Bundle Audit & Risk Assurance Committee 27 August 2019

4.8 WAO Review of Operational Quality & Safety Arrangements Update

Presenter: WAO/Mandy Rayani/Dr Philip Kloer

SBAR WAO Review of Operational Quality & Safety Arrangements ARAC August 2019

WAO Review of Operational Quality & Safety Arrangements: Final Report (with Mgmt Response)

6.1 Internal Audit Plan Progress Report

Presenter: James Johns

SBAR IA Plan Progress Report ARAC August 2019

IA Plan Progress Report ARAC August 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	WAO Review of Operational Quality and Safety Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Passey, Assistant Director of Nursing, Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Audit & Risk Assurance Committee the management response to the Wales Audit Office (WAO) report following the review of the operational quality and safety arrangements and the management response to the recommendations made by the WAO.

Cefndir / Background

As part of the WAO 2018 audit plan for the Health Board, WAO included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: Are the Health Board's operational quality and safety arrangements and structures effective?

In undertaking this work, WAO examined arrangements and structures at a directorate and corporate level. The arrangements and structures at a committee level were also considered.

Asesiad / Assessment

The WAO found that the Health Board has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements, however these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be. The final report (provided as an annex to this paper) made eight recommendations:

Recommendations	
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.

R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC; b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

A meeting to consider the recommendations, and the Health Board response to the recommendations, was held with the Director of Nursing, Quality and Patient Experience, Medical Director and Director of Strategy, the Executive Director of Therapies and Health Science and the Board Secretary attending. The report has also been presented to the Quality, Safety & Experience Assurance Committee (QSEAC). The management response (appendix 1 of the annex) has been formulated, taking into account the discussions at the meetings.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to:

- Receive the WAO report following the review of operational quality and safety arrangements;
- Receive assurance that the findings of WAO have been considered and appropriate actions have been identified to address the recommendations; and
- Support the management response to the recommendations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2. Safe Care 3. Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Associate Medical Director (AMD) Operational Quality, Safety and Experience Sub-Committee (OQSEC) Quality, Safety and Experience Assurance Committee (QSEAC) Wales Audit Office (WAO)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Nursing, Quality and Patient Experience Medical Director and Director of Strategy Executive Director of Therapies and Health Science Board Secretary Assistant Director of Nursing, Assurance and Safeguarding

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Requirement to implement changes to strengthen Governance arrangements in relation to quality Governance committee arrangements
Gweithlu: **Workforce:**	Staff released to attend meetings – recommendations should streamline and enhance Governance arrangements
Risg: **Risk:**	Risks to concerns not being escalated adequately if arrangements are not in place
Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	Need strong Governance arrangements to ensure there is appropriate escalation of risks
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	All reports to new committee structure will complete EQiA as this becomes established

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Review of operational quality and safety arrangements – **Hywel Dda University Health Board**

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This document has been prepared as part of work performed in accordance with statutory functions.

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

The team who delivered the work comprised Anne Beegan and Phil Jones.

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Summary report

Introduction

1 In our 2017 Structured Assessment report for Hywel Dda University Health Board (the Health Board), we identified that the operational directorate teams at that time needed to mature, and that the operational structures needed to be further developed, to support the Health Board's governance arrangement, particularly in relation to quality and safety.

2 We also identified that improvements were needed to ensure that the Board received the necessary assurances from its committees, in particular, from its Quality, Safety and Experience Assurance Committee (QSEAC), Work was underway to reconfigure the QSEAC and its supporting structures at that time, with the aim to improve assurance flows.

3 In our 2018 Structured Assessment report we further identified that the Health Board continues to strengthen governance and management arrangements, but there is recognition that there remain some weaknesses in quality and safety governance arrangements. We identified that work has taken place to revisit and refine the QSEAC supporting structures, but agendas remain long, duplication exists between sub-groups and many issues discussed are best placed at an operational level.

4 As part of our 2018 audit plan for the Health Board, we included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: **Are the Health Board's operational quality and safety arrangements and structures effective?**

5 In undertaking this work, we have examined arrangements and structures at a directorate[1] and corporate level. We have also examined the arrangements and structures at a committee level. This has included QSEAC and its supporting sub-committees, in particular, the Operational Quality, Safety and Experience Sub-Committee (Operational QSESC).

6 Our work has included interviews with all directorate senior management teams as well as senior leads for quality and safety across the Health Board. We have also reviewed documentation including minutes of meetings, committee papers, organisational structures and risk registers. We have observed the QSEAC and the Operational QSESC.

[1] We have reviewed ten directorates. These are the four hospital directorates (Bronglais, Glangwili, Prince Philip and Withybush), the three county directorates (Carmarthenshire, Ceredigion and Pembrokeshire), and the three Health Board wide directorates (Mental Health and Learning Disabilities, Scheduled Care, Women and Children).

Summary of findings

7 We conclude that the Health Board now has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be.

8 In reaching this conclusion we have found that:

- Some directorate level arrangements are good, but they are not sufficiently consistent;
- Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be;
- The operational quality, safety and experience sub-committee is evolving with scope to take greater assurance from directorates and to focus more on key risks, but attendance is problematic; and
- The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and improve the quality of papers.

9 We explore these findings in more detail later in this report.

Recommendations

10 In undertaking this work, we have identified a number of recommendations. These are set out in Exhibit 1 below.

Exhibit 1: Recommendations

Recommendations	
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC;

Recommendations	
	b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

Detailed report

Some directorate level arrangements are good, but they are not sufficiently consistently

11 Our work has identified that each of the directorates discuss quality and safety matters, but there is variation in the local quality and safety structures and the depth of the discussion.

12 Six of the directorates have separate governance meetings focusing solely on quality and safety. These meetings are at the highest level within the respective directorates and run alongside the routine business meetings which focus on finance and performance. With the exception of the Prince Philip directorate, meetings are on a monthly basis and cover a wide range of quality and safety aspects. Prince Philip directorate hold governance meetings twice a month.

13 Three of the directorates include quality and safety matters as part of the monthly business or management team meetings. These meetings are also on a monthly basis, but discussion is generally limited to concerns, complaints and risks.

14 For the Mental Health and Learning Disabilities Directorate, directorate level quality and safety is the focus of a dedicated sub-committee reporting directly to the QSEAC. This means that discussions for this directorate take place at a much higher level within the Health Board. This is an historical arrangement as a result of previous concerns, which are no longer evident. The agendas cover a wide range of quality and safety matters, but frequency of meetings is limited to every two months.

15 The arrangements across the directorates are set out in Exhibit 2.

Exhibit 2: Directorate arrangements for quality and safety

Directorate	Committee	Sole focus on quality and safety	Frequency
Bronglais	Hospital Management Committee	No	Monthly
Carmarthenshire	County Management Team	No	Monthly
Ceredigion	County Management Team	No	Monthly
Glangwili	Governance	Yes	Monthly
Mental Health & Learning Disabilities	Sub-committee of QSEAC	Yes	Every 2 months
Pembrokeshire	Governance	Yes	Monthly
Prince Philip	Governance	Yes	Twice a month
Scheduled Care	Governance	Yes	Monthly
Withybush	Governance	Yes	Monthly

Directorate	Committee	Sole focus on quality and safety	Frequency
Women & Children	Governance	Yes	Monthly

Source: Wales Audit Office analysis of interviews and documentation

16 In the six directorates with separate governance meetings, there is a good range of agenda items. As well as concerns, complaints and risks, agenda items include:

- compliance with Welsh Health Circulars;
- Healthcare Inspectorate Wales reports;
- results of audits, both internal and external;
- Royal College reports;
- results of Community Health Council visits;
- serious incidents;
- mortality reviews; and
- patient experience.

17 The range of discussion however is not consistent or standardised across the six directorate governance meetings.

18 In the three directorates where quality and safety is considered as part of wider business meetings, the relevant directorates are reliant on supporting assurance groups which sit below the directorate level. Reports from these groups however are not always available for the management team meetings. This is particularly the case for the Ceredigion directorate.

19 Across all of the county directorates, there is limited focus on the quality and safety aspects of primary care provision within the governance and management meetings. The quality and safety of primary care is instead managed through the central primary care team reporting directly to the Director of Primary Care, Community and Long-Term Care.

20 Over the last six months, the Health Board has been developing a quality and safety dashboard. Initially developed for the QSEAC, it is the intention to develop underpinning dashboards for each of the directorates. Our work has identified that the directorate dashboards are not yet in place, although the directorates are drawing on the relevant sources of information. There is however a bespoke dashboard available to support the Women and Children's Directorate, focusing predominantly on maternity services.

21 The directorate heads of nursing and general managers are largely driving the quality and safety agendas. Where quality and safety forms part of the routine business meetings, membership is largely based on the core directorate team. For directorates with governance meetings, membership is larger and more multidisciplinary. Representation from nursing and therapy professions is good,

and there is regular attendance by corporate teams including patient experience, clinical audit and redress.

22 Clinical directors and cluster leads are members of all quality and safety structures, but medical representation at meetings is generally limited with frequent part attendance or apologies sent. Directorates identified challenges engaging medics in the quality and safety agenda, including concerns, complaints and incidents largely because of time constraints around clinical commitments.

23 All directorates have their own professional nursing forums to bring together lead nurses from across the underpinning departments to consider quality and safety. These forums feed into the quality and safety discussions in the directorates and the senior nursing team meetings across the Health Board with the Director of Nursing, Quality and Patient Experience.

Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be

24 The Health Board has corporate teams in place to support key aspects of quality and safety, including concerns, complaints, serious incidents, patient experience and clinical audit. These teams report directly to the Director of Nursing, Quality and Patient Experience.

25 These corporate teams have previously worked in isolation. The Community Health Council, in particular, has raised concerns over the variability in the management of issues, and the differing approaches within each team. Through the senior nursing team meetings, these corporate teams have become more connected over the last twelve months, with approaches starting to become more consistent.

26 Capacity within some of the corporate teams however is an issue. The Audit and Risk Assurance Committee (ARAC) is sighted of the capacity constraints within the clinical audit team, and the Health Board's own benchmark indicates that patient experience capacity is the lowest in Wales. Although the Board supported a new patient experience framework in December 2018, funds have only recently been made available to support the rollout of the 'Friends and Family Test' system.

27 In July 2018, the Board approved the Health Board's Quality Improvement Strategic Framework. This places greater emphasis on sharing the learning from improvement activities. All of the corporate teams focus on learning; however, capacity is such that attention is drawn to supporting the directorates respond to incidents and events as they arise, restricting the ability of the corporate teams to share learning more widely to prevent the issues reoccurring. The Health Board formally launched the Quality Improvement Strategic Framework in March 2019 which should start to help promote the learning agenda more widely.

28 The number of directorates within the Health Board also places demands on the corporate teams' capacity, particularly in relation to attending governance meetings. The bringing together of some of the quality and safety arrangements within directorates, such as county and hospital directorates, may help alleviate the capacity constraints on the corporate teams. This would align with the approach taken within the Executive Performance Reviews which is increasingly considering the performance of county and hospital directorates on a joint basis.

29 Quality and safety is also the professional responsibility of the Medical Director and Director of Clinical Strategy. Amendments are currently being made to the Medical Directorate structure with a proposed new Associate Medical Director (AMD) lead for quality and safety. In addition, there are two new operational AMD posts for primary and secondary care, which are designed to provide day-to-day support to the directorates on medical related issues. It will be important for these posts to work together to make sure that quality and safety is not managed in isolation but collectively across operational and professional domains.

The operational quality, safety and experience sub-committee is evolving with scope to provide greater assurance from directorates and to focus more on key risks, but attendance is problematic

30 In July 2018, the Primary and Community Quality, Safety and Experience Sub-Committee merged with the Acute Quality, Safety and Experience Sub-Committee to become the Operational Quality, Safety and Experience Sub-Committee (QSESC).

31 The new Operational QSESC has met on six occasions and is still evolving. It meets on a bi-monthly basis and reports directly to the Quality, Safety and Experience Assurance Committee. It is one of eight sub-committees reporting to QSEAC, with plans to also merge the Mental Health and Learning Disabilities QSESC into the Operational QSESC once the current sub-committee is fully embedded.

32 The Operational QSESC however is not yet working effectively. Membership is large at 24 as it seeks to include representation from all directorates and corporate teams, but attendance by members is a problem. For the three meetings held between September 2018 and January 2019, significant numbers of members were not represented. There is however attendance from a wider group of staff outside those identified on the terms of reference (exhibit 3).

Exhibit 3: attendance at Operational QSESC

	Number of members (or representatives) in attendance	Number of members not present or represented	Total number of staff in attendance included members (or representatives)
September 2018	12	12	17
November 2018	12	12	20
January 2019	11	13	15

Source: Wales Audit Office analysis of documentation

33 The sub-committee aims to seek assurance from the directorates that actions are being taken to address quality and safety issues through exception reporting. However, directorates are not always present at the meetings to report back or there are frequently no issues to report. The sub-committee also seeks to monitor the management of operational risks but the number of risks that need to be considered has meant that this has become unmanageable within the time available in meetings.

34 Risks and action plans to address quality and safety issues however are increasingly being considered as part of the Executive Performance Reviews (EPRs) with the directorates, posing a risk of duplication between the EPRs and the business of the sub-committee. Risks and action plans are also being considered by relevant operational forums.

35 To reduce the risk of duplication, the sub-committee should focus its attention on taking assurance that learning from risks and action plans is being shared across directorates. This should include severe and high risks, as well as risks that are affecting a number of directorates.

36 Not all of the directorates however are represented at the sub-committee, with Mental Health and Learning Disabilities the focus of the separate sub-committee reporting to QSEAC.

37 Primary care is also not a key feature of the sub-committee despite its scope. Our work has identified that primary care quality and safety matters appear to be largely reported and managed through operational structures to the Director of Primary Care, Community and Long-Term Care, with limited scrutiny and assurance through any of the Board's committee structures. This is of particular concern given the recent changes to the GP indemnity scheme which requires health boards to have a much greater understanding of the level of quality and safety risks that they are carrying in primary care.

38 Like the directorate structures, there is some medical representation on the sub-committee but this is largely because they are chairs or representatives of sub-groups, for example, the Rapid Response to Acute Illness Learning Set (RRAILS) sub-group. Attendance can also be limited to part of the meetings due to other clinical commitments.

39 The sub-committee has a number of groups from which it takes assurances. Good assurances are taken from the Medical Devices Group and the Mental Capacity Act & Consent Group. Assurance is also taken from the Nutrition and Hydration Group although it is acknowledged that this group is only focused on inpatient care. Attendance at the Organ Donation Group and RRAILS Group however have been problematic resulting in cancelled meetings. Although assurances are taken from these groups, these are not as frequent as they should be.

40 As well as duplication with the EPRs, there is also some duplication between the sub-committee and QSEAC in relation to agenda item discussions. Some of this is on purpose by way of having initial discussions ahead of a more focused discussion at QSEAC, but this is not always a case.

41 The sub-committee however is not yet able to provide assurance to the QSEAC that operational quality and safety issues are being managed. There is currently no formal standardised reporting from the directorates to the sub-committee with reliance placed predominantly on exception reporting. Consequently, there is a gap between the QSEAC and the directorate teams.

42 The sub-committee has the potential to address this by seeking standardised assurances from all directorates, or combined directorates, on a range of quality and safety issues, by means of a standardised report. These can then be summarised to provide collective assurance to the QSEAC and ultimately the Board.

The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and to improve the quality of papers

43 Historically, the attendance at the QSEAC has been large, agendas have been long, and the committee members have been unable to take assurance on a number of agenda items either due to the quality of the papers presented, or cancellations of sub-committee meetings.

44 Our recent observations of the committee during 2019 have identified that the functioning of the QSEAC has however started to improve. The committee attendance has now been refined to only include those who need to be there, and accounting officers are now called in to the meeting for specific agenda items as and when required. This has helped address the large attendance levels which largely consisted of representation from corporate teams.

45 The committee however still struggles to take assurance from a number of its sub-committees. This includes the operational QSESC, due to the reasons set out in paragraphs 32-42, but also the Effective Clinical Practice sub-committee and the Improving Experience sub-committee. Both of these sub-committees have struggled with attendance making it difficult to fully explore many of the agenda items for these meetings. On a number of occasions, these meetings have also had to be cancelled because of low attendance rates. The Effective Clinical Practice sub-committee has also struggled with a lack of clarity on its role. The Medical Director and Director of Clinical Strategy has recently taken over the chair of this committee to improve its effectiveness.

46 QSEAC papers also continue to be large with some concerns remaining that there is too much detail, which detracts attention away from the key issues and mitigating actions being taken. Some papers also focus too much on performance matters which are the separate consideration of the Business Planning and Performance Assurance Committee. This can in part be due to the authors not always being able to provide the right focus for the QSEAC.

47 The committee has undertaken a recent self-assessment exercise which reflects the issues raised through our work. An action plan is being put in place to take forward many of the improvement areas raised.

Appendix 1

Action plan

Exhibit 4: management response to recommendations

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.	Improved consistency across directorates, which also includes primary care where relevant.	Yes	Yes	Options for standardising the approach to quality and safety arrangements have been agreed. This includes templates for terms of reference, agendas for meetings and standardised reporting. Templates will be developed in collaboration with the Corporate Governance Team. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Quality and safety matters are included in the county directors meetings and this will be monitored.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.	Increased multi-disciplinary focus, drawing on the expertise of all professions.	Yes	Yes	A restructure of the Associate and Deputy Medical Directors has been undertaken. This new structure includes the appointment of a new Associate Medical Director for Quality and Safety and the proposal to strengthen quality medical lead roles throughout the services.	October 2019	Medical Director and Director of Strategy
R3a	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC.	Improved use of staff time. Improved shared learning.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Transition arrangements for changes to Mental Health and Learning Disabilities quality report arrangements will be developed and worked through with the triumvirate team. Any specific exceptions requiring escalating to QSEAC escalated via OQSEAC, and appropriate staff asked to attend QSEAC as appropriate.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Sciences Clinical Director for Mental health and Learning Disabilities

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3b	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee.	Improved consistency across directorates.	Yes	Partial	There is a Mental Health and Learning Disabilities directorate level governance committee. Work will be undertaken to strengthen and standardise the reporting arrangements to OQSEC (as recommendation 1)	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
R3c	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should align all directorate level governance committees, so they report directly to the Operational QSESC.	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
R3d	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1).	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.	Improved effectiveness of meetings. Reduced duplication with Executive Performance Reviews.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1). Agreement that risks and learning will be, embedded into the standard reporting templates. The templates will also advise on how learning from risks and action plans are being shared across Directorate and other areas. Deep dives are currently being discussed at each OQSESC meeting and will continue, these will support in-depth conversation required. The Risk Registers are to be used to inform these. A Listening and Learning Group is being established to facilitate shared learning across the organisation. Reporting arrangements for the group will be finalised and endorsed through QSEAC.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Science. Director of Nursing, Quality and Patient Experience
R5a	To improve quality and safety assurance flows to the QSEAC, the Health Board should support and encourage attendance at the Improving Experience sub-committee and	Improved flow of assurance from sub-committees to QSEAC and the Board.	Yes	Yes	The appointments of a new AMD for Quality and Safety and the enhanced roles of clinical leads will support the wider medical engagement at sub-committees. The terms of reference for both the Improving Experience sub-committee and Effective Clinical Practice sub-committee	October 2019	Medical Director and Director of Strategy Director of Nursing, Quality and Patient

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	Effective Clinical Practice sub-committee; and				have been reviewed, including membership, with the aim of focussing membership and attendance at meetings.		Experience/Medical Director and Director of Clinical Strategy.
R5b	To improve quality and safety assurance flows to the QSEAC, the Health Board should revisit the scope of the Effective Clinical Practice sub-committee.	Improved effectiveness. Improved flow of assurance from sub-committee to QSEAC and the Board.	Yes	Yes	The terms of reference for the Effective Clinical Practice sub-committee have been reviewed including membership; with a paper to be submitted to the Audit & Risk Assurance Committee.	Complete	Medical Director and Director of Strategy
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.	Improved whole-system focus on quality and safety. Improved shared learning. Effective use of limited corporate team resources.	Yes	Yes	Whilst this recommendation is accepted the approach and arrangements to facilitate this will require further consideration with the Director of Operations and chairs of the various quality meetings. Meeting to be held to work through the arrangements and options to enable effective join up of governance meetings periodically throughout the year.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.	Improved consistency across directorates.	Yes	Yes	Task and finish group established which is jointly chaired by Director of Nursing and Director of Planning. The work of the task and finish group has been expedited. A project plan is in place including agreement of the priority indicators to be populated and rolled out to directorates.	April 2020	Director of Nursing, Quality and Patient Experience
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.	Improved shared learning. Improved whole-system focus on quality and safety.	Yes	Yes	The appointments of a new AMD for Quality and Safety and clinical leads will work closely with the two new operational AMD posts for primary and secondary care. There will also be close working relationships with Assistant Director of Nursing for Quality and Assurance and Head of Goverance for Quality and Assurance	October 2020	Medical Director and Director of Strategy

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 August 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit & Assurance Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Internal Audit

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Internal Audit Progress Report provides specific information for the Audit & Risk Assurance Committee covering the following key areas:

- Detail relating to outcomes, key findings and conclusions from the finalised internal Audit assignments
- Specific detail relating to progress against the audit plan and any updates that have occurred within the plan.

Cefndir / Background

The work undertaken by Internal Audit is in accordance with its plan of work, which is prepared following a detailed planning process and subject to Committee approval.

The progress report provides the Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee. The Committee also receives the finalised audit reports for review and scrutiny.

Asesiad / Assessment

The findings and assurance ratings from the Internal Audit Reports provide the Committee with a level of assurance as to the adequacy of the risk, governance and control environment in the areas audited.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to consider the Internal Audit Progress Report and the assurance available from the finalised Internal Audit reports.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.16 The Committee shall ensure that there is an effective internal audit and capital/PFI function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board. 5.17 This will be achieved by: 5.17.1 review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation; 5.17.2 consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit plan. Evidence gathered as part of the delivery of audit assignments.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Executive Directors and Senior managers relevant to the individual audits. Board Secretary.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not applicable
Gweithlu: **Workforce:**	Not applicable
Risg: **Risk:**	Not applicable
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board

Audit & Risk Assurance Committee

August 2019

Internal Audit Progress Report

1. INTRODUCTION

1.1. This progress report provides the Audit & Risk Assurance Committee (ARAC) with the current position regarding the work being undertaken by Audit and Assurance Services as part of the 2019/20 Internal Audit plan.

1.2. The report includes details of the progress made to date against individual assignments, outcomes from finalised Internal Audit reports along with details regarding the delivery of the plan and any required updates.

1.3 The plan for 2019/20 was agreed by the Audit & Risk Assurance Committee in April 2019 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. OUTCOMES FROM COMPLETED AUDIT REVIEWS

2.1 A number of assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

2.2 The full versions of these reports are included on the agenda as separate items.

ASSIGNMENT	ASSURANCE RATING	
Carbon Reduction Commitment	Substantial	
ARCH	Reasonable	
Annual Quality Statement	Reasonable	

Environmental Sustainability Reporting	Reasonable	

3. DELIVERY OF THE INTERNAL AUDIT PLAN

3.1 The detail of the plan of audit work for the year is outlined in the schedule which is included at Appendix A.

3.2 Since the last meeting of ARAC, one audit has been finalised with a rating of Substantial Assurance, three audits a rating of Reasonable Assurance.

3.3 Further to the finalised audits a number of other audits are in currently in progress and are again highlighted in Appendix 1.

3.4 Following discussion with management there have been requests to move two audits (Rostering and Commissioning & Contracting) to later in the year.

3.5 Discussion have been ongoing with the Board Secretary around they potential requirement for further audit work around additional estates assurance topics and is currently being assessed.

3.6 A workshop was held by our SSU team with the Women & Children's Project Board (Group) on 16th of July 2019. The workshop involved a combination of a short recap of key principles of the role/ responsibility of a Project Board, followed by an interactive session where attendees rated and assessed a series of statements to generate discussions and identify certain areas for future appropriate consideration.

Appendix A – Internal Audit Plan 2019/20 – Progress Schedule

Planned output	Outline timing	Current progress	Executive Lead	ARAC	Assurance	H	M	L
Corporate governance, risk and regulatory compliance								
Governance & Risk Overview Governance, leadership and Accountability module & AGS.	Q1-4	---	Board Secretary	In Annual report				
Health and Care Standards	Q4		Director of Nursing, Quality & Patient Experience	Feb				
Welsh Risk Pool Claims	Q3/4		Director of Nursing, Quality & Patient Experience	Feb				
Standards of Behaviour	Q3/4		Board Secretary	April				
Health & Safety	2/3	Assignment Planning	DCEO, D of Operations	Dec				
Welsh Language Compliance	Q2	Fieldwork in progress	Director of Partnerships and Corporate Services	Oct				

Planned output	Outline timing	Current progress	Executive Lead	ARAC	Assurance	H	M	L
Strategic Planning, Performance								
Patient Access	Q2	Fieldwork in progress	DCEO, D of Operations	Oct				
Programme Management	Q2/3		Director of Planning	Dec				
Health & Care Strategy (TCS)	Q4		Medical Director	Apr				
Research and Development	Q1/2	Planning /wip	Medical Director	Oct				
Business Continuity	Q4		Director of Public Health	April				
ARCH	Q1	FINAL	Director of Planning	Aug	Reasonable	-	-	-
Financial Governance and management								
Core Financial Systems -	Q3	Planning	Director of Finance	Dec				
Finance Assurance Framework	Q3	Planning	Director of Finance	Feb				
Commission and Contracting	Q4	Mgt. request to move to Q4.	Director of Finance	Feb/Apr				
Clinical governance quality & safety								
Annual Quality Statement	Q1	FINAL	Director of Nursing, Quality & Patient Experience	Aug	Reasonable	0	4	0
Medical devices	Q3	planning	DCEO, Director of Operations	Dec				

Planned output	Outline timing	Current progress	Executive Lead	ARAC	Assurance	H	M	L
Mortality rates	Q4		Medical Director	Apr				
Nursing Medication Errors	Q3/4		Director of Nursing, Quality & Patient Experience	April				
Closure of Actions	Q3/4		Director of Nursing, Quality & Patient Experience	Feb				
Information Governance and Security								
Cyber Security	Q3/4	planning	Director of Planning	April				
Virtualisation	Q2	planning	Director of Planning	Oct				
Departmental IT system	Q2/3	planning	Director of Planning	Dec				
IT Service Management	Q2	planning	Director of Planning	Oct				
IT Follow up	Q3/4		Director of Planning	Feb				
Operational service and functional management								
Directorate Review – Estates	Q1/2	Fieldwork in progress	DCEO, Director of Operations	Oct				
Directorate Review - Bronglais	Q1/2	Assignment Planning	DCEO, Director of Operations	Oct				

Planned output	Outline timing	Current progress	Executive Lead	ARAC	Assurance	H	M	L
Records Management	Q4		DCEO, Director of Operations	Apr				
National Standards for Cleaning	Q4		DCEO, Director of Operations	April				
Workforce management								
Consultants Job Planning	Q2	Fieldwork in progress	Medical Director	Oct				
Medical Leadership and aspiring leaders programme	Q3/4		Medical Director	Feb				
Electronic Staff Record System	Q3/4		Director Workforce	Feb				
Rostering	Q3	Mgt. request to move to Q4.	Director Workforce	Dec/Feb				
Variable Pay	Q3		Director Workforce	Dec				
PADR Follow up	Q4		Director Workforce	Oct				
Capital and Estates								
Environmental Sustainability Reporting	Q1	FINAL	DCEO & Director of Operations	Aug	Reasonable	0	5	0
CRC	Q1	FINAL	DCEO & Director of Operations.	Aug	Substantial	--	--	--
Follow up (Capital and Estates)	Q4		Director of Planning, Performance and Commissioning/ DCEO & Director of Operations	Apr				

Glangwili Hospital, Women & Children's Development Phase 2	Q3	planning	Director of Planning, Performance and Commissioning	Dec				
Bronglais Hospital Front of House Development and Fire Lift - Final Account	Q3	Planning.	Director of Planning, Performance and Commissioning	Feb				
Capital Systems (Financial Safeguarding)	Q2/3	Fieldwork	Director of Planning, Performance and Commissioning	Feb				
Informatics Projects	Q3		Director of Planning, Performance and Commissioning	Feb				
Estates Assurance (Water Management)	Q2	Field work complete, report being prepared.	DCEO & Director of Operations	Dec				
Major Strategic Investment Programmes	Q3		Director of Planning, Performance and Commissioning	Feb				

For Reference: The assurance ratings are defined as follows:

Assurance rating	Assessment rationale	Guide to Rating
	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.	Few matters arising and are compliance or advisory in nature. No issues about design of policies or procedures or controls. Any identified compliance (O) issues are restricted to a single control objective or risk area rather than more widespread. No high priority audit findings. Few Low or Medium priority findings. Even when taken together any issues have low impact on residual risk exposure even if remaining unresolved.
	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.	Some matters require management attention in either control design or operational compliance. Any control design (D) limitations are isolated to a single control objective or risk area rather than more widespread. However compliance issues (O) may present in more than one area. Typically High priority findings are rare; but/or some Low or Medium priority findings. Even when taken together these will have low to moderate impact on residual risk exposure until resolved.
	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.	More significant audit matters require management attention either in materiality or number. Control design limitations (D) may impact more than one control objective or risk area. Compliance issues (O) may be more widespread indicating non-compliance irrespective of control design. Typically some high priority audit findings have been identified and these are not isolated; and/or several Medium or Low audit findings. Either individually or when taken together these are significant audit matters with moderate impact on residual risk exposure until resolved.
	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.	Significant audit matters require management attention both in terms of materiality and number. Control design limitations (D) impact the majority of control objectives or risk areas. Alternatively compliance issues (O) are widespread indicating wholesale non-compliance irrespective of control design. Several high priority audit findings have been identified in a number of areas; and/or several Medium audit findings.

Assurance rating	Assessment rationale	Guide to Rating
		Either individually or when taken together these are significant audit matters with moderate impact on residual risk exposure until resolved.

For Reference: The priority of the findings and recommendations are as follows:

High	Medium	Low
Poor key control design OR widespread non-compliance with key control PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or mis-statement Timescale for action- Immediate	Minor weakness in control design OR limited non-compliance with control PLUS Some risk to achievement of a system objective Timescale for action- Within one month	Potential to enhance design of adequate systems further OR Isolated instances of non-compliance with control with negligible consequences Timescale for action- Within three months

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