Mortality Reviews

Final Internal Audit Report

2020/21

Swansea Bay University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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1 EXECUTIVE SUMMARY

1.1 Introduction and Background

This review originated from the 2020/21 internal audit plan.

Since 2010, the health board has adopted processes to undertake reviews of all in-hospital deaths. Where prompted by responses within the initial review, a second stage review is undertaken by senior clinician. Following a number of delays, the roll out of an All Wales Medical Examiner service is due to commence from April 2021. This will shift responsibility for undertaking the first stage of the mortality review process to the Medical Examiner and his representatives, bringing an additional level of independence to the process. He will determine whether a death requires onward referral to the coroner or second stage review within the health board. Currently, the first stage review remains the responsibility of the health board and the outcome of this review stage determines whether a second stage review is required.

Previous Internal Audit reports have derived 'Limited' assurance ratings. While preparations are made ahead of the introduction of the Medical Examiner Service, there is an ongoing need for timely review of patient deaths and learning of lessons where applicable.

1.2 Scope and Objectives

The overall objective of the audit was to review arrangements in place to learn lessons following patient deaths and provide assurance to the Board.

This scope considered the following:

- Policies & procedures setting out the approach to undertaking mortality reviews and learning from patient deaths;
- Arrangements in place to ensure that all patient deaths are subject to timely completion of stage 1 reviews (Universal Mortality Review/UMR) to determine if case record review is required;
- Arrangements in place to ensure that stage 2 case record reviews are completed in a timely way;
- Arrangements for the sharing of themes and areas for improvement emerging from mortality reviews;
- Corporate arrangements to monitor and ensure the timely completion of stage 1 and stage 2 reviews, their outcomes and actions taken to improve quality; and
- Information reported to the Quality & Safety Committee to support assurance regarding the mortality review process and outcomes.

There is no nationally mandated approach to the mortality review process. This review has considered the operation of corporate systems supporting

the current approach adopted within Swansea Bay UHB. The audit approach has included an analysis of data extracted from the electronic mortality review system (eMRA), and a review of the assurances available corporately via that system and within the notes and reports of corporate meetings. ***We have not assessed processes within service groups, nor have we assessed the clinical judgments made within individual mortality reviews.***

Our audit scope considered the health board review of deaths subject to the national Universal Mortality Review and reporting process. This excludes deaths within Accident and Emergency; Paediatrics and Maternity; or Mental Health and Learning Disabilities departments.

1.3 Associated Risks

The potential risks considered in the review were as follows:

- Lessons may not be learned if the review of deaths is not comprehensive;
- Delays in completion of reviews may reduce the effectiveness of the process and lose the opportunity to act promptly where there are lessons to be learned;
- Sub-optimal practices may continue if improvements are not made where required and these are not shared more widely where beneficial; and
- There may be a lack of assurance if Board or Committees are not adequately informed of the effectiveness of the process and outcomes.

2 CONCLUSION

2.1 Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the area reviewed is **Limited Assurance.**

RATING	INDICATOR	DEFINITION
Limited Assurance		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.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

2.2 Assurance Summary

The summary of assurance given against the individual review areas is described in the table below:

					
1	Policies and Procedures.		✓		
2	Timely stage 1 reviews.				✓
3	Timely stage 2 reviews.			✓	
4	Lessons learned from reviews.			✓	
5	Corporate monitoring of reviews.		✓		
6	Quality and Safety Committee reporting.		✓		

The above ratings are not necessarily given equal weighting when generating the audit opinion.

2.3 Design of Systems/Controls

The findings from the review have highlighted **two** issues that are classified as weaknesses in the system control / design.

2.4 Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weaknesses in the operation of the designed system / control.

3 FINDINGS & RECOMMENDATIONS

3.1 Summary of Audit Findings

The health board operates a three stage process for mortality reviews. It has a good record for timely completion of stage 1 universal mortality reviews (UMRs), consistently exceeding the Welsh Government (WG) target of 95% being completed within 28 days of date of death. This stage provides an initial assessment as to whether a death warrants a more detailed review.

Performance in respect of stage 2 reviews has been poorer historically, resulting in the accumulation of a backlog of cases for review. However, by October 2020 the health board had cleared all of its historic (pre-2020) incomplete stage 2 mortality reviews from a reported 63 at January 2020. The current year's pending stage 2 position reported by management as at January 2021 shows that the majority of those outstanding for completion within 2020 relate to the most recent months. However, the health board rarely meets its internal timeliness target requiring 100% of stage 2 reviews to be completed within 60 days of date of death, and a number of cases arising from the first quarters of the year remain outstanding. Further action is required to address these.

The stage 2 review provides an assessment of probability as to whether the death was preventable. There are no written directions as to whether a stage 3 thematic review should be completed for all stage 2 reviews undertaken or whether these should be aligned to the preventability score assessed at the close of stage 2 reviews. This stage is the part of the process that records any learning identified / action taken and categorises the case thematically – it supports sharing of learning and reporting. Our examination of stage 3 reviews that were undertaken in 2020 confirmed that the approach is inconsistent across units/service groups. This highlights the need for clarity around expectations in areas such as this within formal directions.

The health board has not produced policies and procedures on the current process following the last audit review. With the Medical Examiner Service (MES) taking over responsibility for stage 1 UMRs shortly and a new electronic system 'Once for Wales' being implemented imminently, any procedure would need to reflect revised arrangements. The Interim Deputy Medical Director was working on the first draft of a mortality review framework for the new process following transfer to the MES. Our report

makes some recommendations for consideration in development of that framework.

The Quality and Safety Committee (QSC) receives regular reporting on the targets for timeliness of completion of stage 1 and stage 2 reviews via the Integrated Performance Report (IPR) and periodic update papers on mortality reviews (the last being August 2020). However, there was no evidence of the QSC receiving updates on any outcomes or actions taken arising from mortality reviews. At the time of our audit the newly developed Clinical Outcomes & Effectiveness Group (COEG) had not come into operation – this group will be an important aspect of the framework for monitoring and considering the outcomes of the mortality reviews process and informing assurances provided to the Committee. We have made recommendations aimed at improving the assurances provided.

At the conclusion of our work we identified three **high** priority findings:

- The health board does not have formal policies and procedures describing expectations in relation to the current system as recommended in our previous Internal Audit report. This may result in inconsistent practices e.g. with regard to undertaking, recording and reporting of stage 3 reviews.
- The COEG was not operational at the time of our audit or in the period preceding it. This will be the forum where it is intended that the corporate monitoring of mortality review performance, outcomes and learning will be undertaken.
- The QSC has not been provided with assurance regarding outcomes and action taken following mortality reviews. In addition to reporting on cases where learning has been identified, positive assurance where deaths are assessed as unlikely to have been preventable and there are no lessons to learn could be provided also.

The key findings by the individual objectives are reported below with full details on issues and associated recommendations in Appendix A.

3.2 Detailed Audit Findings

Objective 1: Policies & procedures setting out the approach to undertaking mortality reviews and learning from patient deaths.

The health board has not produced policies and procedures formally setting out roles & responsibilities and expectations regarding the mortality review process. However, operationally, the process is supported by an in-house Electronic Mortality Review Application (eMRA) and the Clinical Audit and Effectiveness Facilitator indicated the system is a relatively straightforward standardised three stage process with assigned responsibilities at each

stage. There is a user guide to provide step-by-step guidance on the use of the system.

The responsibility for stage 1 reviews (Universal Mortality Review / UMR) is due to be transferred to the Medical Examiner Service (MES) on 1 April 2021. This will have implications for future processes. The health board will continue to have responsibility for undertaking secondary reviews and for sharing any lessons learned or emerging themes identified from reviews. At the time of our audit the Interim Deputy Medical Director was working on the first draft of a mortality review framework which will be the suggested approach for the health board going forward, and for consideration nationally.

Our last audit of this area recommended that the Executive Medical Director review the arrangements in place within the Health Board for the conduct and use of mortality reviews and the expectations of officers within Units, setting these down within a policy as a clear reference point for future. The absence of policies could lead to inconsistent practices – for example see later findings under Objective 4 for differences between service groups regarding the completion of stage 3 reviews.

See finding 1 in Appendix A.

Objective 2: Arrangements in place to ensure that all patient deaths are subject to timely completion of stage 1 reviews (Universal Mortality Review/UMR) to determine if case record review is required.

The Clinical Audit Effectiveness Facilitator confirmed that the process is administered using the in-house eMRA system which is fed data on deaths automatically from the health board's patient administration system (PAS). Weekly e-mails are sent to key staff on hospital sites who coordinate the completion of stage 1 mortality review forms. This promotes the prompt completion of forms to ensure that the health board consistently exceeds the Welsh Government national target for stage 1 reviews to be completed within 28 days, of 95%. Our review of a data extract from the eMRA system confirmed that for 2020, 98.4% of deaths had had a stage 1 review completed within 28 days. We also note that 86.3% had been completed within and up to and including 7 days.

The stage 1 form includes five trigger questions which determines whether a stage 2 case record review is required. We analysed the eMRA data extract for each trigger question with an affirmative answer. We identified only one instance where a stage 2 review had not been triggered. This related to a death in 2014. However, this death had been referred to the coroner and as such would have had an external secondary review.

We were informed that not all questions need to be answered on the stage 1 form in order to complete the form. We analysed the eMRA data extract for completed stage 1 forms where all five trigger questions had been left blank, which could result in a stage 2 review not being appropriately triggered. We identified only 9 instances where the stage 1 form had been completed without any trigger questions being answered (the general completeness of five of these forms was very limited). These deaths occurred in 2015, 2016 and 2017 – no recent cases were identified.

This is highlighted for management information. There are no further matters arising.

Objective 3: Arrangements in place to ensure that stage 2 case record reviews are completed in a timely way.

It was reported in the performance report for October 2020 that the historic backlog of stage 2 reviews had been cleared. We analysed the eMRA data extract for all deaths prior to 2020 where a stage 2 was required but not recorded as completed on the system. This showed 16 deaths where the stage 2 review was not completed on the system – 15 of these related to 2015 and one related to 2016. We were informed that 15 had been triggered by Question 2 (which was removed as a trigger question in 2016) and one had been progressed via a Datix incident.

The Integrated Performance Report (IPR) presented at the Quality and Safety Committee (QSC) details an internal target of 100% of stage 2 reviews to be completed within 60 days. The Clinical Audit & Effectiveness Facilitator provides monthly reports to Service Group Medical Directors which detail any pending stage 2 reviews to assist with the monitoring and management of these. While this is the case, review of the IPR indicates that this target is rarely achieved.

We reviewed the pending stage 2 reports as at end of January 2021. Analysis of these indicated that at the end of January 2021 there were 60 pending stage 2 reviews. The following is noted:

Period	Stage 2 Reviews Remaining
Pre-2020	0
Jan – Mar 2020	1
Apr – Jun 2020	8
Jul – Sep 2020	12
Oct – Dec 2020	22
Jan 2021 only	17

Given that the historical backlog of prior-year reviews has been cleared and the majority remaining within this year relate to deaths that have occurred within the last 3 months of 2020 and January 2021 – it is evident that while performance targets are not being met, action is being taken to manage the completion of stage 2 reviews. While this is positive, the presence of cases outstanding from Quarter 1 highlights that additional attention is required to ensure the older reviews are cleared to prevent a backlog from growing.

We note that the responsible reviewer is not detailed on the current Pending Stage 2 Report provided to Service Group Medical Directors. This information had been manually added to reports circulated earlier in the year to assist with clearance of the backlog and could be useful to include for appropriate monitoring of older pending reviews to ensure that the health board doesn't build up another backlog.

The health board will continue to be responsible for stage 2 reviews when responsibility for UMR transfers to the MES. It is possible that the approach taken by the MES service to the initial review of deaths may result in a greater number of secondary reviews required within the health board. We acknowledge that the Interim Deputy Medical Director is developing a mortality review framework and would highlight the need to ensure clear direction is given on expectations of health board staff for the completion of this stage. In the meantime, further action is required to address the increasing backlog of cases.

See finding 2 in Appendix A. See also later section on reporting.

Objective 4: Arrangements for the sharing of themes and areas for improvement emerging from mortality reviews.

The majority of deaths within the health board are not flagged as requiring further review beyond the stage 1 review. For deaths in 2020, only 6.2% (135) of completed stage 1 reviews triggered the need for a stage 2 review – 93 in Morriston, 32 in Singleton and five in NPT. At the time of our review 83 (61.5%) of these stage 2 reviews had been completed. Only 51 of the 83 had a completed stage 3 thematic review recorded within eMRA – all these having been undertaken for one unit, Morriston.

Completion of stage 2 requires the reviewer to assess, on a scale of one to six, the preventability score for the death, these are:

1 - Definitely not preventable

2 - Slight evidence for preventability

3 - Possibly preventable but not likely, less than 50/50 but close call

4 - Probably preventable, more than 50/50 but close call

5 - Strong evidence for preventability

6 - Definitely preventable

In the absence of policy / procedures there are no written directions as to whether a stage 3 thematic review should be completed for all stage 2 reviews undertaken or whether these should be aligned to the preventability score. This could result in inconsistent approaches throughout the health board.

The health board will still be responsible for undertaking a "proportionate" review of stage 2 cases when the stage 1 UMR is transferred to the MES. We also note that the eMRA system is set to be replaced by the 'Once for Wales' system. Recognising these upcoming changes and the ongoing consideration of a revised mortality review framework, we note this as a matter for clarification within the health board.

We analysed data to assess the risk associated with the gaps in completion of stage 3 reviews. Our analysis of the eMRA data extract confirmed that for 2020 deaths, only one had been assessed as having preventability score of four or above. We analysed the entire eMRA data extract (containing data as far back as 2014) which identified that there have only been 30 cases that have been scored four or above, and of these only five assessed as having strong evidence for preventability and five assessed as definitely preventable.

We selected eight deaths, all occurring in or after January 2019, which were assessed at stage 2 as having preventability score of four or above (seven in total) and an additional death occurring in December 2018 with a preventability score of six. We reviewed the stage 3 thematic review section of the eMRA system for evidence of further review and outcome/action. All contained notes recording further review undertaken. Notes were brief, but sufficient on the most part to indicate the outcome/actions taken which ranged from discussion within directorate / wider groups, re-assessment of preventability, or the referral onwards via the serious incident reporting process. Only one had recorded potential learning points had been identified but had not indicated how they were taken forward (the case was one of the ones re-assessed as unlikely to have been preventable). It appears that those deaths assessed at stage 2 as having the greatest probability of preventability have received further scrutiny and discussion. While this is the case, there may be learning to be gained from others – the expected approach to this third stage of review is something that should be considered when developing the new review framework.

We analysed a data extract from the database beneath the eMRA system. Information on stage 3 reviews is entered across a number of separate fields within the eMRA system. This information is not readily reportable within the eMRA system reporting functionality."

See finding 3 in Appendix A.

Objective 5: Corporate arrangements to monitor and ensure the timely completion of stage 1 and stage 2 reviews, their outcomes and actions taken to improve quality.

As noted earlier, emails are provided to service group medical directors and the Assistant Medical Director to facilitate monitoring and action to improve the timely completion of stage 1 and stage 2 reviews via weekly and monthly e-mails respectively. Information provided presents the percentage of expected UMRs and stage 2 reviews completed and the total outstanding stage 2 reviews for each service group. However, there was no evidence of outcomes and actions taken being reported corporately. It was identified at the outset of our audit by the Assistant Medical Director that his review of the backlog had not identified any significant areas of concern.

Management informed us that there are limitations within the eMRA reporting functionality but that the system is due to be replaced by the 'Once for Wales' system shortly. We highlight the above so that management may consider reporting requirements as the new system is implemented.

For most of 2020, the health board has been without a corporate group whose role has included the detailed consideration of mortality review outcomes and learning. However, at the outset of our audit we were informed that the Executive Medical Director was establishing a Clinical Outcomes & Effectiveness Group (COEG) whose role, as set out in its draft terms of reference, will include the provision of assurance to the Quality & Safety Group, that *"all deaths (from April 1st 2021) are being reviewed and that lessons learned from these reviews are being used to inform Health Board and national improvement programmes"*. We reviewed the ToR for the Quality & Safety Governance Group (QSGG) and found that it did not reference the COEG as a group reporting into the QSGG yet. There will be a gap in the system of assurance for mortality reviews until this group becomes effective.

See finding 4 in Appendix A.

Objective 6: Information reported to the Quality & Safety Committee to support assurance regarding the mortality review process and outcomes.

We reviewed the agenda and papers for the QSC from January 2020 – December 2020. Monthly Quality and Safety Performance reports are presented to the committee, which includes the IPR, and these include completion rates for both stage 1 and 2 mortality reviews.

The IPRs received at every meeting of the QSC only include the in-month percentage completion rates of stage 1 and 2 reviews, and the numbers of stage 2 reviews triggered – they do not detail the total numbers

outstanding. However, the QSC received two specific updates on Mortality Reviews during the year – January and August 2020 which detailed work being undertaken to clear the historic backlog of stage 2 reviews and presented absolute figures for these. The QSC has not yet received an update on the number of outstanding stage 2 reviews within 2020. However, we note that these have been included in performance reports provided to service groups. As a new financial year approaches, it is important that the visibility of reviews remaining from both current and previous years is maintained, so that the committee has knowledge of the total number.

There is no reporting of outcomes from the reviews undertaken and we found no evidence of the QSC receiving assurance on outcomes or learning from mortality reviews. While this is noted, our review of stage 2 reviews with preventability scores of four and above did not identify any 'hotspot' areas of concern, and for the sample we reviewed in more detail, notes recorded within eMRA system indicated (briefly) how consideration had been given to matters by senior clinical staff, including discussion within service group meetings and in one instance further investigation via the serious incident investigation process. Nonetheless, it would be appropriate for the Committee to be provided periodically with assurance from management on the outcomes of reviews and, where required, actions taken by management.

See finding 5 in Appendix A.

3.3 Summary of Recommendations

The audit findings and recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**4**	**2**	**9**

Finding 1 – Policies and Procedures (Design)	Risk
The health board has not produced policies and procedures on the current system as recommended in our previous Internal Audit report. The responsibility for undertaking the stage 1 mortality reviews is due to transfer to the Medical Examiner service (MES) on 1 April 2021. This has implications for future processes. We are aware that the Interim Deputy Medical Director is drafting a mortality review framework currently for national and local consideration.	Missed opportunities to learn lessons if the review of deaths is not comprehensive.
Recommendation 1	**Priority Level**
Policy and procedures for the review of deaths should be documented formally so that expectations regarding scope, roles & responsibilities, processes, record-keeping and reporting, are clear for all. We would recommend that progress in developing the framework for the health board be included as part of ongoing mortality review reporting to the QSC.	**High**
Management Response 1	**Responsible Officer / Deadline**
The formal introduction of the National Medical Examiner Service has been delayed with no official start date at present. The process for scanning records after death across the Health Board is in pilot phase, and the Medical Examiner system is not yet fully operational locally. Consequently, the Mortality Review Framework and its associated protocols will need to be tested as the demand for higher level scrutiny increases and adapted to local and national learning. 1. The Draft Mortality Review Framework will be reviewed **monthly** at COEG and adapted as necessary. 2. Progress on this development will be reported to the QSC **quarterly**	Dr Alastair Roeves Dr Aidan Byrne (ongoing) 1. 1st May 2021 2. 1st July 2021

Finding 2 – Secondary reviews (Operation)	Risk
The health board has an internal target of 100% of stage 2 reviews to be completed within 60 days of the date of death. We reviewed the Integrated Performance Report (IPR) which confirms that the health board rarely meets this target. The health board will continue to be responsible for stage 2 reviews when responsibility for Universal Mortality Reviews (UMR) transfers to the MES. The UMR trigger questions will change which may result in a greater number of secondary reviews being required. We acknowledge that the Interim Deputy Medical Director's mortality review framework may provide the necessary process for the health board going forward. Pending Stage 2 Reports provided to Service Group Medical Directors for January 2020 did not record the names of the doctors responsible for remaining stage 2 reviews. Whilst we acknowledge that there are only 9 pending reviews (15%) from the first 6 months of 2020, including the name of responsible officer could assist in monitoring and help avoid growth of a backlog.	The health board builds-up a backlog of stage 2 and subsequently stage 3 thematic reviews. Delays in completion of reviews may reduce the effectiveness of the process and lose the opportunity to act promptly where there are lessons to be learned.
Recommendation 2	**Priority Level**
Management should ensure that in documenting its future mortality review framework it is clear on arrangements to ensure the prompt review of MES reports.	**Medium**
Additional action is required to clear earlier 2020 cases awaiting stage 2 review, to prevent another backlog build up.	**Medium**
The health board should consider including the name of the responsible reviewer on its Pending Stage 2 Report to assist service group medical directors to monitor and manage older pending reviews.	**Low**
Management Response 2	**Responsible Officer / Deadline**
1. The SBUHB Mortality Review Framework will describe how Medical Examiner concerns are to be reviewed promptly 2. Any outstanding stage 2 reviews from 2020/21 will be taken through the new SBUHB Mortality Review Framework process as test cases within Quarter 1 of 2021/22.	Dr Alastair Roeves Dr Aidan Byrne 1. Completed 2. 1st.June 2021

3. The new SBUHB Mortality Review Framework will describe close tracking of cases, centrally managed to ensure flow through the whole process is maintained	3. Completed

Finding 3 Lessons learned (Operation)	**Risk**
For 2020 deaths, 135 of the stage 1 reviews completed required a stage 2 case file review. Stage 2 reviews had been undertaken for 83 of these. A stage 3 thematic review had only been completed for 51 of these. Morriston was the only unit to have completed stage 3 reviews in 2020. In the absence of clear policies and procedures it is unclear whether a stage 3 review should be undertaken for all deaths which could result in an inconsistent approach across units.	Lessons may not be learned if the review of deaths is not comprehensive. Sub-optimal practices may continue if improvements are not made where required and these are not shared more widely where beneficial.
Recommendation 3	**Priority Level**
Management should ensure that in documenting its future mortality review framework it is clear on expectations in respect of those deaths requiring stage 3 review, the approach to sharing of any learning, and record-keeping.	**Medium**
Management Response 3	**Responsible Officer / Deadline**
The SBUHB Mortality Review Framework will define which deaths will require a stage 3 review, and how learning will be shared and recorded. The Framework will be adapted according to learning as described in *Management response 1: actions.*	Dr Alastair Roeves Dr Aidan Byrne (ongoing) 1st July 2021

Finding 4 Clear reporting lines (Design)	Risk
The Clinical Outcomes and Effectiveness Group (COEG) draft Terms of Reference (ToR) indicated that it will report to the Quality & Safety Governance Group (QSGG). The purpose of the group is to provide assurance to the Quality & Safety Committee via the QSGG and one of its objectives is to provide assurance that *"all deaths (from April 1st 2021) are being reviewed and that lessons learned from these reviews are being used to inform Health Board and national improvement programmes".* At the time of our review this group had not become fully operational. Additionally, review of the ToR for the QSGG confirmed that they did not include any reference to the COEG yet.	Sub-optimal practices may continue if improvements are not made where required and these are not shared more widely where beneficial. There may be a lack of assurance if Board or Committees are not adequately informed of the effectiveness of the process and outcomes.
Recommendation 4	**Priority Level**
Management should ensure that corporate monitoring of mortality review performance, outcomes and learning is undertaken and recorded at the COEG.	**High**
The health board should ensure that there is a clear reporting line for mortality reviews and that this is reflected in the final ToR for the COEG and the documented group reporting structure beneath the QSGG.	**Medium**
Management Response 4	**Responsible Officer / Deadline**
1. The COEG has included the monitoring of mortality reviews in its Terms of Reference and its workplan. 2. The QSGG Terms of reference will include the expectation for COEG to report into it 3. Any Mortality Review report for submission to a group or committee will describe performance, outcomes, an assessment of preventability, remedial actions and learning at Health Board-wide level 4. The COEG/QSGG will submit Mortality Review Reports every quarter to the QSC 5. The QSC Committee chair will be requested to include a report on mortality reviews at quarterly intervals	Dr Alastair Roeves. (Completed) 1. 1st May 2021 2. 1st June 2021 3. 1st May 2021 4. 1st July 2021 5. 1st May 2021

Finding 5 Quality and Safety Committee (Operational)	Risk
The Quality and Safety Committee (QSC) receives regular reports on percentage completion rates of stage 1 and 2 reviews. However, our review of QSC agendas and papers from January 2020 to December 2020 confirmed that the QSC does not receive any health board wide updates on outcomes and action taken from mortality reviews. Additionally, the last report received by the QSC during 2020/21 was in August and no others are scheduled within the work programme. This could impact the committee's ability to scrutinise management of potential backlogs.	There may be a lack of assurance if Board or Committees are not adequately informed of the effectiveness of the process and outcomes.
Recommendation 5	**Priority Level**
Reporting to the QSC should include assurance regarding any health board wide outcomes and action taken following mortality reviews, in particular following those assessed as probably preventable or greater.	**High**
The QSC should receive more frequent updates on mortality reviews and the frequency should be scheduled into the committee's work programme at the start of the reporting year.	**Low**
Management Response 5	**Responsible Officer / Deadline**
See Management Response 4	Dr Alastair Roeves (As per R4 – 1st July 2021)

Audit Assurance Ratings

 **Substantial Assurance** - 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.

 **Reasonable Assurance** - 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.

 **Limited Assurance -** 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.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, which 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.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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