Meeting Date	18th April 2019	**Agenda Item**	**5.4**
Report Title	Audit & Assurance Assignment Summary Report		
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Presented by	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Freedom of Information	Open		
Purpose of the Report	To advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports.		
Key Issues	The Audit Committee looks to other Board Committees to monitor the effectiveness of action taken in response to risks and issues raised in internal audit reports. Key audit reports for Quality & Safety Committee consideration are: • Nursing Quality Assurance • Clinical Audit and Assurance		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • **NOTE** the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management. • **CONSIDER** any further information or action required in respect of the subjects reported.

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. INTRODUCTION

The purpose of this report is to advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports to support monitoring of action and the provision of assurance to the Board.

2. BACKGROUND: REPORTS ISSUED

Since the last meeting of the Quality & Safety Committee the following audit assignments have been reported:

Subject	Rating[1]
Internal Audit	
Clinical Audit & Assurance (ABM-1819-022)	
Nursing Quality Assurance (ABM-1819-027)	

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

Audit report findings and conclusions are summarised below in Section 3. A full copy of the report can be made available to Committee members on request.

Actions have been agreed with Executive Directors in respect of audit recommendations made for Final reports issued. Progress against agreed actions is input into an online database by lead officers and visible to Executive Directors for monitoring. The Director of Finance's team analyses and summarises the status for Audit Committee meetings as a matter of routine.

Audit & Assurance undertake follow-up reviews on key issues within areas deriving limited assurance ratings as part of its agreed plan of work for subsequent years. Additional follow up reviews may be undertaken at the request of the Audit Committee. The timing of follow up work is planned in liaison with Executive Directors.

[1] Definitions of assurance ratings are included within Appendix A to this report

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 CLINICAL AUDIT & ASSURANCE (ABM-1819-022)

Board Lead: Executive Medical Director

3.1.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

The Healthcare Quality Improvement Partnership (HQIP) defines clinical audit as *"a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."*

Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

An internal audit review of clinical audit arrangements was deferred by the Audit Committee in January 2018, pending revisions to arrangements then in place. A revised policy was approved in February 2018 setting out Health Board expectations regarding the organisation of clinical audit activity. More recently, discussions at the Audit Committee and Quality & Safety Committee indicated a desire amongst Board members for improvement in the assurances on the quality of care via clinical audit. Additionally, the development of a formal Board Assurance Framework is likely to look to clinical audit as a key source of assurance in the future. Arrangements are currently subject to review by the Executive Medical Director, supported by the Director of Corporate Governance.

The overall objective of this audit was to review the management of clinical audit, including how it is used by Committees of the Health Board to demonstrate improvement and support assurance.

The audit scope included a review of the following:

Roles, Responsibilities and Resources

- There is a nominated lead clinician with responsibility for clinical audit across the whole organisation;
- Clinical leads for clinical audit/quality improvement are in place at Unit level with dedicated time for this activity;
- There are resources in place for the management & administration of the audit programme.

Programme Planning

- There is a planned programme of clinical audit, which has been agreed at Board Committee and/or senior management level;

- Clinicians, managers and service users/patients have been consulted/engaged in the development of the programme;
- Arrangements are in place to engage clinicians, managers and service users/patients during the development of the programme, and to ensure health board priorities are considered alongside national requirements;
- Audit proposals are registered, reviewed and approved in accordance with policy to ensure that each has clear improvement aims & objectives and a named lead responsible for delivery.

Programme Delivery
- Progress against the planned programme is reported and monitored effectively by corporate and Unit management;
- Arrangements are in place to ensure that the outcomes of all planned audits are clearly reported, providing assurance or identifying action where improvement is required;
- Arrangements are in place to ensure action is agreed and implemented, and improved outcomes achieved (eg follow up audit).

Board Assurance
- The planned programme and subsequent progress of delivery is reported regularly to the Board and/or appropriate Committee(s);
- The Board and/or nominated Committee are provided with assurance on the outcomes of audits, and/or improvements made in response to them.

In undertaking this audit, we also considered the relevant requirements of the current policy and compliance with it corporately and at Unit level. However, we were aware that the corporate structures in place for the governance of clinical audit are currently undergoing change. We reviewed the revisions made to the design of clinical audit arrangements during the audit fieldwork and considered this within our final assurance opinion, the effectiveness of those arrangements was excluded.

3.1.2. Overall Opinion

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.

At the outset of this review the Interim Deputy Medical Director recognised that the quality of clinical audits was not up to expectation and that from clinical audit work completed the improvements made have been difficult to determine but general medical consensus is the improvement delivery is negligible. Also, the Interim Deputy Medical Director indicates that issues

have arisen with some mandated National Audits not being completed properly.

The Interim Deputy Medical Director also raised concerns regarding the effectiveness of clinical audit in improving clinical practice being hampered by the data collection process, a proportion of the National Audits completed having had limited clinician input, and the reduction in the number of audit days in 2018.

The Chair of Audit Committee has also expressed concern with Clinical Audit and the reports and assurances presented at Audit Committee meetings.

Steps are being taken to address these issues. The Organisational Strategy and IMTP have been updated and the Clinical Audit Plan is in the process of being re-written. Additionally the Executive Medical Director is reviewing the end to end process.

There was evidence that the National Clinical Audit Programme was the main focus for Clinical Audit, administered and supported by the Clinical Audit and Effectiveness Team within the Medical Directors Directorate. Local Unit Clinical Audit Programmes were not the key focus of the work of the Clinical Audit and Effectiveness Team although Policy requires the recording of Local Clinical Audit in the Health Board's Clinical Audit Register.

However, there was a variation in approach and process adopted by Units in the production of Unit Clinical Audit Programmes, the approval of plans and the management of the overall Unit programmes. As a result, the assurances arising from this work reported to the Health Board through the Quality & Safety Committee and Audit Committee was limited.

The following have been identified for further action:

- The Units should have a planned programme of clinical audit in place to coordinate audit activity;
- Units should have a Clinical Audit Group (or group whose role includes clinical audit) ensuring outcomes of all planned audits are clearly reported, provide assurance or identify action where improvement is required;
- Audit proposals should be registered, reviewed and approved in accordance with policy.

As noted earlier the Executive Medical Director has begun reviewing processes. He acknowledges that revised arrangements are required for corporate oversight of national audit plans and collation of Delivery Unit responses, with updates being provided to DUs and executives regularly. In addition, Delivery Unit annual audit plans and reporting need to be strengthened. He has agreed that a scoping exercise will be undertaken to establish the resource available to complete and monitor audit work; and this will be used to inform the future model. The target date for this action is September 2019.

3.2 NURSING QUALITY ASSURANCE (ABM-1819-027)

Board Lead: Director of Nursing & Patient Experience

3.2.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

In 2014, an independent review into aspects of care and practice at the Princess of Wales and Neath Port Talbot Hospitals were undertaken by the Dementia Services Development Centre (DSDC) and The People Organisation (TPO) at the request of the Minister for Health and Social Services in the Welsh Government. Amongst its findings the review reported examples of basic failings in the standard of nursing care.

In response, the Health Board embarked upon a significant programme of cultural change and quality & safety improvement, and commenced the development of ward to board assurance framework. The introduction of the 'Matron' role was one such change, one of the responsibilities of the role being undertaken regular audits / spot check audits for professional assurance relating to the expected standard and quality of care.

The Healthcare Inspectorate Wales continues to review care at ward level, and following its unannounced visits it has made further recommendations to improve aspects of care and the quality of record keeping.

The Health Board has a number of policies & procedures setting out record keeping requirements in support of high quality, safe care. In particular, the Record Keeping Policy for Nurses (Oct 2016) sets out the responsibilities of Matrons/Senior Nurses with respect to the conduct of regular checks of nursing documentation including risk assessments, care bundles and plans. Additional policies set out further responsibilities with respect to assuring management of quality & safety on wards eg Policy for the Management of Controlled Drugs (Dec 2016).

In April 2017, following a pilot within Morriston Hospital, the Quality & Safety Committee was presented with a report describing a proposed Quality Assurance Framework including an Ideal Ward/Team Toolkit. The tool kit and assurance framework had been developed in line with the health and care standards domains.

The intention was to deliver it via a multidisciplinary peer review approach. To support this peer review it was also recognized that an electronic ward to board dashboard was required to present a consistent data set of quality metrics.

An update paper in June 2018, reported that following the launch of the Quality Assurance Framework, a further pilot year had concluded with two further Service Delivery Units (Singleton and Neath Port Talbot) and work had been undertaken to adapt the toolkits for use in other specialist areas. It indicated that the Framework was in a position for full implementation, with a view to undertaking annual reviews on all wards, with additional ones

where required. A plan had been developed for the implementation of an information dashboard across the Health Board (it was live on 5 wards at NPT) to support provision of intelligence to review teams, for identifying outliers and performance reporting. Some of the information areas within the dashboard remained in development and timescales for rollout were still to be agreed following an evaluation of the implementation at Neath Port Talbot Hospital.

The overall objective of this audit was to review the role and effectiveness of the Matron in undertaking Quality Assurance audits at ward level.

The audit focused firstly on the implementation of the Quality Assurance Framework (QAF) where implemented within acute units. In areas where this was not fully operational, we considered any equivalent, alternative arrangements in place (though we did not review all of these in detail). The audit also considered the checks required by the Health Board policies and their inclusion within the QAF. Our review of the QAF coverage of these checks has been supplemented by unannounced substantive testing of those checks in a small number of areas sampled at two hospital sites.

The audit scope consisted of the following control objectives:

- Units have a programme of checks designed to provide assurance in respect of the quality of nursing care, environment and equipment across all care environments;
- Checks comply with the requirements of key Health Board policies and address key issues raised by external reviews.
- Records are maintained of checks undertaken and of the person(s) undertaking them;
- The effectiveness of assurance is promoted by the independence of reviewers;
- Progress, outcomes and action agreed are monitored within Unit quality & safety governance arrangements

3.2.2. Overall Opinion

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.

The Quality Assurance Framework provides a structured basis from which to derive ward to board assurance. Our review of its content indicates that it is a comprehensive tool overall and has potential to demonstrate assurance with a good level of independence. However, the QAF alone may

not be responsive enough to provide assurance on areas of current concern quickly. Additionally, discussions with Units suggest that it is a challenge to administer and this is supported by a number of inconsistencies in record-keeping. We have recommended that the approach be reviewed by unit and corporate senior management to ensure that it is sustainable and meets local and corporate needs. Key findings for consideration include:

- The QAF was originally introduced with the intention of covering all wards areas at least once during a year. This will prove challenging for some Units noting previous coverage and the likelihood of recurring pressures as winter approaches. There is no corporate mechanism operating yet to monitor whether all areas of need are covered sufficiently. Unit Directors are positive in respect of the intent of the QAF approach, but some expressed concern regarding the ability to administer it within their current resources. It is possible the continued development and rollout of the ward-to-board dashboard will assist ease some burden, but the difficulties of coordinating a multi-disciplinary teams to undertake the work may continue to be challenging.

- With the expectation of one QAF visit per ward per year, the full approach is not responsive to issues highlighted during the year eg HIW inspections. Whilst Units are free to use individual toolkits as they see fit in between the main, full QAF visits, this aspect of the approach is not coordinated centrally, so the opportunity to provide quick, consistent assurance on such issues – and to demonstrate lessons learnt across the whole of the Health Board – is not being grasped. Additionally, these supplementary checks are undertaken with a reduced level of independence and are not expected to be reported corporately for assurance purposes.

- Our supplementary testing at a sample of wards, reviewing controlled drugs and resuscitation trolley checks – both areas where HIW inspections have found repeated issues, have found areas of poor compliance with expected controls / record-keeping.

- Whilst toolkits were provided for most themes on wards we sampled, a small number were missing. Additionally, some toolkits provided did not include the names of staff who completed the toolkits; and some appeared to include the incorrect names, or content relating to different wards. As currently implemented the toolkit documents do not provide a reliable record.

Action has been agreed with the Director of Nursing & Patient Experience to be completed by the end of July 2019.

4. RECOMMENDATION

4.1 The Committee is asked to note:

- **The internal audit findings and conclusions**
- **The exposure to risk pending completion of agreed management actions**

4.2 The Committee is asked to consider:

- **Any further information or action required in respect of the subjects reported, to support monitoring and assurance.**

APPENDIX A

AUDIT ASSURANCE RATINGS

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	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	 - + Yellow	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	 - + Amber	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	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.