DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Follow-up Review of Governance Arrangements at Cwm Taf University Health Board

August 2015

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Chapter 1   Introduction

1.1   In 2011, following discussions between Healthcare Inspectorate Wales (HIW) and the Chairman and members of the Executive Team of Cwm Taf University Health Board, it was agreed that HIW would undertake a review of the governance arrangements in place at the health board to ensure the quality and safety of patient care. The agreed terms of reference for this review broadly covered an evaluation of the following areas:

- The health board's governance and accountability arrangements to ensure they are clear and consistent
- The primary and additional responsibilities of the non-officer members of the Board
- The arrangements in place to support competent and effective multi-disciplinary clinical teams
- The arrangements in place to deliver 'Putting Things Right', the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

1.2   A report[1] was subsequently published in March 2012. The report included 54 recommendations grouped under 14 general themes for the health board to address, these were:

- Executive Board
- Organisational Structure
- Clinical teams and leadership
- Committee Reporting Lines
- Non-officer members
- Access to information
- Challenge and Scrutiny
- Risk
- Patient complaints, concerns and claims
- Trend analysis, action planning and sharing learning
- Partnership involvement
- Communication of the vision and objectives
- Staff development and appraisal
- Monitoring performance.

1.3   As part of HIW's 2014-15 Operational Plan[2], it was announced that a follow-up review would be undertaken to assess the progress made by the health board in relation to the 14 areas listed above.

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[1]   See: https://hiw.org.uk/sites/default/files/2019-05/120307cwmtafclinicalreview12en.pdf

[2]   See: https://hiw.org.uk/sites/default/files/2019-10/Operational%20Plan%20Outline%202014_15%20-%20English.pdf

1.4   The review took place between February and March 2015 and, in line with the original review in 2011, the follow-up focused on three service areas. The service areas selected were:

- General Practice – to meet with primary care staff to discuss their views on the governance arrangements within the health board
- Mental Health Services – there had been a number of changes implemented by the health board in relation to these services following on from the original HIW review. It was agreed that it would be useful to follow-up on how these changes were managed and the improvements as a result
- Stroke Services – there were a number of service changes pending in this area, and so it was agreed that it would be useful to assess the decision making process used by the health board and how it had managed stakeholder engagement in relation to the scheduled changes.

1.5   A team of peer reviewers with a range of expertise, skills and knowledge were appointed to undertake the review. One of the reviewers selected was also a member of the original review team in 2011, thus allowing for some degree of continuity between the two reviews.

1.6   As with the original review, the follow-up included attendance at high level meetings with members of the Board and the Executive Team. We also undertook visits to selected areas[3] to discuss with staff their views on the health board in general, the changes that have been implemented to services to date and the planned future changes. Meetings were also held with Clinical Directors from each of the selected areas and to increase our coverage at this level within the health board, three other areas (Surgery, Medicine and Diagnostics).

1.7   As part of the review process we also met with representatives from the Cwm Taf Community Health Council and the Wales Deanery to discuss their views of the health board.

1.8   Due to the time lapse between the original 2011 review and this follow-up, HIW decided that the follow-up review would benefit from focusing on assessing the progress made under the broader 14 themes included rather than reporting on the specific progress made against each of the individual recommendations.

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[3]   One GP Surgery within each of the four locality areas, Mental Health services at Ysbyty George Thomas and Keir Hardie University Health Park; and Stroke services at Royal Glamorgan Hospital and Prince Charles Hospital.

Chapter 2:   Summary

2.1   Overall, it is clear that the health board has faced a number of challenges over the last four years, particularly the introduction and implementation of the South Wales Programme[4], which we were informed has been extremely demanding. However, it was clear that the health board has evolved over the past four years, with the follow-up review finding that the health board has achieved a great deal since the original review that took place. There were several examples which evidence the progress that has been made including:

- Improvements made in mental health services, which included a shift in focus from hospital to community based services, which necessitated the transfer of adult in-patient mental health services to one site, the Royal Glamorgan Hospital, along with the redesign of older persons mental health services. Both secondary care staff and service users were fully engaged during these proposed changes, which mitigated the need for any formal public consultation and ensured a smooth transition
- Clinicians within secondary care now feel that they are empowered to come up with their own ideas to improve the services they provide. These included the introduction of a new paediatric assessment unit and the new model for medical admissions at Royal Glamorgan Hospital.
- The health board is now in a clearer position in relation to risk management and, although the Board is aware that further improvements are required, the review team felt that the Board are now more assured that they are aware of the risks facing the health board
- There has been a strengthening in the role of the Board's Independent Members. Independent Members informed us they now feel better equipped and able to provide the level of scrutiny and challenge required. Our observations supported their views.

2.2   However, the review also identified some areas which require focus including some inconsistency across the health board in following processes and procedures, for example, the varying use of Datix[5] to record complaints/incidents, along with reported compliance levels with staff appraisals within secondary care.

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[4]   The South Wales Programme was made up of the five South Wales health boards – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys - working with the Welsh Ambulance Service Trust to create safe and sustainable hospital services for people living in South Wales and South Powys. The Programme's work was led by frontline clinicians, doctors, nurses, midwives and therapists – with the aim of providing high quality and safe specialist hospital services which improve the care of the sickest and most seriously injured patients.

[5]   Patient safety software and risk management software systems for healthcare incident reporting and adverse events.

2.3   Another challenge identified as part of our follow-up review related to engagement with primary care services, and the need for the health board to maintain its efforts on addressing and improving this aspect. Early on during our fieldwork, the Chief Executive gave a presentation to the review team which detailed the key challenges moving forward for the health board. Engagement with primary care services was identified as a key area of work moving forward in the coming months.

2.4   As mentioned above, there have been numerous challenges faced by the health board in the last four years, including the South Wales Programme. As part of the introduction of this programme the health board had to ensure the needs of the population of Cwm Taf were fully considered against the requirement to regionally reconfigure some specialist areas of hospital services. One of the outcomes of the South Wales Programme was the reconfiguration of paediatric, neonatal and obstetric services and a change to the clinical model of A&E services in Royal Glamorgan Hospital. As a result, the health board has embraced the opportunity service change had presented, to develop innovative clinical improvements to services which have included the development and implementation of a new paediatric assessment unit and a new acute medicine model at the Royal Glamorgan Hospital.

2.5   Overall, HIW is pleased and encouraged with the progress that has been made by the health board since the initial review in 2011. Most, if not all of the areas, have seen significant improvements. The recommendations made as a result of this follow up review also highlight the areas which require further improvement.

Chapter 3   Findings

3.1   This section outlines the review team's findings relating to the progress made by the health board since 2011.

Executive Board

3.2   Over the course of the 2011 review, we observed the beginnings of a significant period of change for the Executive Team, this being largely as a result of the appointment of a new Chief Executive. The review team saw this as a welcome opportunity to develop and strengthen the senior management arrangements of the health board. The terms of reference for the introduction of the Executive Board stated that its purpose was to:

'be the body within Cwm Taf Health Board that endorses, prior to the Board consideration, all strategic plans, considers key policy and operational matters, monitors the agreed actions to be undertaken by the Units and ensure that robust performance management arrangements are in place across the organisation. Additionally it will act as the Project Board for key programmes including financial sustainability and service redesign.'

3.3   It was evident to the 2015 review team that there was now an impassioned, committed and integrated Executive Team in place within the health board. The Chief Executive advised that all but one of the Executive Team in place at the time of the 2011 review have changed, and that she now feels well supported, and more importantly, appropriately challenged by the Team.

3.4   The Chief Executive has developed and implemented her plans to reform the Governance and Accountability structures. The functions of the Board and the functions of the Executive Team are now well defined, with a clear distinction between the two. Further to this, there is now a clear Governance and Assurance Structure (Annex A – Governance and Assurance Structure) in place. The Board is now more supported and well informed. There are also clear reporting lines between sub-committees and the Board.

3.5   During discussions with the Chief Executive she explained that she now feels comfortable with the structure at board level and she ensures that the Executive portfolio areas are regularly reviewed.

3.6   However, opinions of those working within service areas about the visibility of the Executive Board and access to the Board were varied. Comments made to the review team ranged from some explaining that they felt 'connected to the board' with a 'clear pathway to feed information to the Board', to those within some of the Primary Care areas feeling disengaged and 'pushed into decisions' made at board level with a perception amongst staff we spoke to

that they did not have sufficient opportunity to inform or influence these decisions.

Organisational Structure

3.7 The difficulties in adequately addressing this theme were recognised in 2011 given that the health board was in a period of transition and was still adapting to the changes brought about from the organisational mergers that had taken place. Further to this, the structural model envisaged by the new Chief Executive was still in the very early planning stages and therefore its effectiveness could not be examined.

3.8 The health board has now overcome the initial instability created by the mergers that led up to the 2011 review, with the Chief Executive stating that that she was happy with the current organisational structure, although adding that it is always open for review and continuous improvement. The review team felt that the organisational structure was visible and there were clear lines from ward level to the Board.

3.9 We were informed during our discussions with senior staff that there are areas across the organisation that require investment; these include addressing the change management capability of the organisation. During our discussion with the Chief Executive, we were informed that the health board is in the process of appointing a new member of staff who will report to the Director of Planning & Performance whose role will primarily be to bring the change management plan forward.

3.10 The health board is pursuing more investment in Primary Care services following the 2015/16 budget announcement which included £80 million investment into Wales. We were informed that the health board has requested £11.9 million for its Integrated Medium Term Plan (IMTP) and that there are plans in place as to how the money would be spent to aid with improving clinical services provided to patients and further developing the organisation structure. These plans include:

- Further development of the Primary Care Support Unit. This unit currently includes salaried GPs, and Primary Care Practitioners but will soon also include Community Pharmacists providing services into the community (including nursing homes)
- New schemes in relation to cardio vascular disease, diabetes and dementia care

- Investment in community mental health, primarily within tier 0[6] and tier 1[7] services.

3.11 At the time of our review, the health board was still awaiting the outcome of its request. The health board's plans, whilst reasonable, must be closely linked with its primary care strategy, which was still in development at the time of our review.

Clinical Teams and Leadership

3.12 During the 2011 review, the team was positive about the talented clinical leaders they had met with and the many staff who were committed to the organisation and its patients. Whilst there was evidence of good leadership at an operational level, there were concerns about the capacity of individuals to be both clinicians and managers. For example, at the time the Medical Director was concerned that there were few clinicians willing to undertake clinical leadership training.

3.13 The follow up review found that the Medical Director had been able to appoint Assistant Medical Directors and that Clinicians were now competing for the role of Clinical Director within their departments.

3.14 The clinical teams we met with during our follow-up review demonstrated an understanding of the financial challenges facing the health board and the need to achieve efficiencies by improving and innovating services. However, there was frustration felt within some clinical teams within primary care, who did not feel that they were empowered or supported to deliver changes to facilitate improvements to patient care within the community. It was perceived by some staff that decision making across directorates was difficult and time consuming, which was further exacerbated by the sense that some of those on the ground felt a lack of involvement in changes being developed at a managerial or corporate level.

3.15 There was a sense of some clinicians feeling isolated from the strategic centre and from some of our conversations with GP staff it was apparent that there was a clear lack of communication with the primary care element of the health board. For example, at the time of our interviews, the majority of staff

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[6]   Mental Health and Well Being – services to provide public awareness about mental health issues and how to manage them effectively – stress control, self help, guided self help (including reading groups), assisted or self directed computerised cognitive behaviour therapy and well-being groups.
[7]   Primary Mental Health Care - The identification, assessment and treatment of common mental health problems, such as anxiety and mild to moderate depression, and monitoring the physical and mental healthcare needs of people with a severe and enduring mental health problem, along with the provision of good quality information and sign posting services.

within primary care we spoke to did not have any knowledge (or evidently any input) into the health board's pending primary care strategy. As mentioned previously, during our early discussions with the health board, it was highlighted to the review team that they were aware of the issues with regards to primary care and that it was an area that it planned to focus on in the coming months.

3.16   The follow-up review has found that there appears to be a difference in opinion between secondary and primary care clinicians when discussing their views on leadership throughout the health board.

3.17   The staff interviewed from secondary care service areas told us that they had good links with the health board and they felt empowered and encouraged to develop solutions that will improve services. During our visits to secondary care services it was evident that staff had been empowered and supported to develop new initiatives to improve services for their patients. As a result there were some good examples of excellent care being provided. For example, during our visit to the Cambrian Ward in Ysbyty George Thomas, we were told about the introduction of the 'natural waking' model for patients with dementia. In this system, patients are not woken by staff but being allowed to wake up naturally. Lighting is kept subdued and noise levels to a minimum until all patients are awake. As a result of the introduction of this system there has been a significant decrease in aggression displayed by patients on the ward. This model has been shared with the wider health board and recently won an award at the 2015 Patient Safety Awards.

3.18   However, visits to some primary care service areas relayed a slightly different account, with an apparent dissociation emerging between strategic and operational levels of the health board. Concerns were raised to us regarding an apparent disconnect between primary and secondary care. There was a sense conveyed to us during discussions with staff that there is not an integrated approach/strategic plan to aid discussions between primary and secondary care service areas. This issue was also raised by the Chief Executive during early discussions as part of this Review. Comments from some primary care staff indicated a feeling that much of the health board's time had been spent on secondary care problems at the exclusion of primary care. For example, some of the staff we spoke to felt that many good ideas put forward from this area had been ignored.

3.19   The establishment of Locality Clusters and the requirement to develop Cluster plans to feed into the Health Board 3-year Integrated Medium Term Plan (IMTP) is a relatively new requirement linked to revised agreements within the GMS Contract in Wales. We were told that the Locality Clusters had achieved varied success, with some of the staff we spoke to feeling that many of the ideas raised during the cluster meetings had not been supported nor had they

been progressed. Numerous examples of how services could be improved were provided to the review team, such as the operation of additional services within practices, none of which appeared to have been taken forward at the time of the Review. Whilst this may have been linked to the timing of the Review in relation to the planning cycle or the prioritisation within the resources available for investment in developments, we were informed that there had been a lack of explanation why these ideas had not been taken forward by the health board. Due to the ineffectiveness of the cluster meetings so far, in one area, we were informed that a GP who works within that locality had volunteered to take more of a leading role. It was hoped that this would help in progressing with the suggestions that are being put forward to the health board to try to improve services.

3.20 During our visits to the four primary care practices, one in each of the four localities, we also had discussions with members of the Primary Care Team. This team's role is to provide the required support to practices across the health board and help practices to develop services. The team also carry out annual development visits to practices which involve discussions around staffing levels, any development ideas they wish to take forward, and to share good practice. We were informed during our discussions with staff that there are currently issues with the capacity of this team; the number of staff within the team has reduced and it was felt that the team did not currently have the capacity to provide the level of support required.

3.21 On a more general note, the Executive Team praised the leadership of the Chief Executive, and general observations were that leadership has improved, with Clinical Directors having more clearly defined roles and are able to better focus their time on their leadership duties. However, despite this view, there were concerns raised by Clinical Directors in relation to their ability to effectively divide their time between their clinical role and their management role.

Recommendations for Cwm Taf University Health Board

Recommendation 1
The health board should consider methods to strengthen engagement with primary care areas across the four locality areas.

Recommendation 2
The health board should ensure that each cluster plays an integral role in the development and implementation of the Primary Care Strategy.

Recommendation 3
The health board should ensure that systems are in place to empower and support primary care staff to develop and implement new ideas to improve services.

Recommendation 4
The health board should ensure that the Primary Care Team is adequately staffed by experienced staff to provide the required level of support to practices.

Recommendation for NHS Wales

Recommendation A
Consideration should be made by NHS Wales of the current model of care for patients with dementia developed on Cambrian Ward and other wards across Wales judged to be excellent in line with learning models, with the view to adopt such models across all health boards in Wales.

Committee Reporting Lines

3.22   During the 2011 review, it was recognised that the committee structures in place within the organisation had been subject to a period of development over the 18 month period since the new health board had been formed.

3.23   During the follow-up review, it was clear from our discussions with staff that the current Governance and Assurance structure is working well, with each sub-committee having clear reporting lines. Measures implemented such as the formation of an Integrated Governance Committee (whose membership consists of the Chairs of all of the other committees) ensures a consistent approach is being taken across the structure. Whilst there was acceptance that potentially the number of sub-committees is excessive, there was also a strong opinion amongst senior staff that all of the committees are performing very important functions.

3.24   The structure of the Board's sub-committees has been subject to periodic reviews by the health board since the last report was published, and we were informed that it is felt that the current structure is fit for purpose. However, during discussions with some members of senior staff, including members of the Executive Teams, it was felt that too much of the Executive Team's and non-officer members' time is being taken up with attending sub-committee meetings. It was clear from our review that the health board has committed staff and members who are willing to attend these meetings as well as performing their own relevant roles within the organisation.

Non-officer Members

3.25   All health boards in Wales are required to include independent members on their Board, who are known as 'non-officer members'. Non-officer members are remunerated for four days per month, and as well as attending Board meetings, they play a key role in the sub-committees of the Board. Their main purpose is to ensure the health board receives challenge and scrutiny in relation to its decisions and actions. Non-officer members are recruited through the Welsh Government public appointment process. Welsh Government guidance sets out their role as follows:

'Non-officer members are equal partners on the Board with their Executive colleagues and are required to play a full part in the governance of the LHB across all areas of its activity, both clinical and corporate. The contribution of non-officer members to the work of the Board is based upon their experience and knowledge, and their ability to stand back from the day to day operational management. They are expected to bring the Board an independent judgement on issues of performance, key appointments, looking ahead and accountability. Non-officer members also need to contribute to and will accept corporate responsibility for all decisions made by the Board[8].

3.26   There were a number of issues identified in the 2011 review in relation to the role of the non-officer members within the health board. Members informed us that they did not feel that their expertise and attributes were being utilised as much as they could have been. There were concerns highlighted by the review around non officer members' lack of knowledge on the governance arrangements in place within the health board, corporate risks and a lack of understanding of planning arrangements in place. The interviews with the non-officer members also revealed that there were gaps within the induction processes for new members and the provision of training and development opportunities.

3.27   As part of the follow-up review, four current non officer members were interviewed. All four were in post at the time of the original HIW review and all felt that there had been considerable improvements in their role since the previous review had been carried out.

3.28   It was clear from our discussions and observations that the non-officer members now felt more empowered and enabled to challenge and ask questions within their relevant committee areas and also to the Executive Team. Those we spoke to stated that they believed there is an acceptance within the health board that the challenge and scrutiny offered by the non-

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[8]   Welsh Government, 'Information for candidates: Local health boards Appointment of Non-Officer Members'.

officer members was beneficial to the organisation and that there is now an increased level of trust between the members and the Executive Team.

3.29   All of the current sub-committees have non-officer member representation. As part of the fieldwork for our review, the team observed a number of different sub-committee meetings in order to witness this scrutiny in action. It was clearly evident during the meetings we attended that the non-officer members play an extremely important role; on numerous occasions we observed non-officer members appropriately scrutinising information presented to them and posing relevant questions to the Clinical Directors and/or Executive Team. We also observed non-officer members requesting action to be taken by the relevant leads and further information they would like to be presented with at subsequent meetings. We were informed by non-officer members that the provision of information provided to them has vastly improved since the initial review took place. In relation to the meetings we attended, non-officer members had been sent information packs prior to the meeting, which meant that they were not reliant on printing for themselves or on electronic copies. During the meetings we observed, where it was identified that a piece of information had not be provided to members, they were quick to point this out and they were assured that it would be provided to them.

3.30   The non-officer members we spoke to informed us that they felt that they have a good, open and honest relationship with both the Chief Executive and the Chair. This in turn has allowed for non-officer members to obtain portfolios and champion areas in-line with their own interest and expertise, and also the opportunity to accompany Clinical Leads during visits to areas relevant to their own portfolio to engage with both patients and staff.

3.31   All of the non-officer members we spoke to informed us that they receive routine appraisals which are carried out by the Chair of the health board. Similarly all we spoke to felt that they receive the appropriate level of support from the Chair and feel that they are able to discuss any issues they may have with him whenever they feel the need.

3.32   There is an induction process for all new non-officer members, with the provision of training and development for non-officer members also improving since 2011. All non-officer members attend a training and development day every other month, where they are able to contribute to the agenda, requesting previously for presentations and/or talks to be delivered by relevant staff on areas of particular interest.

3.33   It was clear from our discussions with the non-officer members we spoke to, and from our observations during the committee meetings we attended, that the current non-officer members are extremely committed to the health board and play a very active and important role. However, the time commitment

required from non-officer members was discussed with current members, including whether the required commitment exceeds the four days they are remunerated for and whether members are providing more than this on good will at present. From these discussions it was clear that current members were fully committed to give the extra time to fulfil their roles. However, we feel that there could potentially be a capacity risk in the future for new members appointed should they not be able to commit to over and above the four days. There were similar concerns highlighted during the 2011 review in relation to time capacity allocated to non-officer members. We are aware that a review is currently being undertaken in Wales to establish how non-officer members to Health Boards and NHS Trusts can adequately discharge their functions within the current allocated time commitment.

3.34 Concerns were also raised around succession planning for non-officer members to ensure that the next cohort of members are able to continue the valuable role that the current members are providing. It was recognised during discussions with senior staff that it will be a big challenge to ensure new members are prepared for their roles so that they feel suitably equipped and empowered to provide the same level of challenge and scrutiny that current members are providing. We were informed that succession planning has commenced within the health board.

Recommendation for Cwm Taf University Health Board

Recommendation 5
The health board should ensure that they prepare thorough succession plans that will support and enable the successful recruitment of new non-officer members, and thus ensure a smooth transition, and the continuation of, the valuable role that the current members are providing the health board.

Recommendation for NHS Wales

Recommendation B
In line with the current review being undertaken in Wales, consideration should be made by NHS Wales, as to whether health board non-officer members within Wales are allocated with enough time to enable them to carry out the full requirements of their roles.

Access to Information

3.35 During the 2011 review concerns were raised in relation to the quality, level and depth of information provided to committees and Board meetings. As referred to above we also identified capacity issues in relation to the time

allocated to non-officer members for the review of relevant information in order to adequately undertake their role.

3.36 Further consideration was required by the health board as to how its committees prioritised and planned to deal with the most serious issues brought to their attention when the current level of information being provided was clearly falling short of what was required.

3.37 During the follow-up review, it was apparent that the health board has made the necessary considerations with regards to how information is presented at Board and sub-committee level. The current use of the information dashboards was a notable improvement and has proved successful in presenting key information in a format which allows for easier interpretation. However, it was recognised by health board staff that improvements in this area have been limited to predominantly secondary care service areas. We were advised that there are plans in place however, to develop a primary care dashboard to ensure that the health board is able to further assess the quality of care being provided to patients by practices.

3.38 Non-officer members confirmed that the information they receive has greatly improved since the 2011 review, and that they now feel fully informed prior to the meetings they attend. However, as detailed in the 'Non-officer Member' section, concerns remained around the time allocated to them to perform their role and whether it was in fact exceeding the four days remunerated. There were similar concerns highlighted during the 2011 review.

Challenge and Scrutiny

3.39 As part of the 2011 review, there were issues identified in relation to the level of challenge and scrutiny provided by non-officer members to members of the Executive Team. It was noted, whilst attending a Concerns (Complaints) Scrutiny Panel, that during the meeting there were some good examples of challenge and scrutiny. However, during the subsequent discussions with non-officer members, it became apparent that some of the non-officer members were less comfortable than others about the extent in which they were able to question rather than accept information.

3.40 The 2011 review also identified during the observations at the meeting that, at times, a minority of members of the Executive Team appeared defensive, poorly briefed and not keen to take on responsibility for follow-up work.

3.41 We have already highlighted in the preceding sections that the follow-up review has highlighted some significant improvements in the role of non-officer members. It is clear that non officer members are now subject to more

formal induction, training and development, and now feel they are better informed and more empowered to undertake their role. These factors all significantly contribute to the level of scrutiny and challenge afforded by non-officer members.

3.42   As previously mentioned in the 'Non-officer Members' section, staff we spoke to now feel there is considerably more scrutiny involved in the role they provide. It was clearly apparent during the team observations that the non-officer members present play an extremely important role in challenging and scrutinising discussions and decisions being made by members of the health board's Executive Team. It was felt that it had been influenced by a cultural change within the health board, which now meant that challenge and scrutiny was seen as a positive and beneficial element of the way in which the health board is run.

3.43   As part of our review, we also held discussions with the Cwm Taf Community Health Council (CHC) to discuss its role in providing the health board with challenge and scrutiny. Representatives from the Cwm Taf CHC routinely attend the complaints committee meetings held within the health board. We were informed that the CHC does feel able to raise concerns and challenge during these meetings about the health board's responses and planned action as a result of a complaint. We were informed that there have been occasions where the CHC has written directly to the Chief Executive to escalate concerns in relation to the length of time that it has taken to resolve certain complaints. During our discussions with the CHC, we were informed that they have concerns around the timescales for the health board to resolve some complaints, due to the complexity of complaints that are now being received. For example, some complaints involve several clinical areas which can make resolution of the complaint a lengthy process. It was clear from our discussions with staff that timeliness in responding to complaints remains an issue and a challenge for the health board to address.

Risk

3.44   Whilst there was an appreciation of the challenges faced by such a diverse health board in addressing risk management, and improvements noted throughout the course of the 2011 review, the team was concerned about flaws in the risk management process. There appeared to be a lack of understanding and appreciation of corporate risk at the most senior level.

3.45   The 2011 review found that there was no integrated approach to risk management from ward level to Board level; furthermore there was no process in place to ensure the standardised assessment, categorisation and

escalation of risk at all levels of the organisation. It was also noted that the risk register did not contain enough relevant information on action plans to enable thorough scrutiny of progress on actions and improvements made. Further to this, there was a lack of lateral application of the learning arising from risks and incidents across the organisation.

3.46 Overall it was recommended that that the health board devise a more robust system of risk management, with an appropriate level of assurance and scrutiny built in, that would ensure a standardised and consistent approach across to managing risk the organisation. The health board was also required to develop new staff training plans to compliment this change in process.

3.47 During the follow-up review, we saw that that the process of risk management within the health board has improved. It was refreshing to see that the health board recognise that it has yet to identify the exemplar system for risk management and is continuously looking for ways to improve. However the health board is satisfied that there is now a clear process in place.

3.48 The health board is now confident that key organisational risks are receiving the highest possible exposure to the Executive Team and scrutiny by non-officer members. The current corporate risk register is now more concise, clearly identifying an Executive Lead, a summary of actions and controls, review dates and the assuring committee responsible for the risk. The risks on the register are listed in priority order. However, the register does not currently detail the date the risk was first identified.

3.49 There is now a clearer process as to how any risk can be removed or de-escalated from the register. Firstly, a discussion would take place at the Corporate Risk Committee, and a revised assessment undertaken. Following this, the responsible executive lead for the risk on the Board would have to justify and rationalise why the risk can be removed. Any changes to the risk register are reported to the appropriate Committee of the Board.

3.50 Despite the improvements made to the process, there still did not appear to be a clear method of ensuring that lessons were being learned and shared across the wider health board areas following the identification of risks and incidents.

3.51 As with the 2011 review, it was highlighted by the follow-up review that not all areas within the health board, primarily primary care, were fully informing the risk register. This is due to issues of staff training and the introduction of the Datix system not being fully completed. During our discussions with staff from primary and secondary care they informed us that they were not routinely using Datix risk (the risk module) to record risks and concerns. The reason for this was either because the system was still in the process of being rolled out

to their area, a lack of training for staff or where it had been felt that the system was not user friendly.

3.52 The key risks raised during our own discussions with staff related to the difficulties experienced with regards to recruiting and retaining new GPs for the health board. We were told that the health board has been in discussion with trainee doctors to ascertain their views on what they feel their ideal job would look like with a view to potentially designing portfolio areas to try to aid recruitment – for example, three days working in a practice and two days working in A&E. We were also informed that other risks included ambulance waiting times, staff sickness levels within some areas, concerns around the capacity of the health board to deal with complaints within timescales and succession planning for the appointment of non-officer members within the health board.

3.53 We were informed that regular one-to-one meetings are held with the relevant clinical leads and should there be any risks or performance issues raised during these meetings, there are methods in place in which to assess the magnitude of the issues. For example, we were informed by the Director of Nursing that on occasions where issues are raised directly with her in relation to a particular area, she has carried out unannounced ward drop ins to observe the area for herself.

> **Recommendation for Cwm Taf University Health Board**
>
> Recommendation 6
> The health board should ensure that start dates are recorded for all risks which are added to the corporate risk register.
>
> Recommendation 7
>
> The health board should look to strengthen methods used to ensure that lessons learned following the identification of risks and incidents are shared widely with other relevant areas within the health board.
>
>
> Recommendation 8
> The health board should ensure that the Datix Risk Module is rolled out to all areas of the health board, that appropriate staff receive the required training in order to equip them to use the software as intended and risks are recorded properly.

Patient Complaints, Concerns and Claims

3.54   The 2011 review identified that the health board lacked a robust system for managing complaints and that the process that was in place was fragmented. A fundamental change implemented by the health board at the time, was to designate the Director of Nursing as the overall lead for complaints and the establishment of a Complaints Team. Despite the changes put in place, there were still a number of issues highlighted by the 2011 review, which included an issue around the capacity of the Complaints Team to deal with complaints within timescales set out by the new complaints system, the timeliness of the complaints process, the system for ensuring challenge and scrutiny of actions taken to address complaints and disseminating learning from the experience. All of these areas were identified as requiring strengthening.

3.55   The overall lead for complaints within the health board remains the Director of Nursing, with the Complaints Team being managed by the Assistant Director for Clinical Governance and Quality Improvement. We were informed that all complaints which are received by the health board are now managed by the Complaints Team.

3.56   The follow-up review found that there is now a clear process in place for dealing with complaints received by the health board, which is in line with the '*Putting Things Right*' process. The complaints team ensures that they involve and liaise with all appropriate members of staff in order to co-ordinate the most appropriate response, with all formal responses to complaints being ultimately signed off by the Chief Executive before release. We were informed that the Chief Executive saw this as necessary to ensure she remains up to date with the complaints being submitted to the health board and to identify any themes that may be arising.

3.57   The health board has introduced an early intervention mechanism into their complaints process, which aims to resolve complaints at an earlier stage and negates the need for a longer drawn out process for the complainant and the health board. The system involves all complaints received by the Complaints Team being triaged to identify the cases which could possibly be resolved via earlier intervention. Once a complaint has been identified, the team then liaise with the appropriate individuals from the relevant Directorate and attempt to arrange for a discussion to take place between them, the patient and/or the patient's relatives in an attempt for early resolution. When the attempts for early resolution are unsuccessful, the complaint would be dealt with via the *Putting Things Right* process.

3.58   We were informed that in some service areas (particularly within acute services) the ability to arrange early intervention meetings proved to be a

problem on occasions due to a lack of engagement and commitment by some clinicians to the process.

3.59   We were told that there has been an 8% reduction in complaints received by the health board in 2013/14 and that at the time of the review there were eight outstanding complaints which were more than six months old. However, as is noted within paragraph 3.61 below, it was highlighted during our visits to GP practices within the health board that despite being asked to by the health board, primary care staff were not routinely using Datix to record complaints/concerns that had been received. This issue presents some doubt about the completeness of the complaints figures for Primary Care.

3.60   During our discussions it was identified that meeting timescales in responding to complaints was a challenge. However, the health board has actively sought to understand the reason behind the delays, with the complexity of some of the complaints being identified as a main causal factor.

3.61   We were informed that during the quarterly complaints panel meetings, which are attended by members of the Executive Team, non-officer members and members of the CHC, that there is an open discussion around complaints/concerns received by the health board. Attendees at these meetings are able to raise questions about any specific complaints that have been received and are also able to scrutinise the proposed response and the action taken as a result of the complaint, including any follow-up of progress.

3.62   During our discussions with staff at the GP practices we visited it became apparent that the majority of complaints were being dealt with via the practices' own internal complaints procedure and not shared with the health board. It was clear that staff were not routinely using Datix to record the concerns/complaints that they were receiving. This was due to the fact that it either had not been introduced to their area, a lack of training or due to staff feeling that the package was not user friendly. We were informed by some staff we spoke to that there had been occasions where they had used Datix previously to log complaints received but had received no feedback from the health board, so they had therefore stopped using it.

3.63   During our discussions with the Cwm Taf CHC, concerns were also raised about complaints received in primary care and that the health board was not having sight of all complaints received. Under the terms of their contract, it is appropriate that Independent Contractors themselves (including GPs) deal with complaints made directly to their practice. They are required to provide high-level data to the Health Board as part of the quality monitoring arrangements but not necessarily the individual detail of all complaints. Where there is a serious complaint or incident that is escalated to the Health Board from any contractor then it is subject to the health board investigation

processes. Equally the CHC felt that some complaints had not been dealt with efficiently by the relevant GP Practice.

3.64   There are systems in place to enable the health board to be more proactive in trying to ensure that lessons are learnt as a result of the complaints received. For example, a member of the Concerns Team attends every Directorate Locality Quality and Safety meetings, thus ensuring that discussions regularly take place in relation to themes and lessons learned as a result of complaints received.

3.65   As with the 2011 review, concerns were raised again by the staff we spoke to in relation to the capacity of the Concerns Team in dealing with the complaints in accordance with the deadlines set by *Putting Things Right*. It was felt by staff we spoke to that the capacity issue for the health board in dealing with complaints should be considered as a risk moving forward.

3.66   The health board has undertaken an analysis to identify the themes arising from complaints and highlighted five areas which the health board plan to focus on. The five areas highlighted following the analyses were:

   ▪ Falls management
   ▪ Pressure ulcers
   ▪ Communication
   ▪ Flow management
   ▪ Dementia care.

3.67   The health board has made attempts to improve in these areas. For example, in relation to the concerns around lack of communication with relatives of patients, the health board has introduced 'visitor rounding'. The aim of this initiative is to try to encourage nursing staff to be more proactive in speaking to relatives on a regular basis. We were also informed that following a number complaints in relation to Ophthalmology the health board has made changes to the clinical pathways in this area in an attempt to prevent similar issues being experienced again in the future.

3.68   The health board has begun utilising communication platforms such as social media as a mechanism to address public concerns. We were informed that the Chief Executive has completed two Q&A sessions, responding to queries and concerns from members of the public. There are also plans to hold more of these sessions with the Chief Executive and Clinical Leads.

3.69   During the past 12 months HIW has been contacted by clinicians employed by the health board who have wished to raise concerns about their service area. This is not unusual as HIW routinely receives intelligence and concerns raised by patients, public and staff. In the cases relating to Cwm Taf University

Health Board, these issues have been raised with the health board, and have been responded to and dealt with accordingly. However, we feel it is important nonetheless to reflect that the health board should ensure that its staff feel confident in raising the matters internally, or in line with its whistleblowing policy.

Recommendation for Cwm Taf University Health Board

Recommendation 9
The health board should ensure that all staff are reminded of the need to record all complaints/incidents on Datix.

Recommendation 10
The health board should ensure that processes are in place to ensure feedback is provided to staff who submit complaints onto Datix in a timely fashion.

Recommendation 11
The health board should undertake a review of its capacity in dealing with complaints and concerns inline with the deadlines set out in the Putting Things Right process and the expectations set out in the 'listening and learning from feedback standard in the new Welsh Government Health and Care Standards.

Recommendation for NHS Wales

Recommendation C

Following on from the comments included in the Evans Report – '*Review of Concerns (Complaints) handling within NHS Wales – Using the gift of complaints',* we are pleased that work has been agreed to introduce an central database used across Wales to enable consistency in the reporting of incidents and complaints. We recommend that NHS Wales progress with the introduction of this new system.

Recommendation D

Following on from comments included with the Evans Report, NHS Wales should consider reviewing the current purpose of the All Wales Forums used to discuss and share lessons learned following on from risks and incidents, to include similar discussions in relation to complaints

Trend Analysis, Action Planning and Shared Learning

3.70   During the 2011 review it was identified that the sharing of lessons learned in relation to clinical effectiveness, audit, complaints and incidents across divisions and directorates was questionable and there was a lack of clear process for doing so. It was also identified that there was a lack of any robust trend analysis of complaints, concerns and incidents. Generally the review found a lack of consistency in the collection and feedback of information.

3.71   As already explained within the 'Patient Concerns, Complaints and Claims' section of this report, the health board now actively monitors themes and trends arising from concerns, complaints and claims and has now taken a more proactive approach to work with staff to implement the necessary improvements identified as part of this analysis. During the complaints panel meetings, attendees are able to question and scrutinise the action taken, including any follow-up on progress as a result of complaints received by the health board.

3.72   There is an independent mortality review process which is undertaken following all deaths which occur in the District General Hospitals and Community Hospitals within the health board. These reviews aim to examine each death individually and assess the care of the patient through primary and secondary care. We were informed that there is one session a week held at each of the District General Hospitals and involves all of the relevant directorates and does include primary care involvement. On average there are around 100 reviews undertaken a month for stage one, which is to complete a review of the medical documents to determine whether there are any issues with the death. Following this, if it is identified that the death was unexpected, the review moves onto stage two which involves speaking to relevant staff to try to gather further information. Should concerns remain after this stage, the review moves onto stage three, which looks to identify any concerns and areas/themes for improvement.

3.73   We were informed that to date 20% of deaths have gone onto stage two and in 1.6% of all deaths reviewed, it was identified that some action could have been taken that may have changed the outcome.

3.74   Our discussions with staff revealed that whilst there was initial reluctance from clinical staff about taking part in these reviews, it is now seen as very beneficial process. The reason for this is that staff felt that the reviews were not solely based on numbers, like RAMI (Risk Adjusted Mortality Index), and instead provide a lot more useful information and opportunities for learning. Issues which have been identified as areas for improvement from some of the

mortality reviews which have been completed have been in relation to communication and delays in diagnosis.

3.75   Despite the progress made with these reviews, the review team was disappointed when we were informed during our visits to primary care settings that not all of the staff at the practices were aware that the mortality reviews were taking place which indicates that they had not been made aware of the lessons learned identified from the reviews.

> **Recommendation for Cwm Taf University Health Board**
>
> Recommendation 12
> The health board should ensure that the learning identified following on from mortality reviews is shared with primary care areas as well as secondary care.

Partnership Involvement

3.76   The 2011 review called for the health board to increase partnership representation at Board and Committee Level, maximise opportunities to involve appropriate stakeholders in planning and improving services and to build and strengthen relationships with other health boards.

3.77   The follow-up review identified that progress has been made in all of these areas. The Director of Social Services from a Local Authority within the health board is an Associate member of the Board and plays an active role in the decision making process. The Local Authorities within the health board area are seen as a partner in many of the health boards processes, particularly in the escalation process for unscheduled care. There are also plans for a social worker to work on behalf of both the health board and the Local Authorities in dealing with unscheduled care cases.

3.78   The health board has a clear process for the management of and communication with stakeholders and partners regarding their plans for services. A single integrated plan has been agreed with each of the Local Authorities and the Third Sector.

3.79   During discussions with the CHC we were informed that there is a strong robust relationship with the health board, and it feels able to raise concerns with the Chief Executive, and is involved in devising any subsequent actions.

3.80   The Chair and Chief Officer of the CHC attend Public Board meetings and also have speaking rights. The CHC are represented at the Complaints Scrutiny Panel and also carry out visits to areas of the health board to

undertake inspections. There are around 50 inspections carried out each year and the location of these inspections is usually determined by concerns received within certain areas.

3.81   The health board has also been able to utilise the good relationship with the CHC during the recent changes to Mental Health services, particularly in instances where hospitals have been closed and services transferred. The constructive and open dialogue between the CHC and the health board during these challenging times resulted in extremely effective stakeholder engagement, subsequently resulting changes to inpatient bed configuration and a hospital being closed without the need for formal public consultation.

3.82   The health board also hold public forums chaired by the CHC, which are increasingly becoming far more clinically led, with more clinical involvement in the discussions taking place at the forums.

3.83   The Chief Executive has taken a very proactive role to engaging with the public – including holding live Facebook chats, an example of such engagement. A weekly blog from the Chief Executive and ann electronic newsletter is also available, and provides updates about the health board to both internal and external stakeholders.

3.84   In order to facilitate the demands and challenges of the South Wales Programme, there had been attempts made by the health board to engage and strengthen links with other health boards in order to consider possible ways in which to implement joined up innovative services.

Communication of Vision and Objectives

3.85   The 2011 review found that there were concerns from staff in relation to the direction of travel of the organisation, particularly in relation to the speed at which the changes would be brought about and the ultimate end point. The review highlighted the importance of engaging staff in order to gain buy in to the organisational vision, proposing the development of a 'Values' campaign.

3.86   More generally, although efforts were being made to disseminate information to staff, the need to improve the accessibility of communication from the corporate centre was noted as an area for consideration.

3.87   In April 2014, the health board launched its three year plan, outlining its vision and the steps it will take in order to achieve its goals. It is clear that the Executive Team is fully bought into the plan, and that secondary care service areas were aware of the three year plan. However, we have concerns in relation to some primary care service areas, which appeared to be less aware

of the plans moving forward, particularly in relation to the pending primary care strategy.

3.88   During the follow-up review, discussions were held with the Head of Communications / Media Manager for the health board that was relatively new in post. We were advised that the current communication strategy was coming to an end and a refresh was underway which would fully integrate with the three year plan. There was an appreciation that the new strategy of public engagement needed a more radical approach, with a new set of expertise and skills required to better manage the impact of digital and social media.

3.89   Currently the Chief Executive produces a weekly blog, which is used as an opportunity to disseminate key messages to staff, which on average is accessed by 2500 readers. There is a Quality blog which is issues fortnightly by one of the Clinical Executive Directors, updating the Board on quality specific improvements and developments. There is also the internal 'Grapevine'[9], which is a means for staff to anonymously ask questions of Senior Management and get a response. The health board is now making more use of social media to improve communication both externally and internally.

3.90   The reliance on the ability of staff to access the intranet in order to access communication remains an issue, as it was in 2011. The Head of Communication is currently in discussions with other health boards to try to find methods to improve the ways in which staff at ward level can be more effectively reached.

Recommendation for Cwm Taf University Health Board

Recommendation 13
The health board should consider additional methods to ensure staff working at ward level can be more effectively reached.

Staff Development and Appraisal

3.91   It was identified in the 2011 review that the approach to employee development and routine appraisals for staff was inconsistent across divisions and individual sites. Good practice was embedded within certain areas, however, it was highlighted that there were some staff who had not received a formal appraisal for six years.

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[9]   An online system which enables individuals to ask questions and gain information anonymously.

3.92   Further to this, it was apparent that there was no formal business planning linking the board, directorates and divisions. Also, not all staff performance was measured against suitable objectives that linked to the objective of the health board. To note on this point, the actions taken by the health board by publishing the three year plan are outlined in the preceding section.

3.93   During our follow-up review, it was again identified that appraisal compliance levels varied across the health board. We were informed that there were good compliance levels within the primary care and this was supported by discussions we held with relevant staff. We were told that the overall appraisal compliance level for the health board was 60%. However, issues around compliance levels in some secondary care areas were relayed back to the review team. These were predominantly in acute medical areas; the compliance level in one such area was reported at the time of our review indicating that only 20% of staff had received their annual appraisal. During our discussions with the Director of Nursing, we were informed that, should the compliance levels within certain areas not improve within the coming months, the relevant Head of Nursing would be held to account.

3.94   We were informed that there is a system in place to review compliance within primary care which is working well. A similar system has been introduced recently within secondary care; however, it was felt by staff that the system required further refinement. We were also told that work is currently being undertaken to ensure that the appraisal system is consistently being carried out as intended and not being seen as a tick box exercise.

3.95   The majority of staff that we spoke to felt that the provision of training opportunities within the health board had improved and that training development opportunities were discussed during appraisal meetings. However, during our discussions with staff it was highlighted that issues had been experienced in relation to staff being allowed the time to undertake the training available due to the demand and capacity in their relevant areas.

Recommendation for Cwm Taf University Health Board

Recommendation 14
The health board should ensure that all staff are allocated sufficient time to undertake their required training needs.

Recommendation 15
The health board should ensure all staff receive regular appraisals.

Recommendation 16
The health board should ensure that there is a robust system in place to monitor appraisal compliance levels within secondary care areas.

Monitoring Performance

3.96   The 2011 review found that there was limited evidence of real performance data being used to evaluate performance. At directorate level, systems for governance and performance management were variable. However, there was an appetite for developing performance criteria and indicators with a view to thinking more innovatively about performance information.

3.97   During the follow-up review, it was highlighted that there is now a clear process for monitoring the performance of each directorate to ensure all areas are keeping in line with the three year plan. The performance dashboard is reviewed by the Executive Team and non-officer members routinely at the Board meetings and during monthly Finance and Performance Committee meetings. It is also reviewed routinely at the monthly Executive Board meetings. This dashboard is continuously being developed to ensure its effectiveness.

3.98   Monthly clinical business meetings in all directorates are held to discuss performance issues and achievement made against Key Performance Indicators (KPIs), such as waiting times in theatres. Any performance issues highlighted at these meetings which require the development of an action plan in order to achieve improvement, is to be discussed at subsequent meetings. Where performance issues are not adequately addressed, 'holding to account' meetings are undertaken (although it was noted that it is rare for the process to go this far).

3.99   Quality reports are produced detailing performance, and issues relating to performance, are subsequently reported to the Board. The Executive Team is confident that sufficient data is available to allow for a suitable oversight of the health boards performance, and feel more equipped to address performance issues.

Chapter 4: Conclusion

4.1   Our review has highlighted that the health board has made significant improvements in the majority of the areas highlighted during the initial review carried out in 2011. Overall, HIW is pleased and encouraged with the progress that has been made. The health board's efforts in this regard are praised and we hope that these improvements continue with a renewed focus on the outstanding challenges which have been highlighted by our follow up review.

4.2   It is our intention therefore to continue to proactively monitor progress against the recommendations made in this report.

Chapter 5:   Recommendations

Recommendations for Cwm Taf University Health Board:

Clinical Teams and Leadership

Recommendation 1
The health board should consider methods to strengthen engagement with primary care areas across the four locality areas.

Recommendation 2
The health board should ensure that each cluster plays an integral role in the development and implementation of the Primary Care Strategy.

Recommendation 3
The health board should ensure that systems are in place to empower and support primary care staff to develop new ideas to improve services.

Recommendation 4
The health board should ensure that the Primary Care Team is adequately staffed by experienced staff to provide the required level of support to practices.

Non-Officer Members

Recommendation 5
The health board should ensure that they prepare thorough succession plans that will support and enable the successful recruitment of new non-officer Members, and thus ensure a smooth transition, and the continuation of, the valuable role that the current members are providing the health board.

Risk

Recommendation 6
The health board should ensure that start dates are recorded for all risks which are added to the corporate risk register.

Recommendation 7

The health board should look to strengthen methods used to ensure that lessons learned following the identification of risks and incidents are shared widely with other relevant areas within the health board.

Recommendation 8
The health board should ensure that the Datix Risk Module is rolled out to all areas of the health board, and that appropriate staff receive the required training in order to equip them to use the software as intended.

Patient complaints, concerns and claims

Recommendation 9
The health board should ensure that all staff reminded of the need to record all complaints/incidents on Datix.

Recommendation 10
The health board should ensure that processes are in place to ensure feedback is provided to staff who submit complaints onto Datix in a timely fashion.

Recommendation 11
The health board should undertake a review of its capacity in dealing with complaints and concerns inline with the deadlines set out in the Putting Things Right process and the expectations set out in the 'listening and learning from feedback standard in the new Welsh Government [Health and Care Standards.](#)

Trend Analysis, Action Planning and Shared Learning

Recommendation 12
The health board should ensure that the learning identified following on from mortality reviews is shared with primary care areas as well as secondary care.

Communication of Vision and Objectives

Recommendation 13
The health board should consider additional methods to ensure staff working at ward level can be more effectively reached.

Staff Development and Appraisal

Recommendation 14
The health board should ensure that all staff are allocated sufficient time to undertake their required training needs.

Recommendation 15
The health board should ensure all staff receive regular appraisals.

Recommendation 16
The health board should ensure that there is a robust system in place to monitor appraisal compliance levels within secondary care areas.

Recommendations for NHS Wales

Clinical Teams and Leadership

Recommendation A
Consideration should be made by NHS Wales of the current model of care for patients with dementia developed on Cambrian Ward and other wards across Wales judged to be excellent in line with learning models, with the view to adopt such models across all health boards in Wales.

Non-Officer Members

Recommendation B
In line with the current review being undertaken in Wales, consideration should be made by NHS Wales, as to whether health board non-officer members within Wales are allocated with enough time to enable them to carry out the full requirements of their roles.

### Patient Complaints, Concerns and Claims

Recommendation C

Following on from the comments included in the Evans Report – '*Review of Concerns (Complaints) handling within NHS Wales – Using the gift of complaints',* we are pleased that work has been agreed to introduce an central database used across Wales to enable consistency in the reporting of incidents and complaints. We recommend that NHS Wales progress with the introduction of this new system.

Recommendation D

Following on from comments included within the Evans Report, NHS Wales should consider reviewing the current purpose of the All Wales Forums used to discuss and share lessons learned following on from risks and incidents, to include similar discussions in relation to complaints.

Annex A: Health Board Governance and Assurance Structure

Cwm Taf University Health Board Governance and Assurance Structure
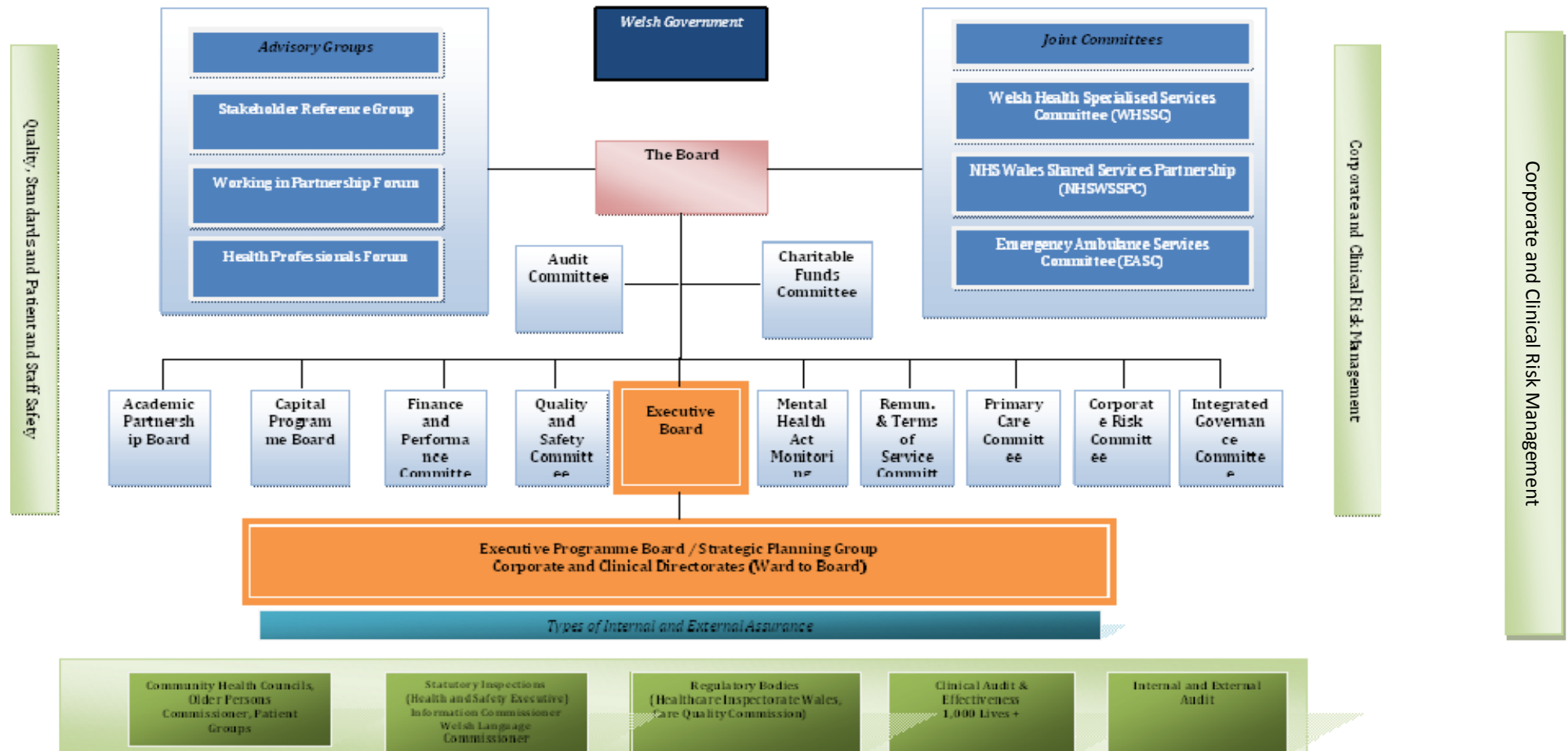
Annex B: Terms of Reference

Independent External Review of Governance Arrangements at Cwm Taf Health Board

In 2010, at the invitation of Cwm Taf Health Board Healthcare Inspectorate Wales undertook a review of the governance arrangements that the Health Board had put in place to ensure the quality and safety of patient care. HIW will now commence a follow up review to assess the progress of the Health Boards actions against the 54 recommendations made.

Terms of Reference

The aim of this review is to provide a collective view of the progress that Cwm Taf Health Board has made since the publication of the HIW report published in 2012. It is intended that the review will:

- Assess the progress that the Health Board has made in respect of the 14 themes identified as part of the initial review.
- Highlight any new areas of concern that may arise from our follow up review.

Methodology and timescale for the review

The review will be managed by HIW and consist of:

- Document and data review;
- Interviews with staff from the Health Board;

HIW established a small review team which had the necessary expertise and consisted of:

- Paul Barnett   Peer Reviewer (Former Chief Executive of Carmarthenshire NHS Trust)
- Rob Hall   Peer Reviewer (Former General Practitioner)
- Richard Jones MBE   Peer Reviewer (Registered Nurse with 40 years post registration experience in clinical educational and managerial aspects)
- Jenny Hepworth   Lay Reviewer