

Falls Management Final Internal Audit Report

October 2024

Hywel Dda University Health Board



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Executive Summary

Purpose

To review the arrangements across the Health Board for the prevention and management of falls and to assess progress made in implementing recommendations arising from the previous internal audit (report HDUHB-2223-19 refers).

Overview

We have concluded **Reasonable** assurance on this area.



We observed some areas of improvement, including reinstatement of the Adult Inpatient Falls Reduction Improvement Group for Health Board-wide shared learning, examples of falls prevention initiatives and learning from NHS England, and a reduction in the proportion of open incidents.

However, whilst we were provided with evidence of some action taken in response to the 2022/23 audit recommendations, the findings of this review highlight that some issues previously identified still remain and further action is required to ensure the associated risks are fully addressed:

- The falls policy has not been updated to incorporate the areas for improvement identified in our 2022/23 audit, including timescales for MFRA completion and update.
- A WNCR report and sample testing identified instances where falls risk assessments had not been completed or were not timely following patient admission, resulting in missed opportunities to take appropriate action to prevent falls.
- Development of the falls strategy has not progressed, and there is no delivery plan or target completion date.
- Delays in the investigation of falls incidents and failure to undertake a 'focused review'.
- Gaps in assurance reporting to the Quality Safety & Experience Committee.

Matters arising are summarised in the table below, with full details provided in Appendix A.

Report Opinion

		Trend
 <p>Reasonable</p>	Some matters require management attention in control design or compliance.	 2022/23
	Low to moderate impact on residual risk exposure until resolved.	

Assurance summary¹

Objectives	Assurance
1 The Health Board is proactive in reducing the risk of patient falls	Limited
2 Falls incidents are investigated and scrutinised	Reasonable
3 There is regular reporting of falls data at an appropriate forum	Reasonable

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

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1 Falls Policy	1	Design	Medium
2 Falls Strategy & Prevention Initiatives	1	Design	Medium
3 Risk Assessments	1	Design & Operation	High
4 Falls Incidents	2	Operation	Medium
5 Scrutiny & Assurance	3	Operation	Medium

1. Introduction

- 1.1 The National Institute of Health and Care Excellence (NICE) identifies that fall-related injuries are a common and serious problem for older people and falls in hospital are the most common patient safety incidents reported.
- 1.2 The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality which also affects the family members and carers of people who fall. Falling has an impact on quality of life, health and healthcare costs and the Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards.
- 1.3 This review seeks to provide the Health Board with assurance in relation to the arrangements for the prevention and management of patient falls and to assess progress in implementing recommendations arising from the previous internal audit (report HDUHB-2223-19 refers).
- 1.4 The potential risks considered in this review are:
 - patient harm;
 - reputational damage to the Health Board; and
 - financial loss to the Health Board

2. Detailed Audit Findings

Objective 1: The Health Board is proactive in reducing the risk of patient falls through the development of a falls strategy, falls awareness and the completion of falls risk assessments

Falls Policy

- 2.1 To minimise falls and their impact on patients and staff the Health Board has adopted the National Institute of Health & Care Excellence (NICE) clinical guidance *Falls in Older People: Assessing Risk & Prevention (CG161)*. The guidance provides recommendations for the assessment and prevention of falls in older people for use by healthcare and other professionals and staff who care for older people who are at risk of falling. The Health Board Policy 401 'Preventing Falls and Post Fall Care in Inpatient Areas Policy' (the 'Falls Policy') is generally consistent with the principles of the NICE guidance and current practice across the Health Board.
- 2.2 Our 2022/23 audit highlighted that the policy is silent on the requirement for a 'focused review' for falls incidents. Comparison with other Welsh Health Board policies also identified opportunity for improvement, including incorporating guidance on the actions to be taken on patient admission and stipulating timescales for completion, review, and update of the patient's Multifactorial Falls Risk Assessment (MFRA).
- 2.3 The policy was reviewed and updated in September 2023, although it still doesn't provide clear direction regarding MFRA requirements for A&E and MIU patients, the timeframe for completion of assessments or the requirement for a focused review of falls incidents. **[Matter Arising 1]**

Falls Strategy & Prevention

- 2.9 Falls prevention is a key priority for the Health Board under *Strategic Objective 5 – Safe, Sustainable, Accessible & Kind Care* and aligns with the 'Healthier Mid and West Wales' health and care strategy which focusses on integrated working and community driven prevention.
- 2.10 The Quality Improvement & Practice Development Team have been tasked with producing, in conjunction with key stakeholders, a collaborative falls framework which aims to:

- promote falls prevention to reduce the number of avoidable falls in the community and in hospitals

- work collaboratively with relevant third sector and social care services

- ensure an equitable three county approach to community fall intervention

- develop a seamless transition for patients between hospital and home

- 2.11 Development of the Health Board Falls Strategy commenced in 2021 and the Falls Prevention Strategy Steering Group, accountable to the Quality Safety and Experience Committee, was established to provide direction and management in planning and developing the strategy.

2.12 Our 2022/23 audit reported that a baseline assessment exercise had been completed and an insight report *Steps towards whole system approach to falls prevention in Hywel Dda* shared with members of the Steering Group in August 2022. However, no further progress has been made in developing the falls strategy, pending review of the Clinical/Executive lead arrangements for falls. The February 2024 Quality & Safety Assurance Report to the Quality Safety & Experience Committee (QSEC) included an overview of the falls strategy work, but minutes do not evidence discussion around the lack of progress with the strategy, delays incurred and expected timescales for completion. **[Matter Arising 2]**

2.13 Despite the absence of a formal strategy, we were provided with examples of learning from NHS England, with initiatives and Enabling Quality Improvement in Practice (EQiP) projects being undertaken to raise awareness and prevent falls, including:

Use of falls sensors and slipper socks	Lunch clubs for patients to socialise and facilitate patient monitoring
'Baywatch' – use of barcode scanners to record enhanced observations of patients at risk of falls	'Milkshake Rounds' – to encourage good nutrition and hydration, known to reduce the risk of falls
Lying and standing blood pressure training	Colour coding on mobility aids to identify patients at risk of falls

2.14 Falls figures are published internally via the *Our Safety Dashboard*. Whilst trend variation for the period April 2021 to July 2024 is reported as 'concerning trend', recent performance has improved with falls reducing from 280 in March 2024 to an average of 201 for May – July 2024.

Multi Factorial Risk Assessments (MFRA)

2.15 Current best practice in the NICE clinical guidance CG161 calls for completion of a MFRA for all inpatients aged 65+, or aged 50-64 who are clinically judged to be at risk. The MFRA focuses on manageable risk factors and incorporates a Falls Prevention Care Plan to identify actions to reduce the risk of falling. This requirement is appropriately reflected in the Falls Policy. There is a statement at the top of the MFRA, an all-Wales form, that directs that the assessment should be completed within 6 hours of admission. Although the falls policy doesn't explicitly state this requirement, an example of a MFRA is embedded within Appendix B of the policy. **[Matter Arising 1]**

2.16 We sampled 12 current inpatients deemed to require an MFRA at GGH and sought to establish whether an MFRA had been completed within six hours of admission. The sample comprised medical/surgical patients on Towy, CDU, Derwen, Dewi and Padarn wards.

2.17 An MFRA was in place for all sampled patients. One patient had been in hospital for three months - we confirmed that the MFRA had been updated at least weekly since admission. However, two MFRA's were incomplete and 10 had not been

completed within six hours of admission – three of which were completed up to six days following admission. **[Matter Arising 3]**

- 2.18 Digital Health & Care Wales provided a WNCR report identifying, for overnight stays between 1 April – 31 July 2024, the percentage of inpatient (aged 65+) admissions with a falls risk assessment completed, and those completed within six hours of admission which indicates particularly poor performance. A full breakdown is included at Appendix C. **[Matter Arising 3]**

Acute Site	% of Admissions with an MFRA	% of Admissions with MFRA within 6 Hours
Bronglais General Hospital	87.7%	25.9%
Glangwili General Hospital	87.7%	33.8%
Prince Philip Hospital	89.4%	56.5%
Withybush General Hospital	86.1%	23.7%

- 2.19 We were provided with examples of ad hoc MFRA compliance audits undertaken at three of the four acute sites between July 2022 and November 2023, following a recommendation raised in our 2022/23 audit. However, no audits have been undertaken at PPH, or during 2024 to date. **[Matter Arising 3]**

Training

- 2.20 The Falls Policy states that staff must access relevant training to ensure that they have the required competencies to comply with their responsibility in implementing the policy and associated procedures. We were advised that ad-hoc training is provided by Practice Development Nurses and a two-day training package has been trialled in GGH and planned for wider roll-out pending approval by the Clinical Education Governance Group.
- 2.21 Falls Awareness week, which takes place annually, provides an opportunity to raise awareness of falls prevention activities.

Conclusion:

- 2.22 Whilst the policy has been recently reviewed it has not been updated to incorporate the areas for improvement and clarity identified in our 2022/23 audit. Development of a Falls Strategy has not progressed, although there is evidence to demonstrate that the Health Board is nonetheless proactive in raise awareness and implementing initiatives to prevent and reduce falls.
- 2.23 Completion and timeliness of MFRAs is highlighted as an issue, potentially indicating missed opportunities to take appropriate patient-specific action to prevent falls before they occur.
- 2.24 We have concluded **Limited** assurance for this objective.

Objective 2: Falls incidents are investigated and scrutinised to identify themes and trends, with action taken to address issues identified

At a Glance – Falls Incident Data

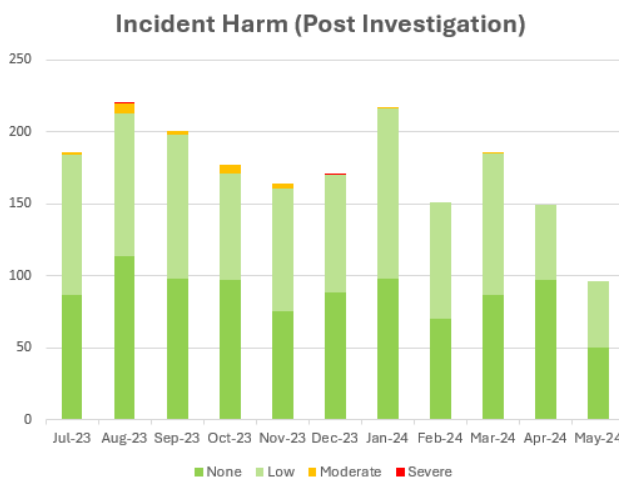
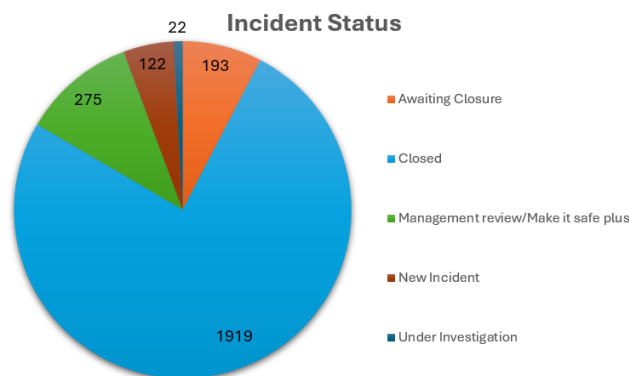
2.25 Analysis of all inpatient falls incidents reported during the period 1 July 2023 – 31 May 2024 identified a total of 2531 incidents.

2.26 24% remain open at the time of audit - an improvement following the 2022/23 audit which reported 35% of incidents as open. 65% of open incidents have been open for more than 60 days.

2.27 At the point of reporting on Datix, most incidents were assessed as resulting in no or low harm (88%), increasing to 99% post investigation and closure.

2.28 There were three incidents reported as ‘catastrophic/death’ during the period – two had been downgraded post investigation and one remains open with investigation ongoing.

2.29 The lessons learned fields on Datix had been completed (to identify learning or confirm none) for 99.5% of incidents closed or awaiting closure.



Investigation of Falls Incidents

2.30 We reviewed a sample of 19 inpatient falls incidents during the period 1 July 2023 – 31 May 2024 to assess the timeliness of investigation and establish whether a focused review¹ had been completed. Our sample focused on closed incidents (i.e. investigation completed), relating to patients aged 65+ (i.e. MFRA required for all), with a severity of moderate or above (i.e. focused review is required) – our sample of 19 represented 100% of the sample population. We identified:

- delays in the commencement of management review, with only two reviews commencing within the recommended maximum three working day timescale, and seven taking between 52 and 145 days; and
- six incidents had not been subject to focused review, and in five cases the investigation did not establish whether an MFRA had been completed.

¹ Focused reviews are a more detailed investigation specific to the nature of the incident. In the case of falls, the focused review concentrates on completion of the MFRA, implementation of resulting care plans, falls prevention activities and post fall management.

Sharing of Lessons Learned

- 2.31 Scrutiny & Assurance Meetings are held for each acute site (with representation from community teams) to monitor and scrutinise inpatient falls, identifying causal factors and sharing learning to prevent recurrence. Outcomes from the Scrutiny & Assurance Meetings feed into the Directorate QSE Groups, which report to the Quality, Safety & Experience Sub-Committee (OQSESC).
- 2.32 The Adult Inpatient Falls Reduction Improvement Group (AIFRIG) was established as a group of the OQSESC in May 2023. The role of the Group is to “review and analyse claims, learning from events and performance reports which will help inform operational direction and contribute to the reduction and improvement of inpatient falls”. We observed the June 2024 meeting which demonstrated shared learning.

Conclusion:

- 2.33 Mechanisms are in place for the sharing of lessons learned both at directorate level and Health Board-wide. Incidents data indicates marginal improvement following the 2022/23 audit, with the proportion of open incidents reducing from 35% to 24%, and the proportion of incidents resulting in no/low harm increasing from 92% to 99%. However, sample testing identified delays in the commencement of management review, with some taking up to 145 days. We also identified non-compliance with the requirement to undertake a focused review.
- 2.34 We have concluded **Reasonable** assurance for this objective.

Objective 3: There is regular reporting of falls data at an appropriate forum to provide assurance to the Board and share learning

- 2.35 The Quality, Safety & Experience Committee (QSEC) is responsible for providing assurance to the Board that lessons are learned from patient safety incidents. Patient safety incident statistics are reported to QSEC via the Quality & Safety Assurance Reports presented by the Quality Assurance & Safety Team at each meeting. Falls are included but not separately identified within the reported incident data. The February 2024 report provided a more detailed update on falls improvement initiatives and an analysis of in-patient falls incidents by level of harm, although this is the only detailed falls update provided to QSEC since June 2022. **[Matter Arising 5]**
- 2.36 Terms of reference for the AIFRIG state that the group is accountable to and will provide regular reporting and advice to OQSESC (a sub-committee of the QSEC), however this is not reflected in the terms of reference for the OQSESC and there is no evidence of reporting. The Interim Assistant Director of Nursing confirmed that the Group is yet to report to OQSESC, although reporting would be by exception. **[Matter Arising 5]**

Conclusion:

- 2.37 We have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Falls Policy (Design)		Impact
<p>Our 2022/23 audit highlighted that the policy is silent on the requirement for a 'focused review' of falls incidents assessed as moderate harm or greater. Comparison with other Welsh Health Board policies also identified opportunity for improvement, including incorporating guidance on the actions to be taken on patient admission and stipulating timescales for completion, review, and update of the patient's Multifactorial Falls Risk Assessment (MFRA).</p> <p>The policy was reviewed and updated in September 2023, although it still doesn't provide clear direction regarding MFRA requirements for A&E and MIU patients, the timeframe for completion of assessments or the requirement for a focused review of falls incidents.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Staff are not aware of and therefore are non-compliant with falls prevention and management requirements, potentially resulting in recurrent incidents and patient harm
Recommendations		Priority
1.1	<p><i>Previous internal audit recommendation reiterated:</i></p> <p>Update the falls policy to ensure it accurately reflects current practice for the prevention and management of falls, including the timescale for completion of assessments and the requirement for a focused review of falls incidents</p>	Medium
Agreed Management Action		Target Date
1.1	<p>The Preventing Falls and Post Fall Care in In-patient Areas Policy (401) will be updated by January 2025 to include following statements:</p> <ul style="list-style-type: none"> 'Once a decision to admit has been made, patients will be required to have a MFRA undertaken within 6 hours of this decision' 'All falls reported via Datix will be required to have a focussed review undertaken prior to the incident being either closed or reviewed at scrutiny and assurance meetings' 	January 2025
		Responsible Officer
		Chair of Inpatient Falls Group

Matter Arising 2: Falls Strategy & Falls Prevention Initiatives (Design)		Impact	
<p>Development of the strategy commenced in 2021 although no progress has been made since our 2022/23 audit, pending review of the Clinical/Executive lead arrangements for falls.</p> <p>The February 2024 Quality & Safety Assurance Report to the Quality Safety & Experience Committee (QSEC) included an overview of the falls strategy work, but minutes do not evidence discussion around the lack of progress with the strategy, delays incurred and expected timescales for completion.</p> <p>Despite the absence of a formal strategy, we were provided with examples of initiatives being undertaken to raise awareness and prevent falls.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inadequate falls prevention activity, potentially resulting in recurrent falls and patient harm. 	
Recommendations		Priority	
2.1	<p><i>Previous internal audit recommendation reiterated:</i></p> <p>A delivery plan for the Falls Strategy should be completed identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.</p>	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	<p>Chair of Inpatient Falls Group to clarify strategic direction and responsibility for development of a HDUHB Falls Strategy direction through submission of a SBAR to the executive team for guidance on the direction of a Falls Strategy and agreement on whether we are aiming for a preventative focus sitting with Public Health, or a management focus aligned to 6 Goals workstreams, deconditioning, frailty and dementia.</p>	March 2025	Executive Lead for Falls / Chair of Inpatient Falls Group

Matter Arising 3: Risk Assessments (Design & Operation)		Impact	
<p>A WNCR report identified that MFRAs are not always completed where required, and few are completed within the required six hours of admission. Sample testing identified delays of up to six days following admission. Two instances were also identified where the assessments hadn't been adequately completed.</p> <p>We were provided with examples of ad hoc MFRA compliance audits undertaken at three of the four acute sites between July 2022 and November 2023, following a recommendation raised in our 2022/23 audit. However, no audits have been undertaken at PPH, or during 2024 to date.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Failure to identify and mitigate falls risks, potentially resulting in recurrent falls incidents and patient harm • Financial loss and reputational damage arising from redress incidents and negligence claims 	
Recommendations		Priority	
3.1	Senior Nurse Management teams to undertake independent checks to ensure the existence, timeliness (for example through WNCR reporting functionality) and quality of MFRAs, particularly in falls 'hot spots'. Independent checking controls have been observed at other Welsh Health Boards.	High	
Agreed Management Action		Target Date	Responsible Officer
3.1	HON and SNM for PPH to lead on the review and development of a SNM Falls Audit Tool which will capture both compliance with falls assessments and MFRA completion as well as the quality of the completed assessments by January 2025.	January 2025	Head of Nursing & Senior Nurse Manager (PPH)
	Monthly SNM audits using the revised Falls Audit Tool will commence in February 2025 and be evaluated after 3 months (May 2025) with support from QIST.	May 2025	Heads of Nursing / QIST


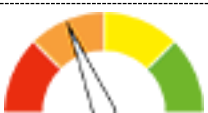

Matter Arising 4: Falls Incidents (Operation)		Impact	
Sample testing identified delays in the commencement of management review, with some taking up to 145 days, and non-compliance with the requirement to undertake a focused review.		Potential risk of: <ul style="list-style-type: none"> • Poor quality incident investigation impacting on learning • Failure to identify and mitigate falls risks, potentially resulting in recurrent falls incidents and patient harm • Financial loss and reputational damage arising from redress incidents and negligence claims 	
Recommendations		Priority	
4.1	<p><i>Previous internal audit recommendation reiterated:</i></p> <p>Monitoring/review of falls incidents to identify those not investigated in a timely manner and non-compliance with the requirement for focused review. Issues identified should be addressed with the responsible individual(s), with action taken for repeated non-compliance where appropriate.</p>	Medium	
Agreed Management Action		Target Date	Responsible Officer
4.1	<p>Formal scrutiny of compliance with focussed reviews for falls incidents will be added to the Inpatient Falls Agenda as a standing item from December 2024 and included in quality discussions through directorate improving together sessions.</p> <p>HONs to monitor compliance with timeliness of investigations and focussed reviews through scrutiny and assurance meetings, escalating to directorate QSE meetings as required.</p> <p>Chair of Inpatient Falls Group to liaise with Assistant Director of Nursing for Quality and Safety to agree formal QSESC reporting processes.</p>	<p>December 2024</p> <p>December 2024</p> <p>December 2024</p>	<p>Chair of Inpatient Falls Group</p> <p>Heads of Nursing</p> <p>Chair of Inpatient Falls Group</p>

Matter Arising 5: Scrutiny & Assurance (Operation)		Impact	
<p>The Adult Inpatient Falls Reduction Improvement Group (AIFRIG) is accountable to the Operational Quality, Safety & Experience Sub-Committee (OQSESC). However, this is not reflected in the terms of reference for the OQSESC, and the AIFRIG is yet to report to OQSESC.</p> <p>Patient safety incident statistics are reported to QSEC via the Quality & Safety Assurance Reports - falls are included but not separately identified. The February 2024 report provided a more detailed update on falls improvement initiatives and an analysis of in-patient falls incidents by level of harm, although this is the only detailed falls update provided to QSEC since June 2022.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> The Health Board is not assured or alerted to concerns regarding falls management, resulting in issues not being addressed. 	
Recommendations		Priority	
5.1a	Update terms of reference for the OQSESC to reflect the AIFRIG and ensure periodic reporting to OQSESC.	Medium	
5.1b	More detailed and frequent (e.g. annual) falls reporting to QSEC, including MFRA compliance, a summary of falls incident themes and trends and action taken to prevent recurrence.		
Agreed Management Action		Target Date	Responsible Officer
5.1a	Chair of the Inpatient Falls Group to liaise with Chair of Quality, Safety and Experience Subcommittee to confirm reporting requirements by December 2024.	December 2024	Chair of Inpatient Falls Group
5.1b	The Inpatient Falls Group will provide an annual report to QSEC (commencing May 2025) which will include oversight of falls improvement work including EQLIP programmes and QI initiatives; compliance with NAIF audits and actions plans, compliance with MFRA reporting, trends and themes of falls incidents including closure timeliness and learning from events / themes identified.	May 2025	Chair of Inpatient Falls Group

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

Appendix C: WNCR Report – MFRA Compliance

Period: 1 April 2024 – 31 July 2024 Inpatients (min 1 night) aged 65+	Total Admissions	% of Admissions with MFRA	% of Admissions with MFRA and within 6 Hours
Bronglais General Hospital	981	87.7%	25.90%
BGH - Cardiac Monitoring Unit	59	100.0%	42.40%
BGH - Ceredig Ward	148	95.3%	25.70%
BGH - Clinical Decisions Unit	209	64.4%	11.50%
BGH - Day Surgical Unit	3	0.0%	0.00%
BGH - Dyfi Ward	135	98.5%	31.90%
BGH - Intensive Care Unit	10	80.0%	20.00%
BGH - Medical Day Unit	1	0.0%	0.00%
BGH - Meurig Ward	48	72.9%	4.20%
BGH - Rhiannon Ward	155	95.5%	50.30%
BGH - Y Banwy Unit	105	95.2%	22.90%
BGH - Y Bwa (Hafan Y Waun)	9	100.0%	44.40%
BGH - Ystwyth Ward	99	92.7%	14.10%
Glangwili General Hospital	1954	87.7%	33.80%
GGH - Ambulatory Care Unit	148	79.1%	43.90%
GGH - Cadog Ward	117	95.7%	17.10%
GGH - Cleddau Ward	142	92.6%	56.30%
GGH - Clinical Decision Unit - Green	126	70.0%	25.40%
GGH - Clinical Decision Unit - Purple	87	75.6%	21.80%
GGH - Coronary Care Unit	169	94.2%	32.00%
GGH - Critical Care Unit	22	70.0%	22.70%
GGH - Day Surgical Unit	15	93.3%	93.30%
GGH - Derwen Ward	288	89.0%	36.80%
GGH - Dewi Ward	40	100.0%	12.50%
GGH - Gwenllian Ward	72	97.0%	23.60%
GGH - Medical Day Unit	3	0.0%	0.00%
GGH - Merlin Ward	128	82.4%	32.00%
GGH - Padarn Ward	86	96.6%	18.60%
GGH - Picton Ward	105	78.1%	40.00%
GGH - Preseli Ward	83	94.0%	36.10%
GGH - SDEC	1	100.0%	100.00%
GGH - Steffan Ward	92	92.4%	27.20%
GGH - Surgical Assessment Unit	60	78.0%	55.00%
GGH - Teifi Ward	91	95.5%	44.00%
GGH - Towy Ward	66	98.5%	21.20%
GGH - Y Lolfa	13	90.0%	15.40%
Prince Philip Hospital	1521	89.4%	56.50%
PPH - Acute Medical Assessment Unit	519	74.4%	47.80%
PPH - Coronary Care Unit	35	100.0%	42.90%
PPH - Intensive Care Unit	9	80.0%	44.40%
PPH - Mynydd Mawr Rehab Unit	17	100.0%	47.10%
PPH - Ward 1	124	100.0%	49.20%
PPH - Ward 3	77	97.4%	58.40%
PPH - Ward 4	106	98.1%	40.60%
PPH - Ward 5	125	97.6%	49.60%
PPH - Ward 6	275	97.1%	92.40%
PPH - Ward 7	135	94.9%	57.00%
PPH - Ward 9	99	94.9%	43.40%
Withybush General Hospital	1528	86.1%	23.70%
WGH - (AD) Frailty SDEC	18	23.5%	5.60%
WGH - Acute Frailty Unit	207	79.5%	16.40%
WGH - Adult Clinical Decisions Unit	249	68.3%	18.10%
WGH - Coronary Care Unit	45	97.7%	42.20%
WGH - Day Surgical Unit	3	33.3%	0.00%
WGH - Endoscopy Unit	1	100.0%	0.00%
WGH - High Dependency Unit	6	83.3%	16.70%
WGH - Intensive Care Unit	3	100.0%	0.00%
WGH - Puffin Ward	34	93.1%	8.80%
WGH - SDEC	1	100.0%	100.00%
WGH - Ward 1	142	96.5%	49.30%
WGH - Ward 10	121	94.3%	22.30%
WGH - Ward 11	93	82.6%	33.30%
WGH - Ward 12	108	95.6%	14.80%
WGH - Ward 4	216	88.5%	28.20%
WGH - Ward 7	141	93.1%	9.90%
WGH - Ward 8	130	96.0%	26.90%
WGH - Ward 9	10	100.0%	40.00%



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