Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Public Health Wales NHS Trust

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Summary report

About this report

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

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

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether organisational governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Public Health Wales NHS Trust (the Trust) carried out between August and November 2021. To test the 'floor to board' perspective, we examined the arrangements for the New-born Hearing Screening Programme.

Key messages

6 Overall, we found that **the Trust is committed to improving its quality governance arrangements. Current arrangements are effective but could be better coordinated to ensure consistency and share learning. Better demographic information in GP records could significantly improve the Trust's understanding of the equity of its screening services.**

7 It is important to note that we conducted our review when the Trust (alongside the rest of NHS Wales) was operating in Emergency Response Enhanced mode which impacted on several programmes of work that had started before the pandemic. Our Structured Assessment 2021 found that the Trust had good oversight and monitoring arrangements to manage key strategic and operational risks.

8 The Trust has a strategy and implementation plan to develop its approach to quality, safety, and improvement. The Strategy has recently been subsumed into a broader 'Quality as a Business' Strategy. The implementation plan includes work to define outcome measures for its high level priorities. As it develops specific measures, the Trust could consider how to involve users in reviewing the quality and safety of services. Depending on the information it wants to monitor, the Trust may need to review its data analytics capacity and capability. There are gaps in the Trust's arrangements to assure senior management that operational risks are being managed, largely due to different parts of the business using different risk management systems.

9 From our observations at Board and committee meetings, and our interviews with staff we saw a positive organisational culture and a clear commitment to improving the quality and safety of services. We also identified individual positive examples where the Trust has listened to user feedback and adapted its services as a result. However, a lack of some demographic information within GP records limits the Trust's understanding of the numbers of people eligible for its adult screening programmes and uptake in relation to inequity and inequality. As a result, it cannot know whether its engagement activity translates into a higher uptake of its services from its target audience to reduce inequity.

10 The Trust recognises that implementing its Quality and Improvement Strategy will require significant, sustained commitment and investment. As such, the first year of the plan to implement the Strategy includes baselining activity to understand current and future resource requirements to deliver the Trust's ambitions. There could also be opportunities to use existing resources differently.

11 The Trust's structures and processes generally support the delivery of quality, safe and effective services. However, the Trust must ensure that its processes join up across different divisions and centrally. In implementing the Quality and Improvement Strategy, the Trust aims to better coordinate its clinical audit and quality improvement work. The Trust is currently assessing the staff resources needed to deliver the ambitions in the Strategy, and more broadly in the Quality as a Business Strategy. It must also ensure that staff have time to complete statutory,

mandatory, and other relevant training to deliver their work. As a priority, the Trust must ensure it complies with targets on staff appraisals. There is also room for improvement in some of the Trust's operational controls to provide assurance that new policies are shared and used appropriately. Need to make reference to the fact that these were in place before COVID and radical changes and focus over the last two years mean we need to back track to go forward.

12 The Trust has good arrangements for monitoring the performance, quality and safety of its services supported by clear, timely information. However, there are opportunities to improve the flow of information to the Quality, Safety, and Improvement Committee from its sub-groups. The Trust continues to explore ways to improve the quality and breadth of performance data to understand and improve services and provide assurance on quality and user safety.

Recommendations

13 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Equality Impact Assessments (EIAs) R1 Weaknesses in the Trust's approach to conducting, sharing, and responding to equality impact assessments limit its ability to deliver quality services that meet the needs of the population. The Trust should strengthen its approach to equality impact assessments by: a. Ensuring EIAs are completed where necessary. b. Agreeing quality standards and a process to assess EIAs, ensuring they are meaningful assessments with appropriate actions to mitigate adverse impacts. c. Developing a central repository to store and share EIAs across the organisation. d. Developing a process to monitor implementation of mitigating actions.

Recommendations

Risk management

R2 The Trust does not have a clear picture of what operational risks are being carried in different parts of the business or how they are managed. Staff in some areas use different risk management software and resources are under pressure. The Trust is halfway through developing confidence levels for the controls in its strategic risk register. The Trust should strengthen its risk management arrangements by:

a. Prioritising implementation of its Risk Development Plan.
b. Continuing to develop systems to assure the quality of controls in the strategic risk register and consider the best forum to share the information.
c. Ensuring consistent software is used to manage risk across the business.
d. Review resources for risk management including the breadth of the Chief Risk Officer's portfolio of work, and whether operational staff have protected time for risk management.

Clinical audit

R3 The Trust does not have central oversight on the quality and totality of its clinical audit programme. It does not have a clear picture of how well the programme links to quality and safety risks, key themes arising from the programme, or whether actions to address recommendations have been implemented. The Trust should strengthen its clinical audit arrangements by:

a. Creating a central repository to store and share all clinical audits, either in the quality hub or elsewhere.
b. Developing a system to track and report progress implementing the recommendations of clinical audit to the Quality, Safety, and Improvement Committee.
c. Developing a process to link the clinical audit plan more clearly to operational, corporate, and strategic risk registers to demonstrate that audits are mapped to key quality and safety risks.
d. Collating themes arising from the clinical audit programme and sharing with the Quality, Safety, and Improvement Committee. Future clinical audit plans should provide assurance that themes are being investigated.

Recommendations

Staff appraisals and training

R4 Compliance with staff appraisals has been consistently below the Welsh Government and Trust's internal target and has recently deteriorated further. Similarly, training compliance falls below the Trust's target, largely because of difficulties providing face to face training in safe environments. The Trust should ensure compliance with staff appraisals and statutory and mandatory training meets the national target within the next 12 months.

Policies and procedures

R5 The Trust does not know whether its directorates have appropriate processes for updating and sharing policies, procedures and Standard Operating Procedures or to test compliance with them. The Trust should strengthen its management of policies, procedures, and written control documents by:

a. Developing a process to update and share policies and procedures at directorate level with staff.
b. Monitoring staff awareness of new or updated policies and procedures.
c. Testing compliance with new or updated policies and procedures including the Putting Things Right Procedure and All Wales Concerns policy.
d. Providing assurance to the Quality, Safety and Improvement Committee that new and updated policies and procedures are being used by staff.

Recommendations

Service user and staff feedback

R6 The Trust does not routinely and consistently collect information about the protected characteristics (under the Equality (Wales) Act) of its users, or of people taking part in research surveys. It does not consistently share learning from staff and user feedback or consistently let people know what changes it made as a result of their feedback. The Trust has invested in the CIVICA system to improve its approach to user feedback. More broadly, the Trust should strengthen its approach to user and staff feedback by:

a. Developing and implementing the CIVICA system and a consistent approach to capture information on the protected characteristics of service users and respondents to research surveys.
b. Developing an approach to combine feedback from staff, service users, complaints, incidents, and compliments to create a more robust picture of the quality and safety of services.
c. Developing mechanisms to inform service users about the impact their feedback has had on service improvement.
d. Including service user feedback in deep dives for the Quality, Safety, and Improvement Committee.
e. Developing an approach to sharing learning from engagement with staff and users through the implementation of the Quality as a Business strategy.

Sub-groups of the Quality, Safety, and Improvement Committee

R7 The terms of references for the Quality, Safety and Improvement Committee do not include its sub-groups. Sub-groups currently report by exception reducing the level of assurance that the Committee can take that these sub-groups are functioning effectively. The Trust should revise its terms of reference of the Quality, Safety, and Improvement Committee to include its sub-groups and reporting mechanisms. In doing so, it should ensure that the Committee has oversight of the breadth of material covered by the sub-groups and key themes or issues arising from discussions.

Detailed report

Organisational strategy for quality and patient safety

14 Our work considered the extent to which there are clearly defined priorities for quality and safety and effective mitigation of the risks to achieving them.

15 We found that **the Trust is committed to improving its approach to quality, safety and improvement and recognises it will need additional staff resources to deliver its ambitions. The Trust has good risk management arrangements but should ensure operational risks are reported consistently across the business to improve central oversight.**

Quality and safety priorities

16 **The Trust has clear corporate and operational priorities for ensuring the quality and safety of its services. It wants to better embed quality, safety, and improvement across the organisation via its Quality as a Business Strategy and other enabling strategies. As it implements the strategy, there are opportunities for the Trust to better integrate its approach to delivering its equality duties and to involve service users in developing and reviewing quality and safety indicators.**

17 The Board approved the Trust's Quality and Improvement Strategy 2021-30 in May 2021. In 2022, the Strategy was subsumed into a broader 'Quality as a Business' Strategy. During the development of the Quality and Improvement Strategy, Officers and non-Executive Directors assessed the Trust as 'foundational' in its approach because it needs significant commitment and incremental investment to develop a more mature approach to quality and improvement. The Strategy set out high level priorities for quality, safety, and improvement in four areas: become a high performing organisation, be quality and improvement driven, create the conditions to enable quality and improvement, and be a learning organisation.

18 The Trust had a three-year plan to implement the Quality and Improvement Strategy with clear milestones for delivery. Much of the work in year one focused on assessing current resources to implement the strategy and identifying gaps in skills and personnel. The implementation plan also included work to determine indicators to measure performance against the priorities in the Strategy. The Trust now plans to deliver actions in the plan and develop performance measures in the broader context of the Quality as a Business Strategy.

19 An important part of the Strategy aims to better embed quality and improvement across the Trust's business. It sets out links with the Trust's Operational Plan, People Strategy, and integrated governance model[1]. The first year of

[1] Integrated governance is about joining up systems, procedures and reporting to better embed good governance across organisations. Our Structured Assessment Phase two report gives more detail on the Trust's model.

implementation includes work to understand potential linkages across the business. For instance, the quality team is currently meeting other parts of the organisation to promote the benefits of quality improvement and understand how they can integrate and support other teams. The Trust's integrated governance model continues to evolve alongside implementation of the Operational Plan and Quality as a Business Strategy.

20 As the Trust works to integrate quality and improvement across its business, it should consider how to better integrate its approach to delivering its equality duties into strategic planning (see **Recommendation 1**). In particular, our work found weaknesses in the Trust's approach to conducting, sharing, and responding to equality impact assessments which limit its ability to deliver quality services which meet the needs of all parts of the population. We found that there is no process or staff resource to check whether equality impact assessments have been completed, or to check the quality of the assessments themselves. There is no central repository to store and share assessments and no process for monitoring whether actions to mitigate impact on parts of the population are carried out.

21 Some other health bodies[2] have developed policies and procedures to assess the potential impact their decisions may have on service quality via quality impact assessments. We found positive examples where the Trust assessed the risks associated with changing or suspending its services. However, it does not routinely or consistently assess the potential impact of its decisions on the quality of services. Moving forward, the Trust should consider ways to assess the potential impact of its decisions about service change so it can plan effectively to mitigate potential adverse impact.

22 The Trust involved its staff in the development of the Quality and Improvement Strategy but, due to the constraints of the pandemic, did not directly involve service users. However, the Trust's engagement approach: Our Approach to Engagement includes work to develop its approach to learning and improvement through user feedback. As the Trust implements the Its Quality as a Business strategy and approach to engagement, there are opportunities to consider how to involve service users in the development and review of quality, safety, and improvement measures.

23 The New-born Hearing Programme has an action plan and accountability framework which set out their specific quality and safety priorities The priorities are reviewed annually by the Quality and Clinical Governance group which includes health professionals and patient representatives from primary, community and secondary care, and the third sector. Priorities and Screening Performance Activity Reports (SPARS) for the New-born Hearing Programme changed to reflect infection, prevention control measures and the suspension of community clinics between March and August 2020 in response to COVID-19. As a result, the Group agreed a new priority for the programme to follow up babies who were not

[2] Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards.

screened as a result of clinic closures. Most recently, the Group reviewed the priorities in September 2021. More broadly, the screening division has delivery and improvement priorities such as supporting learning and development which are agreed by the division's senior management team and tailored for each programme. See **paragraphs 74 to 79** for more information about monitoring performance.

Risk management

24 **The Trust has good arrangements to identify and manage operational and corporate risks but varying use of Datix limits central oversight of operational risks across the business.**

25 The Trust's Risk Management Policy was updated and approved by the Board in November 2020. The policy sets out high level roles and responsibilities and structures for risk management. Executive and divisional directors are responsible for reviewing their risk registers and ensuring that mitigation plans are in place. Datix is the risk management system used across the screening division. Within the New-born Hearing programme all staff are trained to record clinical and non-clinical risks on Datix. Managers, assistant managers, and programme coordinators are trained to compile risk registers and run reports.

26 Risks to the New-born Hearing programme are discussed as a standing agenda item at team meetings and at Quality and Clinical Governance Group meetings to give a broader, system view of risk. Programme risk registers are reviewed monthly and escalated via risk reports to the divisional management team if the likelihood or impact of the risk increases beyond target tolerance. Eight risk reports were shared with the divisional management in the last year. We identified examples in the programme where new risks were identified and appropriate controls put in place. For instance, the programme risk register was updated to reflect the suspension of clinics (see **paragraph 21**).

27 Our Structured Assessment Part 2 report 2021 found that the Trust has good arrangements to identify, manage and report risks via its corporate and strategic risk registers. Our review of quality governance arrangements found that the New-born Hearing Programme has good arrangements to identify, monitor and escalate risks. However, there is a gap in assurance because the Chief Risk Officer and Executive team do not have a clear picture of what operational risks are being carried in different parts of the business or how they are managed, largely because not all staff use Datix (see **Recommendation 2**)[3]. We heard that staff find Datix difficult to use and are using a mixture of Microsoft Word and Excel which means that information on risk is not available in one place for senior management oversight. The Chief Risk Officer and team currently aim to manage the gap in

[3] All staff in the Newborn Hearing Programme and the broader screening division use Datix.

assurance with regular meetings with relevant managers to review operational risks. The Trust aims to strengthen its oversight of risk management by implementing its Risk Development Plan (see **paragraph 27**).

28 The Trust's annual review of its risk management systems in 2021 described the lack of one consistent risk management system across the organisation as a challenge. The review also highlighted limited resources to manage risk. In particular, the Chief Risk Officer has a large portfolio of work including information governance. Increased requests under the Freedom of Information Act during the pandemic and data protection impact assessments have increased workload further. The Trust is reviewing its information governance workforce requirements to understand whether it needs to invest in additional staff. We also heard that although many staff are trained in risk management, many are too busy as a result of ongoing pressures responding to the pandemic and recovering services. The Trust approved a Risk Development Plan in February 2022 to improve its approach to risk management.

29 The Trust's strategic risk register includes a specific risk on the quality and safety and effectiveness of its services[4]. The Quality, Safety and Improvement Committee regularly reviews the Trust's controls to mitigate the likelihood and potential impact of risk two occurring. The Trust has also added a risk relating to preparedness to implement the Quality and Engagement Act, Duty of Quality to the Corporate Risk Register.

30 In 2019, the Trust started further developing its strategic risk register to indicate the level of confidence the Board could have in the controls for each risk. Development was paused to respond to COVID-19 but will resume as part of the Risk Development Plan. More broadly, the Trust has also started considering what level of information is needed to give its board and committees assurance that risk is well managed. As it implements its Risk Development Plan and refreshes its strategic and corporate risk registers, the Trust should consider how it will assess the strength of its controls, and the most appropriate place to share the assessment (see **Recommendation 2**). Clinical audit is a key control, source of assurance and way of identifying risk but we found weaknesses in the Trust's approach (see **paragraph 36**).

Organisational culture

31 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Trust is promoting a quality and safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are

[4] The wording of the risk changed during 2022 as part of the Trust's review of its strategic risks but retains a focus on quality and safety.

integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

32 We found that **the Trust has embarked on an ambitious journey to embed quality and improvement across its services, programmes and functions. Moving forward, it must ensure it has staff resources, integrated processes for clinical audit and quality improvement, and meaningful information about service users. The Trust should also prioritise improving compliance for staff appraisals and statutory and mandatory training and raise the profile of its raising concerns policy and Putting Things Right policy amongst staff.**

Quality improvement

33 **The Trust intends to review staff resources and strengthen clinical governance arrangement as part of the Quality as a Business Strategy. It has invested in a dedicated officer to coordinate the Quality and Clinical audit programme but there are currently gaps in assurance in the plan demonstrating how it is informed by key risks to users and staff and whether recommendations have been implemented.**

The approach to quality improvement

34 The Trust has a small, dedicated Quality team comprising one trained Improvement Advisor. It is currently training a second person to support the team and has recently completed baseline information on improvement resources to inform its investment decisions on additional resources. It also intends to build the capability of existing staff in improvement approaches and methodologies to support individual teams.

35 Improvement Cymru is one of the Directorates in the Trust and will be leading the implementation of the Quality as a Business Strategy and organisational approach to improvement. Improvement Cymru will support staff development through the 'Improvement in Practice' education and training and where appropriate access to the Gold network of improvement coaches available through the Improvement Cymru website. In addition, the Trust's Quality team provides some bespoke support to teams in relation to quality and improvement work they are trying to achieve. Such as outcome measures, building logic models, process mapping etc, available support is limited by capacity in the team. Staff from both Improvement Cymru and the Quality team were redeployed to support the COVID-19 response until August 2021 which also restricted capacity.

36 The Quality as a Business Strategy aims to better embed quality and improvement in the planning and delivery of services because currently, the Trust does not have a strategic approach to planning its improvement programme. Projects are chosen on an ad hoc basis where resources allow and learning is not shared widely. To strengthen quality and clinical governance arrangements, the Trust intends to triangulate corporate and performance data with complaints, concerns, and

incidents to understand areas where improvement is needed and can make an impact. It also plans to establish an Improvement hub to increase capability in improvement across the organisation with access to guidance, tools and learning from improvement projects.

37 The screening division and programmes within it do not have dedicated improvement leads which, as with other parts of the Trust, limits quality improvement in the division. Nonetheless, we heard examples of improvement activity based on user feedback and engagement with the broader population (see **paragraph 48** on user experience). The Trust recognises there may be gaps in its capacity to support quality improvement initiatives is assessing its resources part of Quality as a Business Strategy.

Clinical audit

38 Quality and Clinical audit is an important way of providing assurance about the quality and safety of services. In the New-born Hearing programme, we saw positive examples where clinical audits were identified based on risk and recommendations implemented. Learning from clinical audit is shared across the programme team and screening division in some instances but not consistently shared with the broader organisation. Until recently, the Trust had no dedicated central resource for quality and clinical audit. Individual teams were, and continue to be, responsible for identifying and conducting quality and clinical audit activity and the Quality Nursing and Allied Health Professionals Directorate is responsible for the organisational approach to quality and clinical audit, coordinating and developing the quality and clinical audit plans, and reporting progress to the Executive team and the Quality, Safety and Improvement Committee. There are plans commenced to strengthen our overall approach to Quality and Clinical audit. Some clinical audits were delayed during the pandemic, particularly due to staff resources.

39 There are gaps in the Trust's central oversight of quality and clinical audit (see **Recommendation 3**). Most, but not all clinical audits are included in the clinical audit plan, but the Trust does not have a clear picture of the totality of clinical audits across the organisation. It does not have enough information in the plan to demonstrate that the audit programme is based on the key risks to users and staff, or whether recommendations have been implemented. The recommendations of clinical audits in the clinical audit plan are included in the progress and annual reports to the Quality, Safety, and Improvement Committee but the information is in embedded links and not easy to read. The Committee does not have a system for tracking the Trust's progress implementing the recommendations of clinical audit. In addition, the Trust does not have a consistent process The Trust does not currently collate or share the themes arising from clinical audit but is exploring ways to do so as part of wider improvement work in quality and clinical audit.

40 From February 2021, the Trust employed a dedicated officer to coordinate and strengthen its approach to quality and clinical audit. The work will also consider

whether to create a central repository of quality and clinical audits to share learning and good practice. Creating a central repository also has the potential to improve oversight of the quality and clinical audit programme. It will also seek to address inconsistencies in the Trust's processes to assure the quality of its clinical audit programme, and to identify areas for follow up audit work.

Values and behaviour

41 **The Trust is committed to embedding its values and behaviours framework across its business but must do more to improve compliance for staff appraisals and statutory and mandatory training.**

42 As part of this review and our structured assessment work, we observed Board and committee meetings and interviewed staff and non-Executive Directors. We observed an open, learning culture that could be further improved with better integration particularly by better linking learning from staff and user feedback and the Trust's approach to delivering its equality duties to improvement activity across the organisation. The Trust's integrated governance model and Quality and Improvement Strategy both aim to improve integration and share learning. Positively, the latest NHS Wales staff survey[5] shows that very few of the Trust staff who responded to the survey experienced bullying, harassment, or abuse by a manager, another colleague, or member of the public in the last 12 months (8%, 12%, and 8% of respectively).

43 Our survey revealed a positive picture in relation to the culture around reporting errors, near misses or incidents and raising concerns[6]. Unfortunately, the low response to our survey means it unlikely to be representative of the Newborn Hearing Programme or more broadly. From its own work, the Trust is aware there are parts of the organisation where staff do not feel able or confident to report errors, near misses or incidents. The Trust is working to improve organisational culture and support staff to report issues as part of its Quality as a Business Strategy.

44 The Trust updated its values and behaviours framework at the end of 2019 and is currently incorporating the framework into its organisational processes including recruitment and staff appraisal. The Board approved the new People Strategy in January 2020. The Strategy has a strong emphasis on ensuring culture and values

[5] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission. The survey response rate was 22%.

[6] We invited operational staff working across the new-born hearing programme to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. The estimated response rate is 14%. Although the findings are unlikely to be representative of the views of all staff across the new-born hearing programme, we have used them to illustrate particular issues.

are a key part of staff's lived experience[7]. The Strategy includes actions to measure and monitor organisational culture, supporting staff and managers to embed organisational values and building a psychologically safe organisation where people are confident to raise ideas and concerns (see **paragraph 44** on raising concerns).

45 As the Trust starts to embed its values and behaviours framework, it must improve compliance for managers completing annual appraisals and updating ESR software (see **Recommendation 4**). The quality and safety of healthcare depend on those who deliver it. Annual appraisals are therefore a key, but not the only part of understanding the skills, knowledge and support needs of the workforce. There are many other aspects of the Trust's approach to ensuring its staff have the skills and support they need to deliver safe, quality services[8]. Two internal audits identified issues with compliance in the Trust's 'My Contribution' process. In May 2020, Internal Audit gave the Trust's appraisal process limited assurance when compliance was at 73%. The follow-up review, in January 2021, gave the Trust reasonable assurance and noted some improvement in its approach. However, at 61% in October 2021, compliance has deteriorated and is still below the Welsh Government target (85%) and the Trust's internal target (90%). Compliance is even lower in the screening division where 54% of staff have had their appraisal in the last year. Low compliance during the pandemic is likely to reflect the Trust's decision to prioritise regular contact with its staff to ensure wellbeing over compliance with formal appraisals.

46 Statutory and mandatory training is important for ensuring staff and service user safety and yet at 87% in October 2021, training compliance with core competencies falls short of the Trust's target. 85% of staff in the screening division have completed statutory and mandatory training in the last 12 months. Two of the seven staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training whilst two disagreed or strongly disagreed[9]. Providing face to face training has been particularly challenging during COVID-19 and the Trust is looking at providing online training and small group training that meet infection prevention controls requirements where possible. The Trust should continue to explore ways to deliver essential training to ensure compliance with national training targets (see **Recommendation 4**).

47 The Trust's Board Secretary is responsible for implementing the All Wales Raising Concerns (whistleblowing) policy and works with the People and Organisational Development team to decide whether concerns fall under whistleblowing or

[7] The Trust uses the terms 'lived experience' and 'psychologically safe' in its Quality and Improvement Strategy.

[8] Including training, and informal conversations about quality and safety.

[9] Three staff neither agreed nor disagreed that they have enough time at work to complete statutory and mandatory training.

grievance policies. The Trust includes information on its staff intranet about how to raise a concern but does not actively promote the policy or importance of raising concerns amongst staff. Officers told us that in the past few years no whistleblowing concerns have been raised. However, the Trust cannot be sure that the lack of reported concerns means concerns do not exist because it does nothing to understand awareness of the policy and procedure amongst its staff. The Trust is currently reviewing its approach to the All Wales Raising Concerns policy. As it updates the approach, the Trust should do more to promote the policy and ensure that staff know how to report a concern (see **Recommendation 5**).

Listening and learning from feedback

48 **The Trust has good arrangements to collect staff and user feedback within the screening division but central resources for user experience are limited. It plans to use Civica to more systematically collect and report user feedback and share learning. The Trust must also continue to work with the Welsh Government to improve the demographic information in GP records to help it measure population take-up of screening services. Staff resources to investigate concerns are under pressure.**

Service user feedback

49 As part of our work, we asked the screening division about the mechanisms used to seek user and staff feedback and how the learning from this feedback was disseminated. The division collects feedback from service users via surveys and feedback forms on its website. The division's Head of Nursing chairs the divisional service user experience group where actual feedback is discussed along with the mechanisms for collecting it. There are also individual examples of the Trust engaging with users or potential users of screening services to improve or manage changes to its services. Before the pandemic the New-born Hearing programme collected videos of user stories which were shared with staff and relevant screening networks. More broadly, the Trust is working to create a single user experience system across the organisation and has recently invested in a digital platform called Civica and intends to start using it in 2022. Going forward, the Trust anticipates that Civica will make it easier to record and analyse user feedback, including producing videos.

50 The Trust currently has one corporate post dedicated to service user experience: the Engagement and Collaboration Manager. Central resources for user experience have been under pressure because the Manager has been supporting the Trust's COVID-19 response.

51 The screening division has a dedicated engagement team who work with communities and specific groups to understand and address barriers to participation in its programmes. For example, the team continues to work with transgender and non-binary people to improve breast and cervical screening

programmes. The team has also led ‘walkthroughs’ with specific groups to understand how users with protected characteristics under the Equality Act (Wales) 2010 experience its clinics which led to improvements such as new leaflets to make them more accessible. The screening division also has a dedicated email address for user feedback which is copied to the division’s director giving senior management oversight of feedback and staff response times. There may be opportunities to better share learning from the screening engagement teams work, including feeding back the results of engagement activities and techniques to engage effectively.

52 Learning from screening engagement activity is shared within the division and some screening networks, and sometimes with the Quality, Safety, and Improvement Committee but not consistently across the whole organisation. The Committee also has regular deep dives to give insight and share learning on how screening programmes are working. User experience has not been part of the deep dives during COVID-19. There are opportunities to better share learning from engagement with staff and users as the Trust develops its quality hub. When resources and infection prevention measures allow, the Trust should reinstate service user feedback into deep dives for its committees (see **Recommendation 6**). We identified some positive examples where service users were informed of the impact their feedback had – such as the ‘you said, we did’ section in the Annual Quality Statement. However, officers recognised that the Trust could be better at ‘closing the loop’ to let people know how it listens and responds to feedback (see **Recommendation 6**). The Trust could also improve its evaluation of the quality and effectiveness of its engagement activity, particularly its impact on take-up of its services.

53 A key part of service user engagement is about understanding who does and does not use services and whether user experiences differ depending on gender identity, age, ethnicity, sexual orientation or whether they have a disability or life limiting illness. However, like much of NHS Wales, the Trust does not currently collect information to understand the demographic profile of its users against the protected characteristics in the Equalities (Wales) Act. As a result, it cannot measure equality of access to its services, identify parts of the population who are not participating in its programmes, or measure whether its efforts to encourage certain groups to participate are successful. The Trust is concerned that collecting potentially sensitive demographic information directly from people attending screening services may dissuade people from using its services. Also, because GP records do not include some demographic information, the Trust cannot accurately identify the number of people eligible for its screening programmes. The Trust’s National Director of Public Health Knowledge and Research is exploring ways to improve the information on GP records with the Welsh Government.

54 More broadly, the Trust does not have a consistent approach to including questions to understand the protected characteristics of respondents in its research activities. There are also opportunities for the Trust to improve the

information it collects on protected characteristics through user surveys and its research programme (see **Recommendation 6**).

55 Before the pandemic, the Trust used a quarterly service user experience group to share good practice and provide oversight of activity across the organisation. The group stopped meeting during COVID-19 and has not yet resumed. The Trust is currently establishing an experience and learning group to replace the service user experience group. The new group which will develop the approach to service user engagement informed by the Quality and Engagement (Wales) Act 2020.

Feedback from incidents, complaints, and compliments

56 The Trust has arrangements to record incidents, complaints and compliments arising from the delivery of its services. It is currently updating its Putting Things Right policy and procedure to create one overarching policy with three distinct strands: complaints, incidents, and redress. The Trust has a central concerns team that provides training and support to staff to use Datix to record incidents and complaints. The team currently comprises five full time equivalent staff. In the last financial year, the Trust invested in a new dedicated lead role for Putting Things Right and Concerns.

Across the organisation, 34 staff are trained to investigate complaints, 106 to investigate incidents and 38 to do root cause analysis. However, many staff have additional duties associated with the COVID-19 response and recovery, which limits their availability to investigate concerns. At the same time, the number of reported concerns increased during COVID-19, particularly in relation to delayed screening activity. Increased workload has reduced the concerns teams' ability to deliver concerns training to additional staff. Learning from complaints is shared with the Quality, Safety and Improvement Committee in the annual Putting Things Right report and quarterly updates. For quarter two 2021, the Trust met national targets for timely acknowledgement of complaints but missed the 30-day response time target for three complaints during the period.

Feedback from staff

57 The Trust engages with its staff via the NHS Wales staff survey, regular pulse surveys during the pandemic and specific projects such as staff focus groups in 2021 to develop the Trust's strategic priorities. Within the screening team, staff give informal feedback during team meetings, reviews of incidents or complaints, and in summer 2020 as part of an improved ways of working project. Staff feedback is shared with the division's senior management team and relevant screening networks. Directorates develop action plans to understand and address issues in staff surveys and progress is monitored by the People and Organisational Development Committee.

58 85% of screening staff who responded to the NHS Wales staff survey in 2020 strongly agreed or agreed that they would be happy with the standard of care

provided by the organisation if a friend or relative needed treatment. This compares considerably higher than the wider Trust staff response (68%). However, only 52% of screening staff strongly agreed or agreed that team members take time out to reflect and learn. Most staff responding to our survey (six out of seven) agreed or strongly agreed that they receive regular updates on patient feedback for their work area.

Governance structures and processes

59 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

60 We found that **the Trust's structures and processes generally support effective governance with plans for further improvement. The Trust should ensure it has sufficient staff resources and that staff are suitably trained to carry out their duties.**

Organisational design to support effective governance

61 **The Trust's organisational design supports good governance and plans to create a Quality and Improvement Board and quality hub have the potential to improve coordination and share learning across the business. The Trust could do more to test compliance with new policies.**

62 The Executive Director of Quality, Nursing and Allied Health Professionals and the National Director of Health Protection and Screening Services/Executive Medical Director have joint responsibility for quality and clinical governance. Each has specific responsibilities for quality and safety which are set out in schemes of delegation and reservation of powers. There are designated leads for quality and safety at division and programme level within Screening and Microbiology. Operational roles and responsibilities are set out in relevant policies and procedures. In the Public Health Services Directorate accountability and governance for quality and safety are managed at both a divisional and directorate level. The microbiology and health protection division has a quality and safety group responsible for overseeing performance, quality, and safety. In screening services, each screening programme has a programme board or/and a quality board.

63 Our review of arrangements in the New-born Hearing programme found that there are good lines of accountability between the programme, screening division, the Business Executive Team, and the Quality, Safety, and Improvement Committee. Governance arrangements for the New-born Hearing programme include representatives from different parts of the network for supporting parents and babies via the Quality and Clinical Governance group. The group monitors performance against service standards and quality and safety priorities monthly via Screening Performance Activity Reports (SPARs). SPARs are reviewed at the

programme's quarterly quality and safety meetings, and at fortnightly screening division management meetings. All heads of programme attend the meetings and present updates to the management team and Director of Screening Services. The Director of Screening regularly presents updates on the performance, quality, and safety of services to the Trust's Business Executive Team and at every meeting of the Quality, Safety, and Improvement Committee.

64 The Trust provides assurance to the Quality, Safety, and Improvement Committee that its policies are up to date via a policy register. It also provides regular assurance that patient safety alerts and notices are being managed effectively via alerts reports. However, the Trust does not know whether its directorates have appropriate processes for updating and sharing updated policies or to test compliance with them. The Trust revised its policy for policies, procedures and other written control documents but paused work to communicate and test compliance with the policy due to COVID-19. The Trust must provide assurance that its staff are aware of new policies and procedures and are complying with them (see **Recommendation 5**).

65 The Quality, Safety and Improvement Committee also receives annual assurance on the Trust's compliance with the Health and Care standards. In 2021, the Trust identified areas for improvement in its approach to assessing compliance against the standards, including integrating its assessment with quality improvement and clinical audit processes.

66 The concerns team conducts quality reviews to assess whether investigations into incidents comply with the Trust's Putting Things Right procedure. In the future, the team would like to extend its quality reviews to cover the complaints process (see **Recommendation 5**). Responses to complaints are reviewed and approved by the Executive Director of Quality Nursing and Allied Health Professionals, the Executive Director responsible for the service area in question and then by the Chief Executive for final sign off. The sign-off process provides Executive oversight and ownership of complaints.

67 Within the New-born Hearing programme, either the New-born Screening Manager or Clinical Programme Coordinator investigates complaints and incidents, depending on the nature of the concern. Learning from complaints and incidents is discussed at programme meetings, divisional senior management meetings and at relevant training events. We also identified positive examples where learning from incidents was shared with networks beyond the screening division, although this is not done routinely (see **Recommendation 6**). All staff responding to our survey either agreed or strongly agreed that communication between staff and senior management is effective and that the Trust acts on concerns raised by staff.

68 The Trust's organisational design is evolving as it implements the Quality and Improvement Strategy. It recently set up a cross-directorate Quality and Improvement Board to agree and oversee the Trust's annual quality improvement development programme. The Board is chaired by the Executive Director of Quality, Nursing and Allied Health Professionals. It meets monthly and held its

inaugural meeting in December 2021. The Trust is also developing plans for a quality improvement hub to share learning and develop improvement skills.

69 The Trust made some changes to its governance structures during the pandemic including using virtual operational, board and committee meetings, and more regular Quality, Safety, and Improvement Committee meetings. It will continue with the more frequent committee meetings. The New-born screening programme found that attendance at some meetings increased due to the virtual format and will consider continuing with some virtual meetings in the future.

Resources and expertise to support quality governance

70 **The Trust is assessing its staff resources to support quality improvement to inform a business case for investment. The Trust should also ensure staff have time to complete statutory and mandatory training.**

71 The Trust currently has a small central resource to support quality governance[10]. However, there are designated leads for individual aspects of quality governance within divisions and individual teams. The Trust has also delivered training to support operational teams including aspects of risk management and putting things right. However, staff capacity to put training into practice is limited due to additional COVID-19 or recovery work (see **paragraphs 25 and 47**). The pandemic has affected corporate teams' ability to support other parts of the business. The Trust recognises it may have gaps in certain areas and is currently assessing its capacity in quality improvement, engagement, information governance and risk management to inform business cases for more staff resource.

72 The pandemic also had a significant impact on the Trust's Infection, Prevention Control team because all routine work was suspended to focus on COVID-19. However, the corporate lead for infection prevention control continues to meet with operational teams on a needs-led basis and routinely, and more regularly when required. Representatives from across relevant areas of the organisation attend the corporate Infection Prevention and Control group on a quarterly basis which reports as a minimum an annual report to QSIC.

Arrangements for monitoring and reporting

73 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

[10] There are five whole-time equivalents (WTE) in the Concerns team, one WTE for user experience, one WTE in clinical audit, 1.5 WTE in risk management and two WTEs in the quality improvement team. The Trust has one WTE for Infection Prevention Control but provides support to the NHS through its wider Health Care Associated Infection and Antimicrobial Resistance team.

74 We found that **the Trust has clear information for scrutiny and assurance and good coverage of quality, safety, and improvement at operational, corporate and board level.**

Information for scrutiny and assurance

75 **The Trust has clear information on the quality and safety of its services and continues to seek ways to improve the quality and breadth of information to understand, improve and assure.**

76 At a corporate level, information about the quality, safety and performance of the Trust's services is included in its interactive performance assurance dashboard and supporting report which are received by the Business Executive Team and Board. The dashboard includes the latest information on incidents, complaints and claims across the organisation. The Trust has assessed the quality of the data itself as 'bronze' level and intends to improve data quality as it implements the Once for Wales Complaints Management System. It is also working with Datix users to improve compliance with data entry procedures which also affects data quality. In November 2021, the Quality, Safety, and Improvement Committee discussed how they can use the performance dashboard in meetings to improve scrutiny.

77 The Trust's corporate analytics team produces the performance assurance dashboard. Officers within the Trust's Quality, Nursing and Allied Professionals directorate analyse quality and safety data and are exploring ways to better use the data to identify trends and monitor compliance.

78 Information on the numbers of complaints, compliments and incidents and performance against response time targets is included in the annual Putting Things Right Report and quarterly updates to the Quality, Safety, and Improvement Committee. Prior to the pandemic, the Committee also received information and regular deep dives on user experience, but the focus on user experience has varied during 2020 and 2021. Once the pressures of COVID-19 subside, the Committee intends to include more consistent focus on user experience, which will be incremental as the benefits of the Civica system are realised. In addition, the Trust regularly shares themes arising from complaints in its integrated performance report to the Board. In the future, the Trust plans to triangulate Putting Things Right information with service user and staff feedback for a more robust picture of quality and safety (see **Recommendation 6**). There are also opportunities to share learning from complaints, compliments, and incidents more routinely via the quality hub.

79 We observed officers providing clear reports and verbal presentations to the Quality, Safety, and Improvement Committee. Members of the Committee provide helpful, robust scrutiny in meetings. Before the pandemic, the Board Business Unit was developing an annual programme of site visits for the Committee. The Unit planned to host Committee meetings at different Public Health Wales sites to give Committee members chance to meet frontline staff and understand delivery in

person. Most Committee members continue to attend meetings virtually whilst some attend in person at the Trust's offices. Throughout COVID-19, the Trust's Chair, Vice Chair/Chair of the Quality, Safety and Improvement Committee, Chief Executive and other Executives have done site visits to various parts of the business.

80 At operational level, divisions have datasets on performance, quality and safety which are monitored at divisional and directorate level. The screening division uses SPARs to monitor each screening programme.

Coverage of quality and patient safety matters

81 **Coverage of quality and user safety at the Trust's operational, corporate groups, and at the Quality, Safety and Improvement Committee is good but the Trust should tighten structures for its sub-groups to report to the Committee.**

82 We found that the coverage of quality and safety matters in the New-born hearing programme is good. Quality and safety are a standing agenda item in new-born management team meetings and are the specific focus on quarterly quality and safety meetings. The programme is also represented at the Trust's operational quality and safety group.

83 The Trust's Quality, Safety and Improvement Committee has a clear remit in relation to the oversight of quality and user safety. Committee agendas have a strong focus on the quality and safety of services, with useful insights into key areas of business via deep dives. Since the onset of COVID-19, the Committee has had a clear focus on the indirect impact of COVID on its screening programmes, especially for screening programmes which were suspended for parts of 2020. As such, the Committee has received papers and presentations on the Trust's assessment of risk associated with suspending its screening programmes. Since then, it has received regular updates on progress recovering screening backlogs. The Committee chair provides a report to the Board at every meeting setting out key areas of work covered by the Committee. The Committee also provides an annual report to the Board. More broadly, the Trust continues its programme of work to understand and report the direct and indirect harms associated with COVID-19.

84 The Quality, Safety and Improvement Committee reviewed its terms of reference in February 2021. However, the terms of reference do not set out sub-groups of the committee or arrangements for sub-groups to report into the committee.

85 The terms of reference for both the infection prevention control and the safeguarding groups were reviewed in 2021. Both terms of reference explain that the sub-groups provide support to the Quality, Safety and Improvement Committee reporting risks and issues by exception. The Committee receives an annual corporate safeguarding report and an annual infection prevention control report. The reports explain the Trust's management of safeguarding and infection

prevention control and the role of the sub-groups. However, the Committee does not receive regular information from its sub-groups reporting items discussed by the group. As a result, the Committee cannot assure itself that its subgroups are effective or whether there are gaps in assurance. The Trust should clarify the structure and relationships between its sub-groups and the Quality, Safety, and Improvement Committee (see **Recommendation 7**). In the past, the Committee also had a service user experience sub-group, but the group has been suspended throughout COVID-19 as it is in the process of being reinstated as the refreshed Experience and Learning Group.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
R1 **Equality Impact Assessments.** Weaknesses in the Trust's approach to conducting, sharing, and responding to equality impact assessments limit its ability to deliver quality services that meet the needs of the population. The Trust should strengthen its approach to equality impact assessments by: a. Ensuring EIAs are completed where necessary.	The importance and value of Equality Impact Assessments in supporting quality services that meet the needs of the Welsh population is understood. This is currently a high priority issue as we realise the importance of enhancing the current arrangements to help the organisation meet the needs of the Socio-Economic Duty. There is a cross-organisational working group currently reviewing the tool for completing impact assessments, with the view to integrating various impact assessments and readying the organisation to develop a digital tool. This tool will support		

Recommendation	Management response	Completion date	Responsible officer
b. Agreeing quality standards and a process to assess EIAs, ensuring they are meaningful assessments with appropriate actions to mitigate adverse impacts. c. Developing a central repository to store and share EIAs across the organisation. d. Developing a process to monitor implementation of mitigating actions.	staff to engage with and complete the Equality Impact Assessment process. Currently there is limited dedicated resource to support staff in the organisation to complete these. We are scoping improved support for staff to ensure they are completed in a meaningful way and actions are monitored and completed. This will take into consideration the recommendation that a central repository is held to store EIAs, which was already planned as part of the ongoing implementation of the Socio-Economic Duty. In addition, we are launching an Engagement & Experience Network for colleagues across the organisation who have responsibility for designing and delivering our services, programmes and functions. There will be opportunity in the workplan of this network to further develop the capability of staff to complete Equality Impact Assessments to a high standard, including ensuring that the public's voice is at their centre.		

Recommendation	Management response	Completion date	Responsible officer
	• Scope and agree the solution • Implement the agreed solution	March 2023 March 2023	The Executive Director Team
R2 **Risk Management.** The Trust does not have a clear picture of what operational risks are being carried in different parts of the business or how they are managed. Staff use different risk management software and resources are under pressure. The Trust is halfway through developing confidence levels for the controls in its strategic risk register. The Trust	We are in the process of rolling out the first year of the Risk Management Development plan which is based upon the aim of strengthening risk management and delivering a consistent approach to risk management across the organisation and from Board level down through Directorates and Divisions. Specific actions include: • A revised Board level risk appetite against organisational priorities as the basis for an aligned and embedded system of establishing risk appetite across the Trust. • Risk management embedded as a standard agenda item in relevant meetings across the organisation.		Executive Director Quality, Nursing and AHPs

Recommendation	Management response	Completion date	Responsible officer
should strengthen its risk management arrangements by: a. Prioritising the implementation of its Risk Development Plan. b. Continuing to develop systems to assure the quality of controls in the strategic risk register and consider the best forum to share the information. c. Ensuring consistent software is used to manage risk across the business. d. Review resources for risk management including the breadth of the Chief Risk Officer's portfolio of work, and whether operational staff have protected time for risk management.	• Revised and improved schedule and presentation of the Corporate and Strategic Risk Registers at Executive, Committee and Board levels. • Establish the role of the Leadership Team in Corporate and Directorate Risk Management. • Work in partnership with the Planning Team to embed risk management into the DaDD in all Directorates. In implementing the Risk Management Development Plan, focus will also be placed on the quality and effectiveness of controls within the Strategic Risk Register, the Corporate Risk Register and Directorate Risk Registers. The Strategic and Corporate Risk Registers will be regularly reviewed by the Business Executive, Committees and Board and the Corporate Risk Register and Directorate Risk Registers will be reviewed by the Leadership Team. The Trust has successfully implemented the majority of the Once for Wales Concerns Management (Datix Cloud)	March 2023 March 2023 November 2022	

Recommendation	Management response	Completion date	Responsible officer
	System but, as with the rest of NHS Wales, is awaiting test release of the Risks Module. This is scheduled for September 2022 with implementation due in January 2023. The roll out of the Risks module will include user training for a system which is expected to be more intuitive and easier to use. In the interim, a training needs analysis to improve the consistency of the use of the current Datix Risks Module will be carried out. The Quality, Nursing and Allied Health Professionals Directorate is currently finalising a re-purposing change programme where it is proposed that the role of the Chief Risk Officer is split into 2 roles: Head of Information Governance and Head of Risk Management: • Head of Information Governance post – resource will be identified during 2022. • Risk Management – temporary specialist strategic risk resource will be identified for 2022/23.	August 2022 August 2022	

Recommendation	Management response	Completion date	Responsible officer
	• Head of Risk Management post – further investment will be sought to support a new post which will report to the Assistant Director, Integrated Governance.	March 2023	
R3 **Clinical Audit**. The Trust does not have central oversight on the quality and totality of its clinical audit programme. It does not have a clear picture of how well the programme links to quality and safety risks, key themes arising from the programme, or whether actions to address recommendations have been implemented. The Trust should strengthen its clinical audit arrangements by: a. Creating a central repository to store and share all clinical audits,	An implementation plan has been developed for several improvement deliverables to the Quality and Clinical Audit programme. Key objectives include: Facilitating the sharing of learning from completed audits across the organisation: • In the interim, the staff intranet (SharePoint) will be used. • A longer-term solution for a central repository will be scoped. The PHW Innovation and Improvement Hub is one potential option for this. Once the options are scoped then a feasibility analysis will take place to determine the optimum solution and move to the implementation phase.	August 2022 March 2023	Executive Director Quality, Nursing and AHPs.

Recommendation	Management response	Completion date	Responsible officer
either in the quality hub or elsewhere. b. Developing a system to track and report progress implementing the recommendations of clinical audit to the Business Executive Team and Quality, Safety, and Improvement Committee. c. Developing a process to link the clinical audit plan more clearly to operational, corporate, and strategic risk registers to demonstrate that audits are mapped to key quality and safety risks. d. Collating themes arising from the clinical audit programme and	Improving the oversight of implementation of audit recommendations through the development of a central action log: • All actions for the 2021-22 quality and clinical audits have been collated into a central action log template. • Updates on the progress of these actions are provided to the Quality, Nursing and Allied Healthcare Professionals Directorate on a quarterly basis. This progress will then be reported to the Business Executive Team and Quality, Safety and Improvement Committee in the interim (6-month) and year-end reports. Introduce a risk-based approach to the quality and clinical audit programme: • An initial scoping exercise has been undertaken to determine if audits in the 2022-23 quality and clinical	May 2022 March 2023 May 2022	

Recommendation	Management response	Completion date	Responsible officer
sharing with the Business Executive Team and Quality, Safety, and Improvement Committee. Future clinical audit plans should provide assurance that themes are being investigated.	audit plan are linked to risk registers. The findings were that the overwhelming majority are not. • It is recognised that delivery of this objective is intrinsically linked to the delivery of the Risk Management Development Plan. Matrix working between the Risk Team and the Quality, Engagement and Collaboration Team has been established and a joint approach will be taken to engage with the organisation to improve the approach to risk management and consequently the link between risks, and quality and clinical audits. Improve the oversight of findings from quality and clinical audits, utilising this to generate a thematic analysis to inform future audit plans: • An initial thematic analysis was produced for the year-end completed audits report for 2021-22. • This report will be presented to Business Executive Team and Quality, Safety and Improvement Committee in July 2022. The analysis examined the	March 2023 May 2022 July 2022	

Recommendation	Management response	Completion date	Responsible officer
	audit themes being investigated, as well as the six domains of healthcare and Health and Care Standards these audits provided assurance against. This analysis will also be presented at the Quality and Nursing Allied Health Professionals Clinical Governance Group to plan the dissemination of this information together with quarterly updates (pending the QOS being in place) on progress of the Quality and clinical audit, to inform wider organisational sharing • The introduction, in April 2022, of a standardised template for the reporting of audit results for all 2022-23 quality and clinical audits will further facilitate the generation of a thematic analysis going forward.	April 2022	
R4 **Staff Appraisals and Training**. Compliance with staff appraisals has been consistently below the Welsh	People and Organisational Development will: • Continue to report on compliance monthly.	12 months from date of report.	Director of People and OD

Recommendation	Management response	Completion date	Responsible officer
Government and Trust's internal target and has recently deteriorated further. Similarly, training compliance falls below the Trust's target, largely because of difficulties providing face to face training in safe environments. The Trust should ensure compliance with staff appraisals and statutory and mandatory training meets the national target within the next 12 months.	• Provide detailed individual appraisal data quarterly to the Executive Team and People Business Partners, extending this receiving group to include Business Leads and Leadership Teams, to drive compliance rates up. • Communicate about the current My Contribution Process and My Contribution e-learning at key stages in the year. The inclusion of Appraisal Dashboards in the Directorate and Divisional Dashboards will give local management and leadership teams alternative and more intuitive data. It is anticipated the implementation of the latest all-Wales Pay Progression Policy will positively impact compliance rates and there will be quality assurance to ensure conversations and appraisals remain meaningful. The development of a revised Behavioural Framework and updated Management and Leadership Framework will support the emphasis on both transactional and		

Recommendation	Management response	Completion date	Responsible officer
	transformational management responsibilities regarding appraisals. We are planning engagement activity to ensure this year's review and redesign of the My Contribution process achieves clarity of purpose and drives meaningful discussion and positive behaviour and aligns with PHW's vision of a flexible, skilled and motivated workforce who can deliver our long-term strategy. This review will encompass documentation and recording processes/software in advance of UK-wide developments in people systems. Compliance with the core suite of statutory and mandatory training remains just above the Welsh Government target of 85% (in June 2022). To drive improvement, People and OD hold two ESR drop-in sessions per month. The sessions are regularly communicated via SharePoint and weekly e-mail communications and are well attended. During 2021-22, in-person training was reinstated for Manual Handling B and C, Resuscitation and Violence and		

Recommendation	Management response	Completion date	Responsible officer
	Aggression Breakout Training. We are currently reviewing the position in terms of in-person training to complement the core suite of e-learning. We are aware of some reporting challenges through ESR which is impacting on compliance figures, this also relates to the job planning process for the medical workforce. Work is under way to look at improvements in this area.		
R5 **Policies and procedures**. The Trust does not know whether its directorates have appropriate processes for updating and sharing policies, procedures and Standard Operating Procedures or to test compliance with them. The Trust should strengthen its management of policies, procedures, and written control documents by:	Agree with the recommendation, we will take the following actions: 1. The Policy, Procedure and Other written Control documents Procedure has been strengthened to more clearly outline: • The process for how updates to Corporate Policies and Procedures will be disseminated throughout the directorates.	July 2022	Board Secretary and Head of Board Business Unit

Recommendation	Management response	Completion date	Responsible officer
a. Developing a process to update and share policies and procedures at directorate level with staff. b. Monitoring staff awareness of new or updated policies and procedures. c. Testing compliance with new or updated policies and procedures including the Putting Things Right Procedure and All Wales Concerns policy. d. Providing assurance to the Quality, Safety and Improvement Committee that new and updated policies and procedures are being used by staff.	• The requirement for the Policy Owner to test compliance with, and staff awareness of new or updated procedures, and report to the relevant Committee for assurance, where appropriate. 2. Relating to the process for Local Directorate Procedures, and SOPS, guidance on the appropriate governance arrangements within Directorates will be developed to ensure a consistent approach to the development, dissemination, and testing compliance of Local Procedures. This will be developed in conjunction to the current work being undertaken in this area within the Integrated Governance Model.	October 2022	Board Secretary and Head of Board Business Unit

Recommendation	Management response	Completion date	Responsible officer
R6 **Service User and Staff Feedback**. The Trust does not routinely and consistently collect information about the protected characteristics (under the Equality (Wales) Act) of its users, or of people taking part in research surveys. It does not consistently share learning from staff and user feedback or consistently let people know what changes it made as a result of their feedback. The Trust has recently invested in the CIVICA system to improve its approach to user feedback. More broadly, the Trust should strengthen its approach to user and staff feedback by: a. Developing and implementing the CIVICA system and a consistent	Public Health Wales' Our Approach to Engagement programme aims to support the organisation to build on good practice to develop how we engage with the public. It has a significant role in the implementation of our Quality and Improvement Strategy and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. We agree with the recommendations and we will take the following actions: • Implementation of the Service User Feedback Experience (Civica) system. • Provide training for teams in Public Health Wales to use the Civica system to capture feedback from their service users and/or stakeholders efficiently, equitably and in a consistent manner across the organisation. • Development and implementation of standardised, and evidenced-based, survey questions on protected characteristics. • Recruitment of a new Engagement & Evidence Lead post, whose role will contribute to improved use of existing evidence relating to impacts on people with	June 2022 June 2022 August 2022 October 2022	Executive Director Quality, Nursing and AHPs.

Recommendation	Management response	Completion date	Responsible officer
approach to capture information on the protected characteristics of service users and respondents to research surveys. b. Developing an approach to combine feedback from staff, service users, complaints, incidents, and compliments to create a more robust picture of the quality and safety of services. c. Developing mechanisms to inform service users about the impact their feedback has had on service improvement. d. Including service user feedback in deep dives for the Quality, Safety, and Improvement Committee.	different protected characteristics, including from a range of different sources, including third sector and community groups. • Development and implementation of an Engagement & Experience Network for colleagues across the organisation who have responsibility for designing and delivering our services, programmes and functions. • Existing organisational governance arrangements reviewed and strengthened for all engagement activity across the organisation, enhancing the citizen voice and providing support to the Public Health Wales Leadership Team and Business Executive Team to improve assurance and governance in respect of public engagement. • Develop organisational framework for engagement which outlines how engagement should be embedded in our key strategies and processes with impact and value.	July 2022 September 2022 October 2022	

Recommendation	Management response	Completion date	Responsible officer
e. Developing an approach to sharing learning from engagement with staff and users either through the implementation of the Quality as a Business Strategy and progressing agile methods which have been initiated.	• Review current assurance mechanisms for Service User Experience, to ensure our systems provide for the amplification of citizen voice and capturing learning and improvements in line with the requirements of the Quality & Engagement Act. • Implement recommendation from literature review of evaluation measures to develop an evaluation framework for engagement activity, with clear performance and outcome metrics measured on a regular basis that monitor the impact of our engagement activity. • Develop tools and resources for a best practice approach to engagement and informed by internal engagement with staff to identify learning and knowledge needs. • Collaboratively design and develop an organisational approach to capacity and capability building for skills in engagement and feedback analysis to inform planning and improvement.	October 2022 November 2022 January 2023 March 2023	

Recommendation	Management response	Completion date	Responsible officer
	• Using gathered intelligence to develop corporate resource (eg central stakeholder database) to facilitate shared relationships with external stakeholders and to identify and fill gaps so that we reach all sectors of the Welsh population. • Development and implementation of the Improvement and Innovation hub to support sustainable continuous improvement and innovation.	March 2023 September 2022	Director for NHS Quality Improvement and Patient Safety
R7 **Sub-groups of the Quality, Safety, and Improvement Committee**. The terms of references for the Quality, Safety and Improvement Committee do not include its sub-groups. Sub-groups currently report by exception reducing the level of assurance that	Agree with the recommendation. All Committee terms of reference have been reviewed and clarification added to detail the sub-groups and assuring groups to the Committees.	Completed	Board Secretary and Head of Board Business Unit

Recommendation	Management response	Completion date	Responsible officer
the Committee can take that these sub-groups are functioning effectively. The Trust should revise its terms of reference of the Quality, Safety, and Improvement Committee to include its sub-groups and reporting mechanisms. In doing so, it should ensure that the Committee has oversight of the breadth of material covered by the sub-groups and key themes or issues arising from discussions.	The QSIC Work plan also has been amended to include more frequent reporting from the two assuring groups (IPC and Safeguarding) to increase from annual to bi-annually. We have also scheduled future deep dives into the two areas on the work plan.		

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
1. Care of patients is my organisation's top priority	5	2				7
2. I am satisfied with the quality of care I give to patients	7					7
3. There are enough staff within my work area/department to support the delivery of safe and effective care	2	3	2			7
4. My working environment supports safe and effective care	2	4	1			7

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
5. I receive regular updates on patient feedback for my work area/department	3	3	1			7
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients	6		1			7
7. My organisation acts on concerns raised by staff	4	3				7
8. My organisation encourages staff to report errors, near misses or incidents	5	1	1			7
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	5	1	1			7

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	4	2	1			7
11. We are given feedback about changes made in response to reported errors, near misses and incidents	4	3				7
12. I would feel confident raising concerns about unsafe clinical practice	5	1	1			7
13. I am confident that my organisation acts on concerns about unsafe clinical practice	4	3				1

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

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.