Internal Audit

NHS Lothian

Arrangements to oversee the delivery of the Quality Strategy 2018-2023

September 2019

Internal Audit Assurance Assessment:

Objective One	Objective Two
Limited assurance	No Assurance Rating

Timetable

Date closing meeting held: 26 September 2019

Date draft report issued: 26 September 2019

Date management comments received: 5th November 2019

Date Final report issued: 12th November 2019

Date presented to Audit and Risk Committee: 25th November 2019

Contents

1. Introduction

1.1 In June 2018 NHS Lothian's Board approved the NHS Lothian Quality Strategy 2018-2023. The Quality strategy sets out that NHS Lothian will undergo and manage changes in quality between 2018-2023, built on eight key principles:

- Make it easier for everyone to test their improvement ideas without always needing prior 'permission';
- Leaders devote more time and energy to encourage local testing and improvement;
- Involve everyone in developing improvement priorities and ideas;
- Greater focus on patient and population needs and wishes in improvement work;
- Constantly learn, share and embed new knowledge from all improvement activities;
- Explicitly measure and realise the financial gains of better quality;
- Move to more integrated health and social care quality management and;
- Adopt quality management universally to support everything we do.

1.2 The Quality Strategy seeks to embed quality into all of NHS Lothian's activities, and quality is something all staff are aware of, action and embed into working practices. Quality should not be a separate agenda item but be fully built into team decision-making and not seen as a separate or distinct in its own right.

1.3 During 2018/19, the Chief Quality Officer and NHS Lothian teams have continued to develop the overall approach to quality, seeking to implement the principles of the Quality Strategy and move the quality agenda forward across NHS Lothian. In doing this for 2018/19, there were several programmes/networks.

1.4 These programmes/networks all applied the quality principles but through learned lessons applied the principles differently with the consistent aim of embedding quality in decision making.

Scope

1.5 We have reviewed the controls in place to monitor the delivery and implementation of the Board's Quality Strategy, with a focus on the controls in place across NHS Lothian that then provide assurance to the Chief Quality Officer and NHS Lothian Board that the Quality Strategy is being implemented. In particular we focused on the governance arrangements from the 2018/19 programmes/networks and how they have contributed to the delivery of the Quality Strategy in year 1.

Acknowledgements

1.6 We would like to thank all staff consulted during this review for their assistance and cooperation.

2. Executive Summary

Summary of Findings

2.1 The table below summarises our assessment of the risks and the adequacy and effectiveness of the controls in place to meet each of the risk areas agreed for this audit. Definitions of the ratings applied to each action are set out in Appendix 2.

No.	Control Objective	Control objective assessment	Number of actions by action rating			
			Critical	High	Medium	Low
1	Controls are in place across NHS Lothian that provide assurance through the Chief Quality Officer to the Board that the Quality Strategy is being implemented	**Limited Assurance**		1		1
2	The programmes/networks agreed and undertaken in 2018/19 make a positive contribution to NHS Lothian delivering the Quality Strategy and in particular have sought to embed quality in leadership teams and decision making rather than seen in isolation. (See paragraph 2.2)	**No Assurance Rating**				
TOTAL			-	1	-	1

Conclusion

2.2 The review comprised of two control objectives, of which one received Limited Assurance with the other not receiving an assurance rating. Given the nature of the work undertaken by the various networks and programmes across NHS Lothian, there is not a 'one size fits all' framework that can be used to assess the width and depth of various networks and programmes, which are at differing level of maturity.

2.3 Since the approval of the Quality Strategy by the Board in June 2018, there has been a lack of reporting on the implementation of the Quality Strategy across NHS Lothian governance framework. Additionally, it was noted that there is a lack of the ownership and visibility of the strategy at the Corporate Management Team, who are responsible for the delivery of the Quality Strategy.

Main findings

2.4 The quality discussion forum has been in a state of transition, changing three times in the last two years. Initially the Clinical Quality Steering Group (CQSG) was the discussion forum for quality, however this was disbanded, with Patient Safety and Experience Action Group (PSEAG2) superseding it. This has recently been replaced with the Futures, Innovation and Quality (FIQ).

2.5 From our testing it was noted that there is a potential imbalance in the FIQ meetings, with more focus and discussion on research and innovation and less on quality. Additionally, through our review of the minutes and discussions with members, it became apparent that there was a lack of visibility and reporting to the Corporate Management Team (CMT), who are responsible for the delivery of the strategy.

2.6 The CMT through the Chief Quality Officer should put in place an Implementation/Delivery Plan to support the Quality Strategy. This plan would act as a control over the implementation of the strategy detailing progress, accountability and ownership of each of the programmes/networks as well as other appropriate aspects of the strategy.

2.7 Although we acknowledge the reporting being provided at group and sub-committee level for the various networks and programmes, it was noted through our testing that there is the lack of a concise document, that explains the reporting rationale and how the Quality Strategy will be considered in its entirely.

2.8 An Annual Report on the Quality Strategy should be provided to the Board, showing the progress made against the strategy and provide an indication of pace of implementation.

3. Management Action Plan

Control objective 1: Controls are in place across NHS Lothian that provide assurance through the Chief Quality Officer to the Board that the Quality Strategy is being implemented	
1.1 Without a robust assurance framework, there will be a lack of governance and reporting around the Quality Strategy leading to a lack of assurance over the implementation of the strategy.	**High**

Background:

Initially the Clinical Quality Steering Group (CQSG) was the discussion forum for quality. It was agreed at the CQSG that it would be useful for quality issues to be discussed in a wider forum to aid embedding quality in all areas. It was therefore agreed that the focussed discussions on the network/programmes could be covered in existing meetings between members of the Quality team and the Finance team at the Patient Safety and Experience Action Group (PSEAG) attended by the Executive team.

PSEAG is an informal meeting for discussion of issues rather than decision making. Where formal decision making was required these issues should be escalated to the Corporate Management Team (CMT). It was agreed to trial discussions with regards to quality at the PSEAG and the CQSG was disband the on 1 June 2017.

The PSEAG initially met every month, however and it was decided that it would meet twice monthly and would be split into PSEAG1, which focused on patient related matters such as experience and safety and PSEAG2 which focused on more strategic items such as innovation and quality. PSEAG2 was then rebranded and became Futures, Innovation and Quality (FIQ), with a remit and membership better aligned to discussions taking place at that meeting. FIQ is essentially a management committee, with a reporting line to CMT via the Chief Quality Officer.

Observation and Risk:

We reviewed a sample of minutes from the FIQ, where quality discussion should be taking place, and supplemented this testing through discussion with management who attended the FIQ meeting. From our testing, it was noted that there is a potential imbalance in the meeting, with more focus and discussion on research and innovation and less on quality.

Recently, quality has been added to the agenda of the FIQ in an attempt to provided better balance at the meeting. However, this meeting is not currently fulling it's remit of discussing quality programmes/networks, monitoring progress made, reviewing issues experienced in the implementation of the Quality Strategy and escalating issues to the CMT where appropriate.

We reviewed a sample of minutes from the CMT and interviewed members. Through our work, it became apparent that there was a lack of visibility and reporting to the CMT, who are responsible for the delivery of the Quality Strategy. There was a facilitated discussion on the Quality Strategy at the February 2019 CMT meeting. This discussion highlighted that there is not enough awareness/exposure of the Quality Strategy at the CMT. Additionally, concerns were raised around how NHS Lothian are measuring the impact of strategy, due to a lack of milestone reporting and measuring of progress.

Risk: If the Quality Strategy is not been given due attention at the FIQ, coupled with the lack of visibility and ownership of the CMT, there may not be sufficient focus on the implementation of the Quality Strategy. Additionally, in the absence of a detailed Implementation/Delivery Plan in support of the strategy, there may be a lack of control over the implementation of the strategy, leading to an impact on pace of implementation.
Recommendation: The FIQ should be given time to embed and become the core group overseeing how the strategy is implemented. There should be a greater emphasis on quality at the FIQ meetings going forward in line with the remit of the group. Additionally, there should be greater visibility of the progress made against the Quality Strategy by the CMT, to ensure milestones are met and the Quality Strategy is implemented in line with agreed timescales. Management should put in place an Implementation/Delivery Plan to support the Quality Strategy. This plan would act as a control over the implementation of the strategy detailing progress, accountability and ownership of each of the programmes/networks as well as other appropriate aspects of the strategy. Progress against the Implementation/Delivery Plan should be reported quarterly to the CMT by the Chief Quality Officer, and actions captured where applicable with an action owner assigned. This will allow the CMT to track and monitor qualitative and quantitative measures of quality as well as progress against this plan and the implementation of the Quality Strategy.
Management Response: Recommendation accepted. **Management Action:** Progress against the actions/timescale defined for the first phase of the Quality Strategy will be reported to the Board on 4th December 2019. A plan for further implementation will be developed and monitored as recommended.

Responsibility: Chief Quality Officer	**Target date:** March 31st 2020

Control objective 1: Controls are in place across NHS Lothian that provide assurance to Chief Quality Officer and the Board that the Quality Strategy is being implemented	
1.2: Progress around the implementation of the Quality Strategy is not regularly reported and a monitoring framework is not in place to capture actions when delivery is not as expected, and reporting is not aligned into the NHS Lothian governance structure.	**Low**

Background:

Each of the networks and programmes have a slightly different governance pathway. We selected a sample of networks and programmes (Primary Care Quality network, Stroke Improvement programme and Endoscopy programme) in order to better understand the reporting pathways.

The Primary Care Quality Network reports through the General Medical Services Transformation Board (chaired by the Medical Director who is also the executive sponsor for this network) and then up the governance framework to the Sustainability and Value Group as well as the Healthcare Governance Committee. The 3-Year Primary Care Quality Improvement Network Plan was recently reported to the Sustainability and Value Group for consideration.

Reporting of the Stroke Improvement programme activity and performance takes place through Stroke Services Quality Improvement Board and then the Acute Hospitals Committee and Healthcare Governance Committee.

The Endoscopy programme previously reported to the Endoscopy Quality Improvement forum, however this programme is not currently being funded.

Observation and Risk:

There are various reporting lines within the governance framework for the different networks and programmes within the Quality Strategy, with each of the groups described above provided an operation control over the specific networks/programmes. Although we acknowledge the reporting being provided at group and Board sub-committee level for the various networks and programmes, it was noted through our testing that the level of reporting is inconsistent across the networks and programmes and there is the lack of a concise paper that explains the reporting rationale and how the Quality Strategy will then be looked at in its entirely.

As part of our testing, we reviewed a sample of Board minutes to better understand the reporting on the Quality Strategy at Board level. Despite there being the standing agenda item; 'Quality and Performance Improvement' there is little mention of the Quality Strategy after the June 2018 meeting where the Quality Strategy was approved by the Board.

Risk: In the absence of reporting to the Board, describing the progress against the implementation of the Quality Strategy as a whole, it will be difficult for the Board to gain assurance over the implementation of the Quality Strategy.

Recommendation: As part of the discussion and reporting under the existing Board agenda item 'Quality and Performance Improvement', Management should provide the Board with Quality Strategy Highlights at every meeting, a four monthly Progress Report and an Annual Report, showing the progress made against the strategy and providing an indication of pace of implementation. The Annual report should also provide clarity and rationale over the various management and governance pathways for each of the network/programmes and other aspects of the strategy. The Quality Strategy should be refreshed in order to keep the document 'live', capturing changes to finance and resourcing, revised timescales for completion and actions taken to increase pace and bring the implementation of the strategy back on track, if there are delays to original timescales.
Management Response: Recommendation accepted. **Management Action:** Management intend to report to the December 2019 Board meeting set within the context of the internal audit findings.

Responsibility: Chief Quality Officer	**Target date:** 31 December 2019

Control objective 2: The programmes/networks agreed and undertaken in 2018/19 make a positive contribution to NHS Lothian delivering the Quality Strategy and in particular have sought to embed quality in leadership teams and decision making rather than seen in isolation.

We have not provided an assurance rating in relation to this control objective.

Given the nature of the work undertaken by the various networks and programmes across NHS Lothian, there is not a 'one size fits all' framework that can be used to assess the width and depth of various networks and programmes, which are at differing level of maturity.

We did however review the Primary Care Quality Network, Stroke Improvement programme and Endoscopy programme to better understand the contribution to NHS Lothian these networks/programmes are providing.

We focused on the following areas; Stakeholders engagement, Share learning and alignment to the principles in the Quality Strategy.

Stakeholders engagement

We reviewed communication plans which helped to provided clarity over the objectives of the network/programmes, such as raising awareness of the network/programmes, increase knowledge of quality improvement methodology and promoting more investment and action within the network/programmes. The communication plans also list stakeholders and mapped out the frequency of engagement and method of delivery, such as report, website, twitter, face to face.

From our testing we also noted instances where surveys where undertaken with stakeholders. There was then consideration of the outputs of the survey at the programme's discussion forum and evidence that the outputs of the survey helped to shape decision making.

It was also noted that there were several events held which encouraged stakeholder engagement. Additionally, posters were displayed promoting the Quality activities. Network/programmes have newsletters which are circulated to stakeholders/made available on NHS Lothian Quality specific website (qilothian.scot.nhs.uk). These newsletters aim to keep stakeholders informed of the Quality Improvement work occurring across Lothian, providing information and insights with regards to new developments, upcoming events and provides practice teams with tips about completing quality improvement work in their own network/programmes.

Share learning

A range of mediums are used to share learning across the networks/programmes, such as the NHS Lothian Quality website, which is an outward-facing internet site that has a section dedicated to the Quality Improvement Networks. Additionally, Clinical Change Forum are used as an opportunity to share learning and celebrate success, presenting pieces of work with tangible benefits in terms of patient care. The regular newsletters provided by many of

the network/programmes also share Quality Improvement learning across acute sites and partnerships.

Alignment with the Quality Strategy principles

Many of the networks/programmes have an annual / three year plan, available on the NHS Lothian Quality website. These plans provided clarity over how networks/programmes are aligning with the Quality Strategy principals. Additionally, the plans consider how the networks/programmes are performing against the 'return on investment' model, included within the Quality Strategy.

Plans should evolve with the Quality Strategy and support the Implementation/Delivery Plan, as NHS Lothian continue with the quality improvement journey in years two through five of the Quality Strategy timeline.

4. Internal Audit Follow-up Process

4.1 Approximately two weeks following issue of the final Internal Audit report, a member of the Audit Team will issue an 'evidence requirements' document for those reports where management actions have been agreed.

4.2 This document forms part of the follow up process and records what information should be provided to close off the management action.

4.3 The follow-up process is aligned with the meetings of the Board's Audit & Risk Committee. Audit Sponsors will be contacted on a quarterly basis with a request to provide the necessary evidence for those management actions that are likely to fall due before the next meeting of the Audit and Risk Committee.

5. Appendix 1 – Staff Involved and documents reviewed

Audit Sponsors

- Chief Quality Officer

We selected the following sample of programmes and networks for testing (out of 6);

- Primary Care Quality Network
- Cardiovascular disease: Stroke Improvement programme
- Diagnostics: Endoscopy

Staff interviewed

- Jo Bennett, Associate Director of Quality Improvement & Safety
- Tracey Gillies, Medical Director
- Andrew Coull, Associate Medical Director, Older People & Stroke Services
- Nick Church, Clinical Lead, Endoscopy
- Janis Butler, Director of HR & OD

Documents Reviewed

- NHS Lothian Quality Strategy 2018 – 2023
- Evaluation of the NHS Lothian Clinical Quality Programmes report
- Clinical Quality Steering Group minutes (Apr-17 and Jun-17)
- Clinical Programme Highlight Report for Endoscopy, Primary Care & Stroke
- Communications Plans for Endoscopy, Primary Care and Stroke
- Endoscopy Engagement Event - Agenda (Aug-18)
- Quality Improvement Project Group Newsletters for Endoscopy, Primary Care & Stroke
- NHS Lothian Annual Review for Stroke
- 3 Year Plan for Primary Care network and Stroke Quality Improvement Programme
- Stroke Services Quality Improvement Board (Dec-18)
- Stroke performance update to Healthcare Governance Committee (May-18)
- Stroke care programme Annual Report to Healthcare Governance Committee (Nov-18)
- Stroke care programme Annual Report to Acute Hospitals Committee (Feb-19)
- Board minutes (Jun-18, Aug-18, Oct-18, Dec-18, Feb-19, Apr-19 and Jun-19)
- CMT minutes (Apr-19, Jun-19, July-19 and Aug-19)
- FIQ Terms of Reference and minutes for 2018/19

6. Appendix 2 - Definition of Ratings

Findings and management actions ratings

Finding Ratings	Definition
Critical	A fundamental failure or absence in the design or operating effectiveness of controls, which requires immediate attention
High	A key control failure has been identified which could be either due to a failure in the design or operating effectiveness. There are no compensating controls in place, and management should aim to implement controls within a calendar month of the review.
Medium	A control failure has been identified which could be either due to a failure in the design or operating effectiveness. Other controls in place partially mitigate the risk to the organisation, however management should look to implement controls to fully cover the risk identified.
Low	Minor non-compliance has been identified with the operating effectiveness of a control, however the design of the control is effective

Report ratings and overall assurance provided

Report Ratings	Definition	When Internal Audit will award this level
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk.	The controls are not adequately designed and / or operating effectively, and immediate management action is required as there remains a significant amount of residual risk (for instance one Critical finding or a number of High findings)
Limited assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken.	This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some respects and require management action (for instance one 'high' finding and a number of other lower rated findings)
Moderate assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and, in most respects, achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Significant assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all.	There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)