End of Life Care
Final Internal Audit Report

June 2023

Swansea Bay University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Contents

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Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To assess compliance with end of life care (EOLC) quality standards.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Approval and enhancement of reporting on progress of the EOLC action plan.
- Setting specific targets and timescales to measure performance.

Our overall assurance reflects the work undertaken by the health board on EOLC. It does not provide assurance on the outcomes of future NACEL audit summary scores. We also recognise that the focus of the EOLC key priority (last 12 months of life) is different to that of the NACEL audits which address the patient's last days of life only.

We have not provided an assurance for objective 5 - at the date of fieldwork, it was recognised that digital technology has yet to be used to map compliance. Discussions remain ongoing with the Digital team to confirm the output required from the systems in place to facilitate this process.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	No previous report

Assurance summary[1]

Assurance objectives		Assurance
1	NACEL Report action plan in place.	Reasonable
2	Governance and Oversight.	Reasonable
3	Staff training.	Reasonable
4	Key performance measures.	Reasonable
5	Use of digital technology to map compliance.	N/A

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Action Plan – approval, alignment to NACEL and reporting	1	Design	Medium
2	Key performance measures	1	Design	Medium

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

1. Introduction

1.1 End of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement.

1.2 The National Audit of Care at the End of Life (NACEL) is commissioned by the Health Care Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The overarching aim of the NACEL Audit is to improve the quality of care of people at the end of life in acute, Mental Health and Community hospitals.

1.3 An update paper presented to the Quality and Safety Committee (QSC) in October 2022 detailed that "*The findings of the last NACEL audit indicated that Swansea Bay University Health Board (the health board) was achieving less than the national average in all aspects of care at end of life. It indicated that there may be delays in recognising that someone is dying, and therefore limited opportunity to address the five priorities of the dying person, and those important to them*."

1.4 End of life care has been identified as one of the health board's top five quality and safety priorities. The aim of the priority is to ensure that the population of the health board receive the right care, at the right time, and in the right place during the last year of life. It is recognised that this focus is different to that of the NACEL audits which address the patient's last days of life.

1.5 Following NACEL audits, scores are provided on a national and individual health board level. Both the national summary scores and the health board's submissions for the last four years are included in Appendix B.

1.6 As reported to the QSC (see para 1.3), the health board recognises that its performance is below the national average. The comparison of the NHS Wales acute submission NACEL scores for 2021-22 were as follows:

Organisation and submission (Acute submissions)	CDP	CFO	IDM	IPC	NFO	EOC	G	W	SC	SS	CC
National summary score	**7.9**	**7.0**	**9.5**	**7.7**	**5.6**	**6.5**	**9.7**	**8.1**	**7.5**	**6.4**	**7.3**
Aneurin Bevan University Health Board	5.8	5.6	8.8	-	-	-	10.0	10.0	6.9	5.5	6.8
Betsi Cadwaladr University Health Board	-	-	-	-	-	-	10.0	8.8	7.2	5.1	6.8
Cardiff & Vale University Health Board	6.0	7.4	8.8	7.6	-	-	10.0	8.8	6.8	5.5	6.8
Cwm Taf Morgannwg University Health Board	6.8	5.8	9.1	5.7	-	-	10.0	6.3	6.7	5.4	6.7
Hywel Dda University Health Board	6.0	5.2	9.0	-	-	-	7.5	6.9	7.7	6.1	7.4
Swansea Bay University Health Board	5.5	4.6	9.1	-	-	-	10.0	8.8	-	-	-

1.7 The potential risks considered in this review were:

- Failure to meet the needs and priorities of the dying patient and their families; and
- Failure to effectively communicate the needs of the patient in the last year of life.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	-	2
Operating Effectiveness	-	-	-	-
Total	**-**	**2**	**-**	**2**

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: The findings from the NACEL report have been reviewed and an action plan put in place to improve how EOLC is delivered.

2.3 The health board is assessed against the quality standards as part of the HQIP NACEL audit, as shown in (refer to para 1.6 and Appendix B). The focus of NACEL is on end of life care (EOLC) in an inpatient setting – it looks at the patient's last admission to hospital prior to death and assesses the care delivered against nationally agreed quality standards.

2.4 The relevant quality standards are the '*NICE Quality Standards and Guidance on End of Life Care*' and the '*Five Priorities for Care' (as outlined in 'One Chance to Get it Right')* developed by 'The Leadership Alliance for the Care of Dying People'. The five priorities for care being:

- **Recognise** - recognising that someone is dying;
- **Communicate** - communicating sensitively with them and others important to them;
- **Involve** - involving them and others important to them in decisions;
- **Support** - providing support; and
- **Plan and do** - creating an individualised plan of care and delivering it with compassion.

2.5 Following each NACEL audit, the health board has returned the required Assurance Statements (Part A and Part B) to the Welsh Government. Part A details the key national and local findings / recommendations from the last published report, which the health board needs to address. Part B describes the actions already

taken, or are in the process of being developed, to address the key findings and recommendations, including timescales and details of named leads.

2.6 As detailed in para 1.4 above, EOLC has been identified as one of the health board's top five quality and safety priorities. The health board has recently developed an action plan which details the individual actions, responsibility, start and due date, status (with updates, where applicable) and theme. It is noted that the action plan has yet to be formally approved. We were advised by management that it has been shared with the Service Groups, in the first instance, for their review and consideration. We would suggest that, as with other actions plans linked to Quality Priorities (i.e. Infection, Prevention and Control), appropriate approval is sought. See **MA1.** We also acknowledge that it will take time for actions implemented to embed to make the required improvements in NACEL scores and any EOLC performance indicators.

2.7 The action plan contains 18 actions, eight of which had a due date before our date of fieldwork completion. However, only one of these had been completed, with the remaining seven recorded as either ongoing (6 instances) or not started (1 instance relating to meeting with Digital – see audit objective 5). We noted that the action plan included clear commentary as to how actions are being managed. See **MA1**.

2.8 As detailed in the Part B Assurance statement, "*information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important*". Our review noted correlation between the key findings and recommendations arising from the NACEL report and the health board's action plan, but to be more robust and have a more informed audit trail it would be helpful to evidence the 'golden thread'. See **MA1**.

Conclusion:

2.9 We acknowledge that the recently developed action plan, in respect of EOLC, looks to address the key findings arising from the NACEL audits. Current progress has deviated from expectation, and the action plan which has yet to be formally approved does not currently include reference to the NACEL recommendations / findings. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 2: Appropriate governance and oversight arrangements are in place in respect of EOLC, and key issues are escalated and reported to Board.

2.10 The health board's governance structures in respect of quality and safety were updated during 2022, with a number of groups being replaced. The reporting framework for EOLC includes:

1. Board
2. Quality and Safety Committee
3. Management Board
4. Quality and Safety Group
5. Quality Priorities Programme Board
6. Palliative and End of Life Steering Committee.

2.11 The Board has delegated responsibility for the health board's Quality Priorities, which includes EOLC to the QSC. As detailed in para 1.3, the QSC has received a specific paper on the findings on the last NACEL audit.

2.12 Management Board meets bi-monthly. We reviewed the agendas and papers for these meetings which confirmed that it has received progress updates on the quality and safety priorities, which includes the key priority for EOLC.

2.13 As described in para 2.9 above, the governance structure for quality and safety changed in 2022. The Quality and Safety Governance Group was replaced by Quality Safety and Patient Services Group in June 2022. It then changed to the Patient Safety Group between July 2022 and December 2022, before the Quality and Safety Group was established in January 2023. These are formal monthly meetings and review of the agendas and papers confirmed that it receives highlight reports from the Quality Priorities Programme Board which have included updates on the EOLC quality and safety priority, where applicable.

2.14 The Quality Programme Board meets bi-monthly. However, no meetings were held between March 2022 and September 2022 – for one meeting a workshop was held instead for Quality Priority Leads to review measurement against the priorities and to allow members the opportunity to provide feedback; and one meeting was cancelled due to the number of apologies. As detailed in para 2.8 above, the governance structure changed and this group became the Quality Priorities Programme Board. Review of agendas and papers confirmed that it received progress reports which provided updates on activity around the EOLC quality and safety priority.

2.15 The Palliative and EOLC Steering Committee meets quarterly, or at least three times a year. The Terms of Reference (ToR) for the committee detail that "*the purpose of this Committee is to bring expertise from all parts of the Health Board and its collaborators to assist on delivering the HB's Palliative & End of Life Care agenda. Ensuring that staff have the resources to meet the needs of the population, and those important to them, regardless of age, diagnosis, circumstance or place of residence within Swansea Bay*". At the time of the audit, only two meetings had taken place, being June and December 2022.

2.16 The EOLC Quality Priority sub-group meets monthly. This group is a sub-group of the Palliative and EOLC Steering Committee, detailed above. The ToR of this sub group details that "*Representatives are responsible for ensuring that the aims of this group are taken forward within their individual service groups and that there is effective communication between both. This group provides the overarching governance and accountability arrangements for the EOLC Quality Priority*". Review of the agendas and papers for this group confirms that updates to the group have included, but not limited to, RAG rated EOLC highlight report; EOLC training work plan; 100-day plan and the EOLC driver diagram which details the aim to ensure high quality EOLC across all care settings - right care, in the right place, at the right time.

Conclusion:

2.17 There is a significant amount of reporting and meetings in respect of progress against the EOLC quality priority, with a clear reporting line to the Board. However, recognising that the recently implemented action plan (as per audit objective 1) has yet to be formally approved and the status of the actions escalated appropriately, we have assessed this objective as **reasonable** assurance.

Audit objective 3: Staff are adequately trained in the identification and management of patients approaching EOLC.

2.18 The health board's PARASOL service was developed in July 2021, following further investment into end of life care throughout the health board. The service is defined as:

- **P**erson-Centred Approach: *being proactive in early identification and acknowledgment of uncertainty of individuals in the last year to six months of their life*;
- **A**ssessment: *holistic assessment from multidisciplinary team which include physical, social, psychological and spiritual needs of the individual*;
- **R**ecognition: *possibly a person may die within days/hours is recognised, communicated and documented clearly*;
- **A**pproach: *multidisciplinary team commence All Wales Care Decisions for the last days of life and use the Symptom Control Guidance and have an individual plan of care which is tailored to the individual*;
- **S**ensitive: *communication between staff, the person that is dying and those important to the individual*;
- **O**bserve: *assess for symptoms using Symptom Assessment Sheet. Ensure anticipatory medications are prescribed and then consider contacting Specialist Palliative Care team if input and support is required*; and
- **L**astly: *continue to regularly review, re-assess and discuss with the multidisciplinary team*.

2.19 The work of PARASOL is communicated on the staff intranet, the health board's internet and its social media pages. This has included promotion of the training available to everyone on EOLC.

2.20 There is a forward-looking three year PARASOL training plan. Review of this plan shows that 13 of the 18 actions (for 2022) have been completed. The five that remain are ongoing and relate to the deployment and evaluation of the End of Life Champion Programme, including support from Quality Improvement to develop datasets, and the development of a Service Standard Operating Procedure (SOP).

2.21 Additionally, the PARASOL team have a 12-month training plan in place for EOLC. The plan details the goals, responsibility and actions taken, and this is regularly updated to reflect progress to date. The goals are as follows:

1. *Training needs analysis from ALL Clinical areas;*
2. *SBUHB - End of Life Care Champions Programme;*
3. *EOLC on ALL induction for Health Care professionals including Corporate Induction;*
4. *Develop an EOLC for mandatory e-learning; and*

5. *Increase Awareness and use of the Care Decision guidance.*

2.22 The PARASOL team trains staff to become End of Life Champions ('Champions'), with the training course addressing areas such as: what is EOL and palliative care and recognising dying and Advanced Care Planning (ACP); ethical issues at the EOL; Care decision guidance for last days of life; being comfortable about having difficult conversations with patients, Communication and Care after death service. At the date of fieldwork, a total of 408 staff had attended the EOL Champion training:

EOL Champions by service group / staff group

Attendance by service group		Attendance by staff group	
Agency	5	Add Prof Scientific and Technic (Pathology etc)	4
Care Homes	24	Additional Clinical Services (Clinical Support Staff)	82
Corporate	2	Administrative & Clerical	12
Mental Health and LD	19	Allied Health Professionals (OT, Physio etc)	29
Morriston	182	Healthcare Scientists	1
Neath Port Talbot and Singleton	106	Medical & Dental (Consultants, Doctors & Dentists etc)	2
Primary, Community and Therapies	43	Nursing & Midwifery (Registered/Qualified)	236
Swansea Local Authority	3	Other organisation	33
Third Sector	7	SBU Student	8
University	3	(blank)	1
WAST	11	**Total Champions**	**408**
(blank)	3		
Total Champions	**408**		

2.23 In addition to the EOL Champions training, bespoke training is provided by the PARASOL team, upon request. The most recent training log, details that 131 sessions have been held, covering a total of 2,479 attendees (primarily clinical staff: 2,165).

2.24 EOLC presentations have been developed by the PARASOL team for the bespoke training, and these are specifically targeted to different staff groups, including medics, registered nurses and health care support workers. The presentations reference 'One Chance to get it right' and detail the five priorities of care for the last days of life.

2.25 EOLC is a standard agenda item for staff inductions for clinical staff, and the PARASOL team are invited to attend to ensure new staff are provided with an awareness of EOLC and the wider PARASOL service.

2.26 We were informed by management the mandatory e-learning module for EOLC is being developed at an all Wales level. We understand that snapshot training was undertaken at Morriston Service Group in September 2022 to increase awareness of Care Decision Guidance that will form part of this training.

2.27 From our review of the governance and oversight arrangements (audit objective 2), the meetings considered have included updates on progress with staff training and the work of the PARASOL team.

Conclusion:

2.28 In addition to the three-year PARASOL training plan, there is a 12 month training plan in place. The health board had made good progress with the majority of actions recorded as implemented, including establishing a network of 408 Champions. Bespoke training has also been carried out and EOLC is included on the health board induction. Training materials have been produced and these make reference to the five priorities of care. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 4: Key performance measures have been identified to monitor performance.

2.29 As part of the 2020-21 NACEL audit, the health board reported that action was required on *'establishing baseline of need and performance measures to understand current position around supporting care in the last year of life'*.

2.30 A dashboard was developed by the Quality Information Manager in October 2022. The dashboard includes metrics for the health board as a whole and each of the service groups individually, being Morriston; Singleton and Neath Port Talbot (NPT); Primary, Community & Therapies (PCT) and Mental Health. The dashboard includes data, charts and commentary on the following:

Place of death ▪ *% of SBU resident deaths out of hospital: home, care/residential home, hospice or other care establishment*.	***EOLC planning*** ▪ *Advance Care Plan notifications set following a discussion with the patient about Advance Care Planning Residents in SBUHB.*
Medical Examiner review after death ▪ *Number of hospital deaths in SBUHB reviewed by the Medical Examiner Service;* ▪ *% of hospital deaths in SBUHB reviewed by the Medical Examiner office with a DNACPR;* ▪ *% of hospital deaths in SBUHB reviewed by the Medical Examiner office with a plan for end of life; and* ▪ *% of hospital deaths in SBUHB reviewed by the Medical Examiner Office with a care decision guidance document.*	***EOLC training*** ▪ *SBUHB staff booked on Champion EOLC training: attended, did not attend and future booked;* ▪ *SBUHB staff booked on Champion EOLC training per 100 staff by service group (all staff groups);* ▪ *Champion EOLC training by staff group – staff booked past and future; and* ▪ *Champion EOLC training by service group or organisation: staff booked past and future.*
Inpatient deaths ▪ *% of SBUHB hospital deaths aged 80 within 2 days of admission; and* ▪ *No. of SBUHB hospital deaths aged 80+.*	

2.31 The NACEL Part B Assurance proforma guidance note details that "*Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future must directly align with organisation's quality improvement programmes and lead to improved patient care. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important. Information from audits and reviews should demonstrate a pattern of year on year improvement*". Noting this, the dashboard could be enhanced to include metrics around performance against the five priorities for care (see para 2.4), aligned to the NACEL audit. See **MA2**.

2.32 However, we acknowledge that until the project work to use digital technology to map compliance and notification of patients requiring or receiving EOLC (see audit objective 5) is complete, it may not be possible to report on performance against these priorities of care. See **MA2**.

2.33 From our review of the governance and oversight arrangements (audit objective 2), there was evidence of performance metrics (examples include the proportion of deaths occurring outside of hospital, inpatient deaths for patients aged 80+ and within 2 days of admission, EOLC training and hospital deaths reviewed by the Medical Examiner Service) being presented at Management Board, Quality Programme Board and the EOLC Quality Priority sub-group meetings. Review of the performance dashboard identified that it currently contains a series of graphs which show the trajectories over time. This should be enhanced to include specific targets and expectations to measure performance. See **MA2**.

Conclusion:

2.34 A dashboard has been produced which includes data, charts and commentary, although we note an absence of specific targets and expectations to measure performance. Performance reporting could be further enhanced with the inclusion of metrics around performance against the five priorities for care, aligned to the NACEL audit. However, we acknowledge that due to digital developments required, there are limitations in collating the relevant information. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 5: Digital technology is used to map compliance and notification of patients requiring or receiving EOLC.

2.35 The 2019-20 NACEL review included the recommendation '*put in place systems and processes to support people approaching the end of life to receive care that is personalised to their needs and preferences'*. The health board has recognised that they need to establish a digital solution that captures this information.

2.36 One of the identified outcomes of the EOLC key priority: *Develop the use of digital technology to map compliance and notification of patients who require or receiving EOLC*, is for SIGNAL, the Swansea Bay Patient Flow solution, to be adopted in all clinical areas. We were informed that there has been a delay in releasing the latest version of SIGNAL, which only went live at the end of March 2023. This has impacted the inclusion of the EOLC requirements within the system.

2.37 The health board also recognises that the requirements are wider than the focus on SIGNAL, which is currently a secondary care system. We understand that there is intention to meet with the health board's Digital Projects & Development Team to discuss the needs for EOLC and how they can further support these developments. Updates have been provided to Management Board from the QSG regarding issues with digital intelligence and recording of EOLC planning.

2.38 We were informed that the primary objective is to be able to record all conversations (including between health care staff and with patients and their families) across the various systems, depending on the clinical service, and the appropriate sharing of information between services to ensure everyone has access to the right information to deliver appropriate and effective care for the patient.

Conclusion:

2.39 Given the impact of the delays in development of SIGNAL, it is too early to provide assurance on this objective. However, we recognise that the health board has compiled a list of priorities for the EOLC digital solution to deliver.

Appendix A: Management Action Plan

Matter Arising 1: EOLC Action Plan – approval, alignment to NACEL and reporting (Design)	Impact
Following each of the NACEL audit cycles, the health board has returned the Part A and Part B Assurance Statements to the Welsh Government, as required. Part A details the key national and local findings / recommendations from the last published report which the health board needs to address. Part B describes the actions already taken, or are in the process of being developed, to address the key findings and recommendations with timescales and details of named leads. The health board has recently developed an EOLC action plan which details a total of 18 actions. It is noted that the action plan has yet to be formally approved. We were advised by management that it has been shared with the Service Groups, in the first instance, for their review and consideration. Eight of the actions had a due date before our date of fieldwork completion. However, only one of these had been completed, with the remaining seven recorded as either ongoing (6 instances) or not started (1 instance, relating to the development of a digital solution for which management are awaiting engagement from the Digital team – see audit objective 5). Within this action plan, we were unable to see the 'golden thread' between the key findings and recommendations arising from the NACEL report detailed in the proformas returned to WG. Part B of the Assurance pro-forma details "*information demonstrating there has been a comprehensive review of report findings which are **clearly** feeding into local action plans is important*". We recognise that that the focus of the EOLC quality priority and action plan (being the last 12 months of life) is different to that of the NACEL audit, which addresses the patient's last days of life.	Potential risk of: • Failure to demonstrate the link between the NACEL findings with the EOLC action plan.

Recommendations	Priority
1.1 Following consideration by the Service Groups, in line with other health board quality priorities, the action plan should be approved by an appropriate forum with ongoing updates of progress against target to the same. 1.2 a) Management should review the 'due dates' within the action plan to ensure they are achievable and managed appropriately.	Medium

b) The EOLC Action Plan should include a cross reference to the NACEL audit, to demonstrate the linkage between the NACEL findings and the health board's local action plan.

Management response		Target Date	Responsible Officer
1.1	Agreed. Review of existing action plans to ensure that it is cross-referenced to the revised goals, methods and outcomes of the NACEL audit and has clear achievable actions with realistic timescales, presented to QP Programme Board	September 2023	SRO EOLC QP
1.2	Agreed. a. and b. See 1.1 response	September 2023	SRO EOLC QP

Matter arising 2: Key performance measures (Design)	Impact
The Part B Assurance proforma, which is completed by the health board and returned to the Welsh Government following the results from the NACEL audit, details that "*Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future must directly align with organisation's quality improvement programmes and lead to improved patient care. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important. Information from audits and reviews should demonstrate a pattern of year on year improvement*". As part of the 2020-21 NACEL audit, the health board reported on the Part B pro-forma that action was required on '*Establishing baseline of need and performance measures to understand current position around supporting care in the last year of life'*. A dashboard was developed by the Quality Information Manager in October 2022 - the first dashboard being presented to Management Board in November 2022. The dashboard includes metrics for the health board as a whole and each of the service groups individually, being Morriston; Singleton and NPT; PCT and Mental Health. This included data and charts on metrics such as *Place of death*; *Inpatient deaths*; *EOLC planning*; *Medical Examiner review after death*; and *EOLC training.* Review of the performance dashboard identified that it currently contains a series of graphs which show the trajectories over time. There is an absence of specific targets and expectations against which performance can be measured. In addition, the dashboard does not include metrics around performance against the five priorities for care being; 'Recognise', 'Communicate', 'Involve', 'Support' and 'Plan and do'. However, we acknowledge that until the project work to use digital technology to map compliance and notification of patients requiring or receiving EOLC (see audit objective 5) is complete, it may not be possible to report on performance against these priorities of care.	Potential risk of: • Failure to demonstrate a pattern or year on year performance.

Recommendations	Priority
2.1a The health board should develop performance measures that are aligned to the five priorities of care and the NACEL Action Plan. 2.1b Baseline positions and performance targets / timescales should be defined within the performance measures.	Medium

Management response	Target Date	Responsible Officer
2.1a (i) Identify gaps in existing data which are required to align our measures to the five priorities of care and NACEL action plan; and	July 2023	Director of Digital

	(ii) Present plan to Quality Priority Programme Board with timescales for implementation of measures	September 2023	Director of Digital
2.1b	Establishment of baseline within one month of measures being available.	November 2023	Quality Improvement Data Manager

Appendix B: Extract of Key Metrics Report

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland. NHS Benchmarking Network have been commissioned by HQIP to provide NACEL.

There are three components to the NACEL audit, including case notes reviews and surveys from both service users and staff. The health board has historically only undertaken case note reviews, hence the nil return for staff confidence (SC), staff support (SS), care and confidence/culture (CC), needs of families and others (NFO); and families and others experience of care (EOC). The 2022-23 NACEL audit will be the first time that the health board will undertake all three components.

The table below shows the scores from the health board's audit submissions for the last four years and how it compares against the national average:

	2018-19		2019-20		2020-21		2021-22	
	National summary score	SBU Submission summary score	National summary score	SBU Submission summary score	National summary score	SBU Submission summary score	National summary score	SBU Submission summary score
Recognising the possibility of imminent death **(RD)**	9.1	8.3	Not included	Not included	Not included	Not included	Not included	Not included
Communication with the dying person **(CDP)**	6.9	5.4	7.8	6.5	7.9	5.5	7.9	5.5
Communication with families and others **(CFO)**	6.6	6.0	6.9	5.9	7.0	4.6	7.0	4.6
Involvement in decision making **(IDM)**	8.4	7.2	Not included	Not included	9.5	9.1	9.5	9.1
Needs of families and others **(NFO)**	6.1	-	6.0	6.3	5.6	-	5.6	-
Individual plan of care **(IPC)**	6.7	-	7.2	4.4	7.7	4.8	7.7	-
Families and others experience of care **(EOC)**	7.1	-	7.0	7.7	6.5	-	6.5	-
Governance **(G)**	9.5	-	Not included	Not included	9.7	10.0	9.7	10.0
Workforce / specialist palliative care **(W)**	7.4	-	7.4	-	8.1	8.8	8.1	8.8
Staff confidence **(SC)**	Not included	Not included	Not included	Not included	7.5	-	7.5	-
Staff support **(SS)**	Not included	Not included	Not included	Not included	6.4	-	6.4	-
Care and Confidence / Culture **(CC)**	Not included	Not included	Not included	Not included	7.3	-	7.3	-

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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