion from the most recent Quality and Safety Committee is presented by the Chair of the Committee to the formal Board meeting. The Quality and Safety Committee has a rolling workplan which sets out what it hopes to cover in each meeting. During our fieldwork, the recently appointed Vice-Chair of the Board took over as chair for this committee.

78 There is recognition however that overlap of the Performance & Finance Committee and Quality & Safety Committee is an issue with the same performance report presented to both committees (referred to later in this report).

Health Board Quality and Safety Governance Group

79 The Quality and Safety Governance Group (QSGG) is a subgroup of the Quality and Safety Committee. The group provides timely and comprehensive information to the Quality and Safety Committee that covers a range of key critical clinical systems and processes. This includes incident management and reporting, quality improvement, quality care, compliance with Health and Care Standards and patient experience. The governance group meets monthly and is chaired by the Director of Nursing and Patient Experience with representation from deputy directors, service group directors and other heads of services related to quality and safety. Previously there were issues around attendance from the service groups, but this has now been addressed and attendance improved significantly. Each of the service groups reports directly into the QSGG and key messages are reported up via the QSGG to the Quality and Safety Committee via an update paper on a monthly basis. The update report has been modified over time to meet the Quality and Safety Committee needs and reflect how the Governance Group has divided its agenda into COVID-19 and general quality and safety.

Operational groups for quality governance

80 Within the Morriston Hospital Service Group, there is a dedicated Quality, Safety and Patient Experience meeting which meets monthly to consider issues that are specific to the group and the divisions within it. The Integrated Surgical Services division currently does not have a separate quality and safety meeting but discusses issues as part of its regular management team meeting. We found this is the case in other divisions.

81 There have recently been changes to the leadership team within the Integrated Surgical Services Division. The team has recognised the need to review and refresh the divisional governance arrangements with plans to have a dedicated quality and safety meeting pending carrying out a wider governance review.

82 During our fieldwork, a review of cardiac surgery, which is also managed through the Morriston Hospital Service Group, was completed. The Getting It Right First

Time (GIRFT) review had been commissioned by WHSSC and identified that the Health Board was an outlier on a number of quality metrics, with particular concerns about higher-than-expected mortality rates following mitral valve surgery. The Health Board has responded well to the concerns identified with a detailed action plan being put in place, including work to understand issues around data definitions and potential inaccuracies in data submitted by the Health Board into a national clinical audit. Notwithstanding the positive response to the GIRFT findings, it is worrying that the issues raised by the review came as a surprise to the Health Board and raise serious questions about the robustness of quality governance arrangements at an operational level.

83 On the back of the GIRFT review, the Health Board is undertaking a detailed review of the operational quality governance arrangements across all its service groups. This work is due to conclude at the end of November 2021, with the aim to improve quality governance arrangements within the operational teams.

Resources and expertise to support quality governance

84 **Resources to support quality governance corporately are limited. Additional resources are embedded within the service groups, but these are working in isolation and have the risk of diluting ownership within the divisions. Opportunities exist to make better use of resources and expertise across the Health Board by bringing them together.**

85 Corporately there are two main teams working to support quality and safety issues in the Health Board, the Patient Experience, Legal and Risk Team who report to the Director of Corporate Governance and a small team that supports the corporate Head of Quality and Safety, who reports directly to the Director of Nursing and Patient Experience. This is in addition to the Clinical Audit, Infection Prevention Control and Quality Improvement Teams referred to in this report.

86 Since February 2020, the Patient Experience, Legal and Risk Team has reported to the Director of Corporate Governance. Previously the team reported to the Director of Nursing and Patient Experience. The move was seen to provide more independence when dealing with incidents and concerns. The Director of Corporate Governance oversees the governance of the arrangements but is not involved with individual cases. The departure of the Director of Corporate Governance provides an opportunity to consider whether some of these teams would be better placed reporting to the Director of Nursing and Patient Experience.

87 The Concerns Team (three WTE, four headcount) oversee the policy, ensure consistency in the approach to concerns and manage ombudsman cases. The resources to investigate and learn from concerns are devolved to the service groups. The devolvement of responsibility is designed to ensure more timely investigations and give service groups more ownership of the learning and implementation of actions. The Concerns Team provide training and support to service group staff who investigate complaints, including managers. Currently there are only 30 staff across the Health Board that are trained to investigate complaints.

88 There is a dedicated team for Infection Prevention and Control (16.5 WTE, 21 Headcount). The team has increased over the last few years and provides a seveb-day service to cover community and primary care, mental health and learning disabilities. The team provides training and support to operational staff such as hand hygiene and PPE training. Despite an increase in resources for the Infection Prevention and Control team, initiatives to reduce infection are often compromised by a reliance on temporary staff, over-occupancy, and increased activity, so it is not possible to temporarily move patients to another area to allow for deep cleaning.

89 At an operational level, the Morriston Hospital Service Group has a dedicated quality and safety team resource that supports operational managers, both clinical and non-clinical. (**Recommendation 8**) There is a quality and safety lead from the Morriston Hospital Service Group assigned to the Integrated Surgical Services Division who provides the division with its quality and safety performance data as well as holding fortnightly meetings with the division and writing the division report that is submitted to the service group Quality and Safety meeting. Although this provides support to the divisions, there is a risk that the divisions are not taking ownership of their own data and are becoming deskilled in using and interpreting data.

Arrangements for monitoring and reporting

90 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.

91 We found that **the Health Board has adequate arrangements in place to monitor quality and safety at a corporate level, but the Health Board needs to review assurance arrangements at a service group and divisional level particularly in relation to developing quality dashboards and using data.**

Information for scrutiny and assurance

92 **The Four Quadrants of Harm have been integrated into current reporting arrangements. However, there is a lack of data analytics support, and work to produce quality dashboards and understand the data is needed to enable operational ownership and improved performance monitoring.**

93 The Quality and Safety Performance report is presented monthly to the Quality and Safety Committee by the Director of Finance. It provides an update on the current performance of the Health Board in delivering key local performance measures as well as the national delivery measures. The performance report was modified in light of the pandemic to align the report with the four quadrants of harm as set out in the NHS Wales COVID-19 Operating Framework. The format of the report is clear with key messages and summaries included to help the reader focus on significant issues. The report is typically around 60 plus pages but from our

observations of the committee, the Director of Finance provides a verbal run through of the key messages. We did find however that as the Performance and Finance Committee is held immediately prior to the Quality and Safety Committee on the same day, it is often noted that matters relating to the report have already been discussed considerably, as some Independent Members attend both committees. Our 2021 structured assessment work has made a recommendation in relation to this matter.

94 A Patient Experience Report is produced bi-monthly for the Quality and Safety Committee which covers patient experience updates, concerns and incidents, risk management and updates on responses to Health Inspectorate Wales inspections. The report is generally in the same format for each meeting and populated with up-to-date information. While this information and data are useful, the Health Board needs to consider expanding the report to include information on what the impact and consequences were and how they can improve.

95 Operationally we were told that there is a lack of data analytics support available. The implementation of a Quality and Safety dashboard during 2021 was a key objective for the Morriston Hospital Service Group but at the time of the audit these discussions were at an early stage. Currently there are a number of performance systems and dashboards available to the Service Group but no single location where quality and safety metrics are available and no ability to drill down to ward/department level. Additional data is also available through the use of clinical audit activity, however further work to understand why the Health Board was not sighted of the issues set out in the GIRFT review pointed to a lack of regular reviews of clinical outcomes data.

96 The Health Board recognises that it needs to further build on the informatic and business intelligence systems to enable the service groups to access key metrics on patient safety, experience and outcomes and is committed to focusing on solutions during 2021-22 and 2022-23.

Coverage of quality and patient safety matters

97 **Corporate committee agendas are well managed and allow for a wide coverage of issues for discussion, whereas arrangements for operational groups are more variable and limited in their content.**

98 Performance reporting within the Health Board aligns to the current national delivery framework with the 84 measures in place mapped to the Healthier Wales quadruple aims. These reports are presented to the Board, Quality and Safety Committee and the Performance and Finance Committee. The performance report clearly identifies trend information and commentary is provided to explain performance and high-level actions being taken to address areas where performance is not in line with expectations. However due to ongoing operational pressures, it was agreed that the narrative update would be omitted from the performance report. This was still the case in October 2021.

99 The coverage of agenda items received at the Quality and Safety Committee is vast and covers a breadth of areas, some of which are part of its regular work programme and standing items, and others that are requested by the committee as a result of concerns identified at previous meetings. However, whilst there are efforts to address the balance of secondary, community and primary care at the Quality and Safety Committee meeting, there is frustration from Independent Members that there is not a wealth of quantitative information available around primary care and they do not receive regular information on patient feedback for these services.

100 The agenda for the Quality and Safety Governance Group covers more general policy and reporting items and then the agenda is split into a part A and part B. The agenda template was amended during COVID-19 and is not currently mapped against the Health and Care Standards themes as it was previously. Part A covers COVID-specific related items such as infection control, PPE, safeguarding and putting things right. Part B is the service groups presenting their update reports back to the group. Our observation of the meeting is that there is good debate and discussion but there is too much to cover in the allotted time and the meetings overrun. The update papers we saw were of variable quality in terms of drawing out the key issues for a targeted discussion and some papers were late or only noted as there was no representative available from the service group.

101 The agenda for the Morriston Hospital Service Group Quality, Safety and Patient Experience meeting includes a report for each division highlighting key achievements and challenges on a rolling one in every fourth meeting. This raises the question of whether a divisional update every fourth meeting is frequent enough. At the time of our review, the standardised template for reporting was still being developed and the quality of the update reports from the divisions was variable. Reports could more helpfully pull out and summarise the key issues for the reader. The agenda also covers items at a service group level, risk management, external inspections, complaints and incidents and other reports of note on a wider range of subjects related to quality and safety.

102 As the Integrated Surgical Services Division does not have its own dedicated quality and safety committee but instead has a standing agenda item on its management board agenda, coverage of quality and safety matters is limited.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Risk management R1 The approach taken by operational managers to risk management is inconsistent and risk registers are often incomplete and missing robust mitigating actions. The Health Board should strengthen its management of risks at an operational level by: • providing training to managers across the operational structure to enable them to clearly identify the risks for which they are	In Progress • Series of risk workshops for clinicians and managers, in specialty-related sessions, was completed within Neath Port Talbot and Singleton Service Group in late summer. The sessions provided training on risk management principles, health board arrangements and opportunity to apply this to local risk register entries. Arrangements are being made to roll the training out to the other service groups during the next two quarters and progress will be reported to the Risk Management Group and	September 2022	Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
responsible and update risk registers in line with corporate policy; and • ensuring risk registers are receiving sufficient scrutiny at the operational level and the risk management group.	Management Board. A review of service groups will also be undertaken and reported on. • A programme of service group risk register presentations for 2022 has been agreed at the December Risk Management Group meeting. Service groups will be asked to report on processes in place to manage and scrutinise registers at a local level, and present their registers with a focus on their top risks. This will commence from March 2022 and the programme will complete by the end of the calendar year.	December 2022	
Develop a clinical audit plan R2 During our review we were unable to obtain a copy of the Health Board's most recent clinical audit plan. The Health Board should develop a clinical	Completed. A revised clinical audit policy was agreed in 2021, with a new format for the structure of audits (national, organisation, service and directorate). The policy was approved by Audit Committee. The detail of the individual audit	March 2022	Medical Director

Recommendation	Management response	Completion date	Responsible officer
audit plan for 2021-22 which covers both mandated national audits and local audits which are informed by areas of risk. This plan should be approved by the Audit Committee and progress of its delivery monitored routinely.	plans is being collated. Clinical audit plan on the agenda for the Audit Committee in May 2022 and will be monitored by the Quality and Safety Committee three times a year.		
Frequency of reporting of clinical audit and mortality R3 The Health Board has set up a Clinical Outcomes and Effectiveness Group which provides assurance on clinical audit and mortality outcomes, but this information is currently fed through the Quality and Safety Governance Group and is only reported in its own right to	Completed. On the committee work programme. More regular reports on mortality and clinical audit to be reported to Quality and Safety Committee.	March 2022	Medical Director

Recommendation	Management response	Completion date	Responsible officer
the Quality and Safety Committee once a year. The Health Board should review this frequency so updates on progress delivering the clinical audit plan, and associated learning from mortality reviews are reported to the Quality and Safety Committee more frequently.			
Values and behaviours R4 The Health Board has a well-established values and behaviour framework, which promotes an open and learning culture, but staff are not always aware of the values and behaviours, and some staff do not always recognise a culture that	In progress. Health board culture programme underway which will include a culture audit. Audit recommendations (a and b) will be addressed as part of this work.	December 2022	Director of Workforce and OD

Recommendation	Management response	Completion date	Responsible officer
promotes learning from errors. The Health Board should: • refresh organisational awareness of the values and behaviours framework, so the values are at the forefront of everything staff do in the Health Board; and • undertake work to understand why some staff feel that the Health Board does not encourage reporting of errors, near misses or incidents, and does not act in response to concerns.			
Performance Appraisal and Development Review (PADR)	In progress. This is a priority for the health board, although workforce pressures remain high as staff	September 2022	Director of Workforce and OD

Recommendation	Management response	Completion date	Responsible officer
R5 Our work found that compliance with Performance Appraisal and Development Reviews (PADR) within the operational groups we examined was low. Whilst we recognise the pressures of COVID-19 on the ability of the Health Board to improve performance in this area, these reviews are an important aspect of staff development. The Health Board should put in place a plan to improve performance which sets out when full compliance can be achieved. This plan needs to be monitored at an Executive and committee level.	shortages are a concern. Progress will be monitored via local service group meetings and Management Board and reported to the Workforce and OD Committee.		
Operational design to support effective governance	In progress. The framework will be refreshed in light of learning from the COVID-19 pandemic, and the	June 2022	Director of Nursing and Patient Experience/Medical

Recommendation	Management response	Completion date	Responsible officer
R6 Despite the development of a Quality and Safety Framework in January 2021 it is yet to be rolled out across the Health Board. The framework sets out the process by which the Health Board assures itself that services are of a high quality and safe for all. The Health Board should: • refresh the framework in light of learning from the COVID-19 pandemic, • relaunch the framework, and provide clarity on the quality governance arrangements expected within the Health Board, and	findings of this review/internal review of quality governance. These will also be used to design a series of externally facilitated quality and safety seminars with the aim of taking stock as well as: • sharing the reviews; • understanding the views of the senior leaders on quality and governance; • define what a quality improvement Programme would cover (assurance, improvement etc); • design of the approach we wish to adopt in the health board, and plan/oversee its implementation – this includes re-launching the framework; • focus on roles, responsibilities, accountability, and outcomes; and		Director/Director of Therapies and Health Science

Recommendation	Management response	Completion date	Responsible officer
• monitor compliance with the implementation of the framework across the organisation.	• link in with the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act.		
Ensure collective ownership of the quality and safety agenda R7 Our work found that whilst there was collective responsibility for quality and safety amongst the executive team, there was an overreliance on nursing leads to take forward the quality agenda within divisions. The Health Board should look to ensure that other clinical professionals within the operational teams take an active role in quality governance arrangements.	Completed. The three clinical executives have collective responsibility for quality, the quality work and driving this forward together. They are all now co-chairs of the new QSGG. In addition, the service group triumvirates have been active participants in the workshops.	June 2022	Director of Nursing and Patient Experience/Medical Director/Director of Therapies and Health Science

Recommendation	Management response	Completion date	Responsible officer
Resources to support quality governance R8 There are limited corporate resources to support quality governance and operational resources are working in isolation. The Health Board should: • review current resources and requirements to support quality improvement at a corporate, service group and divisional level; and • seek to maximise the potential of the operational resources by developing opportunities to bring resources together either through network arrangements or changes in lines of accountability.	In progress. Review of the current resources and requirements to support quality improvement at a corporate, service group and divisional level to be completed in March 2022. This will need to link in with the outcomes/output from the quality and safety seminars, and taking the opportunity to develop and bring resources, teams and functions together. Discussions are now taking place within the executive team around what resources are needed.	June 2022	Director of Nursing and Patient Experience/Medical Director/Director of Therapies and Health Science

Appendix 2

Staff survey findings

Exhibit 3: 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	26	33	13	4	2	1	79
2. I am satisfied with the quality of care I give to patients	37	23	7	4	3	4	78
3. There are enough staff within my work area/department to support the delivery of safe and effective care	13	16	16	18	14	2	79

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	
4. My working environment supports safe and effective care	20	27	16	8	6	2	79
5. I receive regular updates on patient feedback for my work area / department	9	21	17	15	15	2	79
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	19	40	12	5	1	3	80
7. My organisation acts on concerns raised by staff	8	28	19	15	8	–	78
8. My organisation encourages staff to report errors, near misses or incidents	14	39	13	6	6	2	78

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	8	21	26	6	2	17	80
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	8	28	20	5	3	16	80
11. We are given feedback about changes made in response to reported errors, near misses and incidents	8	27	22	10	5	8	80
12. I would feel confident raising concerns about unsafe clinical practice	12	36	16	5	6	3	78
13. I am confident that my organisation acts on concerns about unsafe clinical practice	12	30	24	8	2	3	79

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	8	25	18	19	9	1	80
15. My organisation encourages teamwork	14	39	16	7	2	–	78
16. I have enough time at work to complete any statutory and mandatory training	6	23	14	26	11	–	80
17. Induction arrangements for new and temporary staff (eg agency/locum/ bank/re-deployed staff) in my work area/department support safe and effective care	7	26	22	8	8	9	80

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