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Summary report

About this report

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

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

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 additional high-profile reviews into 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 Hywel Dda University Health Board (the Health Board) carried out between January and June 2021. To test the 'floor to board' perspective, we examined the arrangements for

general surgical services. The audit draws on the findings from a previous local review of operational quality and safety arrangements at the Health Board undertaken in 2019 which found that 'there were some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these were not yet consistent, and the flow of assurance from directorates to the Board was not as effective as it could be'.

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 **the Health Board is committed to providing safe, high quality services and has aligned its strategy and plans with risk and quality improvement. While corporate structures and resources provide effective support for quality governance and improvement, inconsistencies in operational arrangements and weaknesses in operational risk management limit the provision of assurance. Monitoring and scrutiny of the quality and safety of services is being strengthened through increased use of quality outcome measures.**

8 The Health Board's recent work to align its strategic objectives, planning priorities and quality improvement priorities has strengthened its ability to ensure that quality improvement is at the 'heart' of its governance arrangements. The Health Board has an established values and behaviours framework, and staff are generally confident to report concerns. The Health Board is committed to listening and learning and ensuring that best practice is shared and communicated, including through the Listening and Learning Sub-Committee of the Quality, Safety and Experience Sub-Committee. Corporate responsibility for quality and safety is well established, and there is good support from corporate teams for operational staff. The Health Board has also developed innovative approaches to strengthen resources and capacity for patient experience. There is growing use of quality and safety outcome indicators to help guidance planning and monitoring arrangements including the implementation of the four quadrants of harm.

9 However, assurances to the Board are limited by inconsistencies in operational risk management, failure to update some risk entries in the operational risk register in line with corporate policy, and shortcomings in the content of registers. While corporate responsibility and structures for quality and patient safety are clearly established, at an operational level leadership, resources, and arrangements to support quality governance remain inconsistent. The way in which risks and issues are reported up through sub-committees and committees to the Board sometimes leads to a dilution of the message being communicated.

Recommendations

10 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
Effectiveness of quality and safety sub-groups R1 The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Sub-committee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: a) mandate the use of the recently issued generic templates with the understanding that the agenda template is a minimum requirement which can be supplemented as appropriate; b) issue guidance on record taking at meetings; and c) ensure that local records are stored in a standard location to facilitate access.
Operational leadership R2 There are inconsistent leadership arrangements at an operational level for assurance, risk, and safety across the Health Board. The Health Board should either strengthen current arrangements where staff resources for assurance, risk and safety are managed by directorates to improve consistency, or move to a model where those staff are managed centrally, ensuring that support available to the operational teams is consistent across the Health Board.

Recommendations

Risk Registers

R3 Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by:

a) ensuring that operational teams clearly identify the risks for which they are responsible for and update risk registers in line with corporate policy.

b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.

Risk Management

R4 The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.

Detailed report

Organisational strategy for quality and patient safety

11 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.

12 **We found that the Health Board has aligned its strategic objectives, planning priorities and quality improvement priorities. Corporate risk appetite has been clarified and the Board Assurance Framework is being further strengthened. However, the provision of assurance to the Board is being limited by inadequacies in operational risk management.**

Quality and patient safety priorities

13 **The Health Board has demonstrated its commitment to quality and patient safety improvement through its strategies and recent work has aligned its strategic objectives, planning priorities and quality improvement priorities.**

14 Quality and patient safety are key elements that run through the Health Board's objectives and priorities. The long-term strategic plan 'A Healthier Mid and West Wales: Our Future Generations Living Well' emphasises quality and service improvement as one of its key enablers.

15 The Health Board has carried out comprehensive work to refresh its six strategic objectives and to establish a set of measurable planning objectives to move the organisation towards its aims over the next three years. The Annual Recovery Plan 2021-22 links strategic objectives to planning priorities and includes success measures that reflect quality improvement priorities. Quality and patient care impact assessments are a mandatory element in the standard template for reports to the Board.

16 The Health Board plans are underpinned by the Health Board's first quality framework, the Quality Improvement Strategic Framework (QISF) 2018-21 which established five Quality Improvement Goals:

- no avoidable deaths;
- protect patients from avoidable harm arising from care;
- reduce duplication and eliminate waste;
- reduce unwarranted variation and increase reliability; and
- focus on what matters to patients, service users, their families and carers, and staff.

17 Operational teams have agreed annual quality priorities with service managers and the Director of Nursing, Quality & Patient Experience. The priorities are aligned with the Quality Improvement Goals outlined in the QISF and informed by the key priorities for quality improvement activities, as set out each year in the Annual Plan. The Health Board is currently reviewing the QISF with a view to feeding in learning to the development of the new Quality Management System (QMS). Progress on

agreeing the new QMS approach has been delayed due to COVID-19, but work is now underway.

Risk management

18 **The Health Board has a clear risk management strategy and has recently clarified its risk appetite. However, assurances to the Board are limited by inconsistencies in operational risk management, failure to update risk registers and confusion over responsibility for risk.**

19 The Health Board has a risk management strategy in place, and there are plans to review this during 2021-22. During 2021 the Health Board also reviewed its corporate risk appetite, and the Head of the Assurance and Risk Team updated the guidance to the Board in relation to the Health Board's tolerance and appetite for risk.

20 In our Structured Assessment Report 2019 we reported that the Health Board was exploring ways in which the Board Assurance Framework (BAF) could be improved to support the implementation of the strategy from 2020 onwards. This work was temporarily delayed due to COVID-19. A reinvigorated interactive BAF was presented to the Board in September 2021. The Health Board has identified 17 principal risks to achieving its refreshed strategic objectives and established principal risk owners for each one, as identified in the BAF. The risk owners and their teams are currently working to identify the associated control arrangements, assurances, and gaps in controls.

21 The Health Board has a dedicated Assurance and Risk Team with five whole time equivalent (WTE) staff (including one WTE support staff member). The Team provides risk management training to the Board as well as to operational and corporate staff. All staff receive risk management training prior to access being issued to the Risk module within DATIX. The Scheduled Care Directorate and General Surgery Team, both tracer areas in our review, reported that they receive regular support for risk management from the corporate team. The Operational Quality, Safety and Experience Sub Committee (OQSESC) have requested refresh training on risk appetite and also that the Assurance and Risk Team attend directorate and hospital quality, safety, and experience groups.

22 The Quality Safety and Experience Committee (QSEC)[1] has delegated responsibility for oversight of all of the quality and safety risks and exercises effective scrutiny of these issues. The Executive Team review the Corporate Risk Register (CRR) every month, using formalised terms of reference for review. Of the risks on the CRR (May 2021), 41 per cent were directly attributed to the quality and safety of patient services, with related implications in a further 15 per cent.

[1] The Quality, Safety and Experience Assurance Committee is now referred to as the Quality, Safety and Experience Committee (QSEC). See paragraph 74.

23 QSEC meeting agendas include highly informative deep-dive reports into particular areas of risk. Two such reports were included at the QSEC meeting in August 2021, one on Cancer and the other on Stroke. Both set out a clear picture of the issues associated with services in these areas and provided a basis for informed discussion. An independent member drew attention to a lack of focus on what patients thought about the outcomes of their treatment and the importance of including their perspective when reporting on the quality of services.

24 However, some members of the Operational Quality, Safety and Experience Sub Committee (OQSESC), which reports to the QSEC, raised concerns at the meeting of the OQSESC in May 2021 about the potential for risks to combine with significant consequences for service delivery. Some risks are also managed separately by different sites without co-ordination. At the August QSEC meeting, there was also a discussion about the entry of risks more than once in operational risk registers. There is an opportunity to bring these risks together which is being explored with the Director of Operations. The planned establishment of county-based quality and safety forums will also help to address this issue.

25 An example of the above relates to the Bronglais General Hospital (BGH) Chemotherapy Day Unit where there is an absence of privacy for patients because the treatment area also serves as a hospital thoroughfare. This also increases the risk of hospital acquired infection for patients, particularly those who are immunocompromised. These factors were formally identified as a red risk in May 2015 (Corporate Risk Reference 55). In May 2021 the OQSESC risk register entry had not been updated since September 2020. Our discussion with the BGH management team suggested that there may have been confusion about whether site-based staff or the directorate team were responsible for updating the risk register. The risk is primarily described in the risk register according to its potential to bring reputational risk, rather than in terms of its implications for patient dignity and safety. The risk updates do not provide a clear narrative over time and there is no record of the significant actions taken during the pandemic to mitigate risk.

26 Our work has also found that some risks entries are not regularly updated as required. The OQSESC report to QSEC in June 2021 indicated that nine red-rated risks had not been updated since 2020 despite numerous requests to operational managers to do so. These included significant risks relating to the potential for patient harm and should be updated regularly to provide assurance to the Board that these risks are being managed and mitigated appropriately. The issue was also reported at the July 2021 Board meeting, although the extent and duration of the problem was not indicated. The Internal Audit report on Quality & Safety Governance (January 2021) also referred to this issue. The Health Board recognise this issue and the need for operational managers to fulfil their risk management responsibilities. The Board Secretary and her team will be carrying out a workshop on risk awareness for the Director of Operations and his senior managers across the operational structure.

27 As part of the tracer for this review we looked at the risk registers for the Scheduled Care Directorate and for General Surgery. Whilst the Scheduled Care

Directorate risk register appears to combine risks from areas within its structure, it does not include the two risks recorded in the General Surgery Team risk register. There are only two risks in the latter, one identified in June 2018 and the other in July 2020, giving the impression that it is not a 'live' document.

Organisational culture and quality improvement

28 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.

29 We found that **the Health Board is focused on quality improvement and has dedicated resources to support it. The new approach to quality improvement will be highly dependent on the capacity of individual staff and on a shared commitment to the approach. Organisational values and behaviours are well established, and most staff are generally confident about reporting their concerns. In addition, listening to and learning from patient and staff experiences is being further embedded in the organisation's approach.**

Quality improvement

30 **The Health Board is focussed on quality improvement and are restructuring the dedicated Quality Improvement Team to ensure alignment with the organisation's strategic objectives. The clinical audit programme is being set in challenging circumstances and the timeliness of Stage One mortality reviews is improving.**

Resources to support quality improvement

31 The Health Board has a dedicated Quality Improvement Team of 11.6 whole time equivalents (WTE), with twelve staff members. However, its capacity has been affected as most of the team were deployed to support the Health Board's operational response to COVID-19 and a number of staff have now taken roles elsewhere within the organisation. The team is restructuring to reflect these changes and to ensure alignment with the organisation's strategic objectives.

32 Quality improvement training is provided through the EQIiP (Enabling Quality Improvement in Practice) Programme. A record is kept of those staff who have completed the training. The Programme supports multi-disciplinary operational teams to take forward improvement ideas linked to the organisation's five Quality Improvement Goals, or to a strategic objective. Although the EQIiP Programme could not be run as planned during the pandemic, the Health Board is piloting

virtual training which should allow it to resume. The Programme was evaluated by Swansea University during 2020. They recognised that staff had engaged a number of successful initiatives although conflicting commitments had affected the extent to which they could engage in the work. The evaluation found that there were difficulties in ensuring the participation of medical and other staff groups, which was necessary to ensure a team-based approach to the work. Despite the limiting impact of the pandemic on this approach to organisational change, the Health Board should maintain and actively support its future development.

33 A range of clinical leadership and mentorship programmes provide staff with the skills they will need to be effective leaders. The Employee Staff Record system contains records of those Health Board staff who participate at bronze level in Improving Quality Together, with the exception of medical staff, although the Health Board was not able to say what proportion of the staff had completed that training.

34 The Health Board has established a Value Based Healthcare (VBH) Programme with a designated Assistant Medical Director lead. The Programme will underpin long-term strategy by focussing on the organisation of services around outcomes that matter to people.

Clinical Audit

35 Clinical audit is an important way of providing assurance about the quality and safety of services. As with other health boards, there has been a significant reduction in the demand and available resource for clinical audit activity during the pandemic. Nevertheless, the Clinical Audit Team has continued to maintain a number of projects, including thirteen national audits. There were 40 local clinical audits and 34 national clinical audits over the two-year period between 2019-21.

36 The capacity of the Clinical Audit Team (9.8 WTE) has been affected by vacancies and the deployment of staff to critical roles as part of the COVID-19 response. However, following a recruitment process, the team is almost at its full complement of staff. A new Clinical Director for Clinical Audit was appointed in February 2021 to work with the Clinical Audit Manager to help strengthen the clinical audit programme.

37 The Clinical Audit Team are to be commended for developing the forward programme in liaison with clinical teams across the Health Board, the Audit and Risk Assurance Committee (ARAC), the Clinical Audit Scrutiny Panel (CASP), Effective Clinical Practice Advisory Panel (ECPAP) and operational quality and safety groups. The CASP is engaging with clinical services to review improvement plans for those audits which have been a cause for concern. The 2021-22 clinical audit programme was due to be reported to the ARAC meeting on 24 August 2021, but the work to finalise the programme had not been completed by that time.

38 The Clinical Audit Team has resumed its programme of Whole Hospital Audit Meetings (WHAMs) in line with pre-COVID plans. The meetings enable clinicians to discuss a range of clinical audit areas and share learning, and are well-

supported. Two events have been held this year (March 2021 and June 2021) with four more agreed. The agenda for the WHAM at BGH in June 2021 for example covered the following topics:

- appropriateness and accuracy of information provided on ultrasound requests for deep vein thrombosis;
- Sentinel Stroke National Audit Programme Organisational Audit; and
- appropriate documentation of Gentamicin administration and monitoring according to Health Board guidelines at BGH.

39 The General Surgery Team, one of the tracer services in our review, has demonstrated a strong commitment to broad engagement and sharing of learning. The Team holds departmental meetings through the year to discuss key data.

Mortality and morbidity reviews

40 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. In August 2018, the Health Board instigated a new process for Stage One[2] reviews in line with other health boards in Wales, and this has improved the timeliness of these reviews. A formal written process for the Stage Two mortality reviews was approved by the Mortality Review Group and the QSEC and has been adopted by all sites.

41 The Mortality Review Group provides a quarterly report to ECPAP, of which it is a sub-group. It focuses on the actions to improve Universal Mortality Review figures and supports the sharing of learning. Directorate and hospital management teams reported significant improvements in the processes underpinning mortality and morbidity reviews.

42 The Health Board has carried out periodic mortality reviews of the impact on patients waiting for a procedure during the COVID-19 pandemic. The Medical Director presented preliminary findings and learning from the mortality reviews of the impact of patients waiting for a procedure during the COVID-19 pandemic at the Quality, Safety, Experience and Assurance Committee (QSEAC) meeting in October 2020. The analysis showed that while the mortality rate in March 2020 was significantly higher than the previous period, it remained significantly lower than the all-Wales average over the period to July 2020. At the time of our fieldwork the Health Board was appointing a lead for the mortality reviews associated with COVID-19, including nosocomial reviews. Most of the work

[2] All deaths in all acute hospitals in Wales are reviewed and health boards are increasingly extending this to include deaths in community hospitals. Case note mortality reviews are a two-stage process. The first is a universal mortality review, which is an initial screening of all deaths. Where concerns are identified that person's case is subject to a more in-depth Stage Two review. This involves a root cause analysis, which can where necessary, coordinate with the Putting Things Right process.

associated with the nosocomial reviews are being carried out by the Quality Assurance Team.

Values and behaviour

43 **The Health Board has a well-established values and behaviours framework which provides a basis for the introduction of the new quality improvement approach, and staff feel supported to report concerns.**

44 In 2015-16, the Health Board consulted with over 2000 staff and developed a framework of nine overarching staff behaviour values and three organisational values:

- putting people at the heart of everything we do;
- striving to deliver and develop excellent services; and
- working together to be the best we can be.

45 They were used as the focus for the Quality Improvement Strategic Framework 2018-21 and are central to the Health Board's strategy and priorities for the next three years. They will also underpin the new Quality Management System which will depend on a culture of openness, transparency and learning when things go wrong.

46 Our survey[3] of operational staff working across the general surgery team (see results in Appendix 2) found that staff generally feel confident about reporting their concerns. Of the respondents to the survey, 21 out of 37 agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. Over half of the respondents (24 out of 38) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly. A majority (27 out of 38 respondents) agreed or strongly agreed that the organisation acts to ensure that reported errors, near misses or incidents do not happen again.

47 Our Structured Assessment Report 2019 showed that overall compliance with statutory and mandatory training is the second highest in Wales (based on figures for July 2019). The staff appraisal rate was the highest in Wales at 97%. However, workload pressures arising from medical staff vacancies resulted in statutory and mandatory training compliance for medical staff falling below the Wales average at just 34%. The Health Board is trying new ways to improve compliance, and it is positive that the Estates Directorate has successfully used virtual approaches to make it easier for staff to attend training. The Health Board should consider further use of this approach.

[3] We invited operational staff working across the general surgery team to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. While the findings are unlikely to be representative of the views of all staff across the general surgery team, we have used them to illustrate particular issues.

Listening and learning from feedback

48 **The Health Board is continuing to develop a range of opportunities to listen to and learn from patient and staff experiences. The Listening and Learning Sub-Committee is further strengthening its approach to help ensure robust action in response to cases where there is key learning so that areas of concern are highlighted and communicated.**

Patient Experience

49 The Health Board set an improvement target of 75% this year for compliance with the requirement to resolve complaints within 30 days. The Board receives regular performance reports which include details about the management of complaints. Performance has varied significantly over successive periods and the impact of COVID-19 on performance is included in the reports. In May 2021 the compliance rate was 70% within 30 days and the Health Board was in 8th position out of 10 NHS Wales bodies.

50 The Health Board published an Improving Patient Experience Charter in April 2020, setting out what patients can expect when they use services and receive care. It was developed with help from patients, local communities, and staff. It sets out five 'always experiences', one of which states that the Health Board will always 'support and encourage you to share your experiences of health care, both good and bad, to help us improve the way we do things'. The Patient Experience Plan 2020-23 lists the key priorities in delivering the Charter, although it does not provide contextual details such as how and why it was developed or how progress is to be monitored and reported.

51 The Listening and Learning Sub-Committee (LLSC) of the QSEC looks at cases where significant learning has occurred and examines proposed actions to reach a conclusion about whether they are sufficiently robust to address risks. In this respect it can provide an informed perspective to QSEC about any assurances provided. It also helps to ensure that best practice is shared and that concerns are communicated to committees and working groups. It has received the results of work to review and rationalise existing patient surveys and has offered to assist services in undertaking surveys which will enable them to improve patient experience.

52 The current LLSC Chair is an Independent Member who has taken the role for a twelve-month period in order to further strengthen the way the sub-committee examines risk, proposed actions, and the learning that arises. At the end of that period there will be a review of the sub-committee and consideration will be given as to the merit of appointing a clinical chair. The Independent Member also serves as the Putting Things Right Champion. The LLSC will submit an annual report on its work to the QSEC in 2022.

53 The Board receives Improving Patient Experience reports from the Director of Nursing, Quality and Patient Experience at each meeting, as well as an annual

report. Current reports address a comprehensive range of issues using a number of different information sources although the format lacks a clear summary of key findings and actions. The Patient Experience Team (PET) is enthusiastic about the potential for thematic reporting that will be provided by the forthcoming implementation of patient experience software.

54 The Health Board receives patient and service user feedback from a number of resources, including the Friends and Family Test (FFT); compliments, concerns and complaints; Patient Advice and Liaison Service (PALS) feedback; local surveys, the all-Wales NHS survey and via social media. The FFT provides an opportunity for people to give feedback on their experience of services by asking the question 'how likely are you to recommend our service to friends and family if they need similar care or treatment?'. The Health Board aimed to rollout the approach to most services and departments by the end of 2019-20.

55 Figures reported for the period 1st May to 30th June 2021 showed a significant increase in the number of complaints received (697 contacts, up from 481 in the previous period). The categories showing the largest increase were:

- clinical assessment and treatment concerns (up 62%); and
- communication, attitude and behaviour related concerns (up 45%).

56 The information is being used to identify themes and trends, which can in turn be used to guide the action taken. For example, in response to the issues around staff attitude and behaviour, the Workforce and Organisational Development Team are developing a customer care training programme to be launched in September 2021. Its content and delivery will be influenced heavily by the patient experience feedback received in this area. The Health Board has obtained feedback from a range of service users using various approaches. For example:

- the Scheduled Care Directorate uses the Patient Satisfaction Audit which informs the Health & Care Standards annual reporting process;
- Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) in line with the national programme;
- through the introduction of the 'Patient Knows Best' scheme which empowers patients to make decisions and gain information about their care plan;
- providing user satisfaction questionnaires with prepaid envelopes on discharge; and
- through feedback gathered by the PALS.

Listening to staff

57 The Health Board is committed to listening to staff so that it can learn from their experiences and concerns. The Chair and the Executive Team are committed to ensuring that there is a culture in which learning can flourish and where staff feel comfortable to raise concerns. As part of this commitment, the Health Board introduced the Speak Up Safely scheme, in support of the all-Wales Raising

Concerns Procedure. Its aim is to support staff to speak up about their concerns and issues with the way things are done.

58 The NHS all-Wales staff survey and the Health Board's own staff survey provide a perspective which is used to help address issues and strengthen the quality of services. The Health Board recently completed its second Discover Report[4] which focussed on listening to staff experiences during the pandemic and reporting them mainly through videoclips and podcasts from staff. It has also established a Rest and Recovery Group to hear from staff about their experiences and need. This work will combine to help inform the way in which it continues to support staff. Some of the feedback was shared at the Annual General Meeting of the Board in July 2021. One of the key responsibilities of the People, Organisational Development and Culture Committee is to use these findings to understand more about staff experience so that approaches to rest, recovery and recuperation can be shaped over the next two years.

59 During the early stages of the COVID-19 pandemic, the Health Board established a forum for the Black, Asian and Minority Ethnic community which has enabled it to engage very effectively with both staff and patients. The forum is to become part of a Diversity and Inclusion Advisory Group (DIAG) which will include staff who can provide a perspective across the legal protected characteristics. The group has direct access to the Board and provides an important opportunity for communication, to listen to staff concerns and to provide reassurance.

60 The Health Board has also introduced a reverse mentoring programme. All Board members have been assigned a staff mentor to help them develop an understanding of the experiences of staff across the organisation. A mid-term session is planned for October so that Board members can share what they have learned so far.

Patient stories

61 The Patient Experience Team has continued to capture patient and staff stories during the fast-moving COVID-19 pandemic as a vital perspective on services and how they can be improved. The LLSC uses patient stories to share experiences and illustrate its findings in order to drive service improvements. Patient stories are also routinely embedded into the Board agendas.

[4] In July 2020, the Health Board's Transformation Steering Group produced its first Strategic Discover Report to identify initial learning from the pandemic response which can be applied to accelerate delivery of the Health and Care Strategy.

Patient safety WalkRounds

62 As with other health bodies, the formal programme of executive and independent member visits had to be stopped due to the COVID-19 pandemic. The WalkRounds are valuable in that they provide an important opportunity for independent members and the executive team to hear the views and concerns of staff and patients in an informal way. The WalkRounds are usually programmed through the year to provide sufficient coverage and opportunities. Plans are being developed to reinstate these in the coming months. Board members have, however, maintained a visible presence during the pandemic by basing themselves in various hospital settings and through visits to particular areas. For example, the Chair of the Health Board made a number of visits across sites during the pandemic to discuss the availability of support for staff well-being during this period.

Governance structures and processes

63 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.

64 We found that **the corporate leadership and structures have been strengthened and the Nursing, Quality and Patient Experience Directorate has deployed its resources very effectively throughout the pandemic. However, operational leadership, resources and arrangements for quality and safety management need further attention.**

Organisational design to support effective governance

65 **Corporate responsibility for quality and patient safety is clearly established across the Executive Leadership Team and governance structures have been strengthened with an increased focus on clinical effectiveness. However, clinical operational arrangements and resources are inconsistent and in need of further development.**

Corporate responsibility and leadership

66 There is clear collective responsibility for quality and patient safety across the Executive Leadership Team. The alignment of strategic objectives, planning objectives and quality goals to individual executive portfolios has provided greater definition of individual responsibilities.

67 The Nursing, Quality and Patient Experience Directorate provides strong corporate leadership and support for quality improvement and patient safety, including responsibility for concerns, incidents, and complaints resolution, and also in relation to patient experience. The Director of Therapies and Health Sciences is

engaged in a range of groups associated with quality improvement and safety, including as the Chair of the Operational Quality Safety and Assurance Committee.

68 Our local review of operational quality and safety arrangements at the Health Board undertaken in 2019.found that work was continuing to develop the Medical Directorate structure to provide the Health Board with stronger medical leadership across operational and professional domains. Since that time, the Medical Director has been successful in strengthening medical leadership and in developing a medical culture which is increasingly focussed on improving quality and patient safety. A team of deputy and assistant medical directors is providing medical engagement in a range of areas. There are three deputy medical directors covering operational services, and three assistant medical directors to support quality and safety, one each for transformation and value-based healthcare, quality and safety, and professional standards. These are also supported by nominated clinical leads, for example, clinical audit as referred to earlier in this report.

Corporate groups for quality governance and planning

69 The new Internal Quality Surveillance Panel (QSP) met for the first time in September 2020. It complements external and internal review processes and pro-actively identifies hot-spot areas across the organisation. The Panel membership includes senior medical staff, Deanery representatives, staff from the Quality Improvement Team, Health and Safety, and members of the Executive Team. The QSP scrutinises hard and soft intelligence from across the organisation with the intention of using it to identify areas that need improvement and support, and also to note areas of good practice.

70 The Quality Panel is led by clinical executives and focuses on addressing clinical risk. Where there is insufficient progress in addressing risks the relevant service leads attend a Quality Panel led by the Director of Nursing, Quality and Patient Experience to bring further attention to what needs to be done to mitigate the risk.

71 The Quality Improvement (QI) Leads Forum was established in late 2020 following the appointment of the Clinical Quality Improvement (CQI) Leads across operational services earlier in the year. The Forum is chaired by the Assistant Medical Director for Quality and Safety and the Assistant Director of Nursing for Quality Improvement, with the aim to establish a work programme to plan and prioritise QI activities.

72 The Effective Clinical Practice Sub-Committee was a sub-committee of the QSEAC but was stood down in 2020. It has been formally re-established as the Effective Clinical Practice Advisory Panel (ECPAP) and was constituted in January 2021. The purpose of the panel is to provide the Medical Director with assurance in relation to clinical effectiveness. It covers a number of associated areas such as the provision of guidance, application of NICE guidance, and the development of clinical policies., The Panel is developing a Clinical Effectiveness Strategic Framework which will be linked to the Health Board's strategy. It will be aimed at supporting staff to examine and improve the quality of care, by identifying and

sharing themes, and using the quality and safety structures to disseminate the learning.

Health Board Quality Safety and Experience Committee

73 In April 2020, the Board agreed temporary variations in its governance arrangements in order to support agile decision-making and to reduce unnecessary bureaucracy governance during the pandemic. The revisions included changes to committee arrangements, which increased the frequency of the Quality, Safety and Experience Assurance Committee (QSEAC) to monthly to enable an alternate focus on COVID-19 and non-COVID-19 related care. The committee has since resumed bi-monthly meetings with the chair retaining an informal catch up with the relevant lead executive between meetings.

74 Learning from the governance arrangements during the pandemic and a need to realign committees more closely to the Health Board's strategic and planning objectives led to a number of changes to the Health Board's governance structure. These were agreed by the Board in July 2021. The title of the QSEAC has been changed to the Quality, Safety and Experience Committee (QSEC) in 2021, to more accurately reflect its role to receive assurance as a committee of the Board.

Operational Quality, Safety and Experience Sub-Committee

75 Several operational quality, safety and experience sub-committees were merged into a single sub-committee two years ago. The Mental Health and Learning Disabilities sub-committee joined the arrangement more recently while keeping its own directorate meetings. The OQSEAC is a sub-committee of the QSEC and takes an exception reporting approach to risks, with cross-cutting conversations about the implications of the risks, and the use of deep dives for particular risk areas. However, the sub-committee struggles with the attendance of its medical staff members and there is a tendency for members to present issues without making suggestions as to how they might be resolved.

County-based quality and safety groups

76 The Director of Nursing, Quality and Patient Experience planned to establish county-based quality and safety groups during 2020 but this had to be postponed because of the pandemic. Work had resumed on the process to put these arrangements in place at the time of writing. The county groups are intended to provide staff with an additional learning opportunity by bringing together local quality and patient safety groups at a directorate level. The Health Board will need to ensure that the distinct roles of the different types of quality and safety groups are clear and maintained over time.

Directorate, Speciality and Department quality and patient safety groups

77 Directorate groups operate across the Health Board structure to underpin the work of corporate committees. Directorate arrangements remain variable and need further attention. The Scheduled Care Directorate (SCD) Quality, Safety and Experience Group is guided by a comprehensive terms-of-reference (adopted February 2017) and a standard agenda. The Group provides a report to each meeting of the OQSESC.

78 Our previous report on operational quality and safety arrangements highlighted the need for greater consistency of approach at an operational level. The report found that the dedicated quality and safety meetings in six of the directorates covered a good range of areas, although those directorates which combined the quality and safety agenda into their general meetings were less comprehensive in their coverage. Across all directorates, the range of discussion was not consistent or standardised. An Internal Audit Quality and Safety Governance Report also flagged this issue.

79 The General Surgery Team Group, which is part of the SCD, does not have a terms-of-reference. We had difficulty in obtaining documents for this group. We subsequently received 'actions and minutes' documents for the General Surgery Team Mortality and Morbidity Group. The notes suggest that these meetings cover a wider agenda than just mortality and morbidity. However, the notes lack detail or narrative and do not give confidence that a systematic approach is taken. We were unable to observe a meeting of the group during our fieldwork due to the infrequent and sporadic nature of the meetings.

80 The Health Board recently published a standardised agenda template and a standardised terms-of-reference for adoption by the local groups of the OQSESC although they have not been adopted across the organisation yet. This template includes a clear focus on clinical effectiveness, including clinical audit, clinical practice, clinical guidance including NICE guidance, and corporate policies relating to clinical effectiveness. However, they are based on an exception reporting approach, which necessitates that underpinning arrangements are shown to be consistent, robust and mature. We are not confident that this can always be demonstrated.

81 Some operational teams manage key aspects of quality and safety as part of monthly operational team meetings but without designating particular leads. There is good corporate support for operational teams on many issues although staff commented on that they would like more support in relation to data analytics.

Resources and expertise to support quality governance

82 **The Nursing, Quality and Patient Experience Directorate has deployed its resources effectively during the pandemic and developed innovative approaches to growing its workforce and capacity. It continues to review its**

arrangements with a focus on working together in support of quality governance.

83 The Nursing, Quality and Patient Experience Directorate is the focus of corporate resources for quality governance and improvement. The Director of Nursing, Quality and Patient Experience has developed these corporate resources over time and continues to review how they are deployed to ensure that they can respond to the evolving needs of the organisation and service users.

84 There is a good level of staff resources across Complaints Management, Incident Management, the Patient Advice and Liaison Service (PALS) and the Patient Support Contact Centre (PSCC), comprising 21.2 WTE in total. This total includes the additional resources allocated to the PALS and the PSCC to increase capacity to manage early resolution concerns and for patient enquiries.

85 The Health Board has a Quality Assurance and Safety (QAS) Team which is compromised of the Patient Safety and Assurance Team and the Quality Assurance Information System Team. The QAS Team works with directorates through a business partner model, linking with each directorate having a named senior patient safety and assurance officer. The Senior Patient Safety and Assurance Officer meets regularly with the directorate's heads of nursing (and other members of the Triumvirate if requested) to support with the quality and patient safety agenda. The Senior Patient Safety and Assurance Officer (or the QAS Team member during periods of leave) is also present at directorate quality and safety meeting. These officers can escalate matters of potential concern directly to clinical executives and also routinely provide them with information relating to quality assurance and safety. They also coordinate the provision of the regular assurance report to QSEC.

86 The QAS Team are responsible for several quality assurance activities including WalkRounds, Health Checks, Observations of Patient Care, and Quality Panels with the clinical executives. They manage the Concerns Management System (DATIX) and the management of serious incidents and nationally reportable incidents. The QAS Team are responsible for the design and the implementation of the policies, systems, and tools to enable staff to identify, assess and manage risk.

87 The dedicated Patient Experience Team (4.2 WTE, 5 staff) has experienced some changes in recent years. Four patient experience apprentices (in addition to the existing five staff) were added in 2019 with further apprentices due to start work in September 2021. This role is part of the Health Board's wider and highly successful apprentice scheme. There were over 600 applicants during the most recent round of recruitment and 56 apprentices were due to start work at the Health Board in September 2021.

88 The apprentices contribute across the work of the Patient Experience Team (PET) including:

- collection and analysis of data, including for patient surveys:
- preparing reports and communications using software and social media;

- supporting initiatives undertaken by the PET;
- collation of patient stories for video and provision of digital transcripts for the Board;
- responding to enquiries and liaising across the Health Board and beyond; and
- assisting in the organisation of patient experience team events.

89 The Team introduced a number of Family Liaison Officer posts (in addition to the five staff referred in the previous paragraph) on a temporary basis across the Health Board during the COVID-19 pandemic, which were well-received by patients, their families, and staff. These temporary posts have been extended and were being evaluated at the time of our fieldwork as part of the current review of the 'team around the patient'. If the Board gives its approval, the plan is that a family liaison and patient experience function will become operational from April 2022.

90 Away from the corporate teams, we found that the arrangements and dedicated resources for quality and patient safety vary at different levels within the organisation. The two tracer areas in our review illustrate this. In the Scheduled Care Directorate, the Head of Nursing is the designated lead for nursing, quality and experience with dedicated time to fulfil this leadership role. The Directorate also has leads for different areas of governance with dedicated time for that work. The General Surgery Team, which is part of the Scheduled Care Directorate, does not have a designated lead role for quality and patient safety.

91 Operational teams do not necessarily know which of their staff have received training on complaints, incidents and root cause analysis. At the time of our review some staff have not received training in relation to use of DATIX. However, the new DATIX system has been launched[5] and a significant programme of training is being undertaken. DATIX entries are reviewed and signed off by a local clinical lead although our survey findings indicated that staff are not always confident that the issues are investigated in line with organisational requirements.

Arrangements for monitoring and reporting

92 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.

93 We found that **the Health Board is making good progress embedding the four quadrants of harm and has set out key metrics. However, reporting of risk issues up through sub-committees and committees to the Board sometimes leads to dilution of the point being communicated, and access to quality information within directorates is limited.**

[5] The Health Board were the first to go live with the new Once for Wales Concerns system.

Information for scrutiny and assurance

94 **The Four Quadrants of Harm are being embedded systematically to guide planning and the monitoring of quality and safety. However, use and access to quality information at an operational level appears limited.**

95 The Director of Nursing, Quality and Patient Experience presents Quality and Safety Assurance Reports at each QSEC meeting. The reports provide an overview of quality and safety across the Health Board by presenting information from assurance processes and quality improvement strategies. They include thematic information regarding complaints and incidents. Additional detail is provided to in-committee sessions of the QSEC to enable a more in-depth discussion of issues.

96 The Health Board launched the Once for Wales Concerns Management System Programme on 1st April 2021 and is implementing its use across the organisation. The system aims to bring consistency to the use of the electronic tools used by all NHS Wales health bodies for that purpose. The Programme will provide the Health Board with opportunities to engage in a number of national workstreams aimed at developing consistent and effective processes and data which will strengthen the assurance that can be taken from them.

97 Implementing the Welsh Government's Four Quadrants of Harm is a significant challenge for all health bodies. We found that the Health Board is systematically adopting this approach across its system of care. It set out 21 monitoring metrics to measure the potential for harm, with a view to increasing them over time. They are monitored and reported to the Board as part of the Integrated Performance Assurance Report (IPAR). For example, the IPAR to the Board on 29 July 2021 highlighted two metrics of concern:

- A&E waits over 12 hours (category - harm from overwhelmed NHS and Social Services); and
- waiting over 36 weeks for treatment (category – harm from a reduction in non-COVID activity) and particularly for treatment by other providers.

98 The Four Quadrants of Harm were a central feature in the Health Board's Winter Plan for 2020-21, and were linked to hospital care, intermediate care and long-term care arrangements. The plan included a schedule of potential harms with more than 60 individual actions and schemes as mitigation. The plan was reported to the QSEC and monitored on a fortnightly basis for its impact on key metrics including quality and safety risks.

99 The planning objective aligned to the QSEC requires that during 2021-22 a process is to be established to maintain personalised contact with all patients currently waiting for elective care. The process should help to establish a systematic approach to measuring harm by bringing together clinically assessed harm and harm self-assessed by the patient to inform waiting list prioritisation.

100 We observed a meeting of the Scheduled Care Directorate Quality, Safety and Experience Group. The meeting was aligned to a fixed agenda which included

details of serious incidents, complaints and compliments. Although all directorates have a quality dashboard, available through IRIS, it was not reviewed at the meeting we observed. In addition, at the time of our work the Health Board were awaiting a system amendment from the Welsh Government Once for Wales Concerns Management team to enable the creation of a consistent dashboard for users in directorates and services.

101 The Quality Assurance and Information System Team (QAIST), formerly the DATIX Team, is evolving. The team (four WTE, with four staff) focuses on quality and patient safety information within DATIX rather than wider quality and safety information. Vacancies within the team have allowed for a rethinking of how resources should be used. Our survey of corporate and operational resources for quality governance showed that staff would like increased support in the use of data to help them manage their services.

Coverage of quality and patient safety matters

102 **Corporate committee agendas are well-managed, and meetings allow good coverage of the areas covered, whereas arrangements for operational groups are more variable. The reporting of risk issues up through sub-committees and committees to the Board sometimes leads to a dilution of the point being communicated. Performance reporting is being developed so that strategic objectives are more closely aligned to quality outcomes.**

103 Monthly QSEAC meetings during the pandemic provided greater opportunity to address issues arising from COVID-19 while also ensuring coverage of the Committee's regular work programme. The arrangement helped to ensure that independent members had frequent and formal opportunities to ask questions and scrutinise arrangements in a rapidly evolving crisis situation. The QSEC receives quarterly reports on improvement activities and achievements, while the Board is provided with twice yearly reports.

104 Corporate committee and sub-committee agendas are well-aligned in content and generally balanced in the coverage. Arrangements for operational quality and safety groups, as mentioned above, are more variable.

105 We found that reporting of risk issues from operational level up through the committee structure to the Board however can lead to a dilution of the message being communicated. Earlier in this report we highlighted an example of how, in our view, assurances provided to the Board did not fully reflect the persistent nature of failures to provide red-risk updates to operational risk registers.

106 Until relatively recently, primary care quality and safety matters were largely reported and managed through operational structures to the Director of Primary Care, Community and Long-Term Care (Director of Primary Care). There was limited scrutiny and assurance through the Board's committee structures. The Director of Primary Care and the Director of Operations have been working together to ensure that primary care issues become a key feature of the QSEC agenda, and they recognise that there is scope for further progress.

107 Performance reporting within the Health Board is aligned to the current national delivery framework. There is ongoing work to develop performance reports so that they can more readily help the Board and committee members to identify areas of concern. Reporting is being moved away from the use of RAG (red, amber, green) ratings towards the use of Statistical Process Control (SPC) reports on the Microsoft Power BI™ platform. They provide the capability to follow the impact of process changes over time.

108 Work is underway to look at how performance information can be split so that committees only need to consider the performance information which is relevant to their objectives. It will also establish how that information links back to the developing Board Assurance Framework through the Microsoft Power BI™ platform. A section has already been added which provides information on strategic objective outcome measures.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Effectiveness of quality and safety sub-groups R1 The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Sub-committee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should:			
a) mandate the use of the recently issued generic templates with the understanding that the agenda template is a minimum requirement which can be supplemented as appropriate;	a) The EDONQPE to reissue templates and instruct utilisation at each quality governance meeting at service and directorate meetings.	31 November 2021	Executive Director or Nursing, Quality and Patient Experience (EDONQPE)
b) issue guidance on record taking at meetings; and	b) Guidance document to be developed and issued with (R1a).		Board Secretary
c) ensure that local records are stored in a standard location to facilitate access.	c) Include within guidance document (R1b) a reminder of the importance of		Board Secretary

Recommendation	Management response	Completion date	Responsible officer
	storing of meeting papers in accordance with corporate records management policy.		
Operational leadership R2 There are inconsistent leadership arrangements at an operational level for assurance, risk, and safety across the Health Board. The Health Board should either strengthen current arrangements where staff resources for assurance, risk and safety are managed by directorates to improve consistency, or move to a model where those staff are managed centrally, ensuring that support available to the operational teams is consistent across the Health Board.	There are consistent leadership arrangements in place at operational level (acute, community and primary care) for assurance, risk and safety, however responding to the pandemic has impacted on the capacity of the leadership teams to be able to discharge all their accountabilities effectively. There has been a daily focus on managing risks across the system, however this has not always been reflected in the risks on the Datix Risk System. A review will be undertaken to enhance the capacity across operational and corporate teams to ensure a consistent approach to managing assurance, risk and safety. It is possible there will be a financial impact of the review and therefore this will need to be considered as part of the IMTP for 2022-23.	31 December 2022	Executive Director of Operations
Risk Registers R3 Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a		

Recommendation	Management response	Completion date	Responsible officer
potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by:	review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this:		
a) ensuring that operational teams clearly identify the risks for which they are responsible for and update risk registers in line with corporate policy.	a) A joint risk review process of risk registers has been instigated with each Directorate by the EDOO and EDONQPE supported by the Head of Assurance and Risk commencing in October 2021.	31 December 2021	Executive Director of Nursing, Quality and Patient Experience and Executive Director of Operations
b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	b) (i) The joint review process will be used to reinforce the role of oversight by the local triumvirate teams. The expectation that there is communication and consultation between services where there are risks and issues that may affect impact more widely will be reiterated.	31 December 2021	Executive Director of Nursing, Quality and Patient Experience and Executive Director of Operations
	(ii) Risk is now a standard item on the newly established Senior Operational Business Meeting and should identify cross directorate	Completed	Executive Director of Operations

Recommendation	Management response	Completion date	Responsible officer
	risks. The agenda will be based around the Senior Operational Business Meeting's work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from members.		
	iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	31 December 2021	Board Secretary
	iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	31 December 2021	Board Secretary
Risk Management R4 The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	31 December 2022	Executive Director of Operations

Appendix 2

Staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements: Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Delivering safe and effective care						
1. Care of patients is my organisation's top priority	18	17	2	1	-	38
2. I am satisfied with the quality of care I give to patients	17	17	2	-	1	37
3. There are enough staff within my work area/department to support the delivery of safe and effective care	1	17	9	10	1	38
4. My working environment supports safe and effective care	9	19	6	3	-	38

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
5. I receive regular updates on patient feedback for my work area / department	5	7	10	10	5	32
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients	13	18	5	-	-	36
7. My organisation acts on concerns raised by staff	9	12	9	5	1	36
8. My organisation encourages staff to report errors, near misses or incidents	8	16	5	2	-	31
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	8	16	5	2	-	31

Attitude statements	Number of staff agreeing or disagreeing with statements					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	8	19	3	3	-	33
11. We are given feedback about changes made in response to reported errors, near misses and incidents	7	15	4	3	4	33
12. I would feel confident raising concerns about unsafe clinical practice	15	12	6	5	-	38
13. I am confident that my organisation acts on concerns about unsafe clinical practice	13	9	10	2	-	34

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Working in my organisation						
14. Communication between senior management and staff is effective	5	13	11	5	4	38
15. My organisation encourages teamwork	13	16	5	2	1	37
16. I have enough time at work to complete any statutory and mandatory training	4	12	9	10	3	38
17. Induction arrangements for new and temporary staff (e.g., agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	7	11	12	5	1	36

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.