Bundle Trust Board (Open Session) 6 January 2020

1.a 09:15 - Welcome and Apologies For Absence (Chairman)

1.b 09:18 - Declarations of Interest (Lead: MW)

2 09:20 - Quality Governance Arrangements Self-Assessment (KC)

To seek Board's comments and agreement to submit the attached self-assessment on the Trust's quality governance arrangements to Welsh Government.

ITEM 2 .0 Trust Board - Governance arrangements SBAR.docx

ITEM 2.0a Cwm-Taf-Morgannwg-UHB-Joint-review-Eng.pdf

ITEM 2.0b MHSS to Chairs and CEOs - All Wales Self-Assessment of Quality Governanc....pdf

ITEM 2.0c MHSS to Chairs and CEOs - All-Wales Self-Assessment of Current Governanc....docx

AGENDA ITEM No	**2**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Quality Governance Arrangements Self-Assessment

MEETING	**Trust Board**
DATE	**6 January 2020**
EXECUTIVE	**Board Secretary**
AUTHOR	**Corporate Governance Manager/ Board Secretary**
CONTACT DETAILS	**Email: Keith.Cox@wales.nhs.uk**

CORPORATE OBJECTIVE	**All**
CORPORATE RISK (Ref if appropriate)	**All**
QUALITY THEME	**All**
HEALTH & CARE STANDARD	**All**

REPORT PURPOSE	**To seek Board's comments and agreement to submit the attached self-assessment on the Trust's quality governance arrangements to Welsh Government.**
CLOSED MATTER REASON	**Not Applicable**

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Trust Board	**6 January 2020**	**Approval**

SITUATION

1 To seek Board's comments and agreement to submit the attached self-assessment on the Trust's quality governance arrangements to Welsh Government.

BACKGROUND

2 The damming report on maternity services at Cwm Taf University Health Board by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwifes, identified a number of serious concerns and service failures within the Health Board. Not least, it raised the question on how, at that point, a Health Board could be perceived as performing well but preside over a service which fell well below the required standards for many of its patients.

3. The Royal Colleges' report highlighted concerns that had previously been raised by the Wales Audit Office (WAO) and Healthcare Inspectorate Wales (HIW). As a consequence of the Royal colleges' findings, WAO and HIW took the view that it was both timely and necessary to undertake further work via a joint review. This is only the second time such a joint review has been undertaken, the previous one being at Betsi Cadwaladr University Health Board in 2013.

4. The joint WAO/HIW report was issued in November 2019. The report highlights a number of fundamental deficiencies in the Health Board's quality governance and risk management arrangements. Of particular concern is the fact that the report echoes failings identified in other reviews both within Wales and across the UK.

5. In total, the Report makes 14 recommendations for the Heath Board to act on. Nevertheless, in order to gain assurance on the robustness of quality governance arrangements across all NHS bodies in Wales, the Minister has requested that Health Boards and Trusts undertake a self-assessment against each of the Reports recommendations on their own quality governance arrangements.

6. To ensure a consistent approach, Health Boards and Trusts have been asked to complete the self-assessment pro-forma and return this to Welsh Government officials by 7th January 2020. The WAO/HIW Report and the letter from the Minister are attached for ease of reference.

ASSESSMENT

4 The attached self-assessment has been carried out by the Corporate Governance team in connection with the Quality, Safety and Patient Experience Directorate. In completing the pro-forma, the teams have tried to keep responses balanced and factual and where there are weaknesses, or where more work is needed, these have been identified.

5. It is worth noting that a major feature of the Cwm Taf report was the Health Board's pre-occupation on achieving financial balance, which may have contributed to the lack of focus on quality and patient safety issues. Whilst it is recognised that the Trust is not necessarily in the same position as the Health Board, nor have the same range of complex clinical services, overall the self-assessment considered that the Trust's controls and processes were stronger and better established than those detailed in the Cwm Taf report.

5 The self-assessment also comments on whether our own controls and processes in relation to each of the recommendations is strong, medium or weak. The Board's independent perspective on these conclusions would be particularly valuable in supporting whether the self-assessment has managed to maintain a balanced view.

RECOMMENDED

Thant the Board:

1) **Review and comment on the attached self-assessment;**
2) **Agree, subject to any comments, that the self-assessment can be submitted to the Welsh Government.**

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

November 2019

A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board

Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office

Contents

Foreword

The recent report on maternity services at Cwm Taf University Health Board by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives identified a number of serious concerns and service failures. Most worryingly, it shone a light on some behaviours and practices that have no place in a modern, caring NHS organisation.

A clear question to emerge from the Royal Colleges' report was how a could a health board that was perceived to be performing well within the NHS Wales system of targets and measures have presided over maternity services which fell well below the required standards of care for many of its patients. There is no straightforward answer to that question and issues such as organisational culture, pressure on services, patient expectations and individual staff behaviours all come into play. More fundamentally, however, the Royal Colleges' report raises questions about the rigour of the quality governance arrangements in the Health Board, that is the system of checks and balances that provide the organisation with the necessary information it needs to know whether its services are both safe and effective.

The Royal Colleges' report threw into sharp focus concerns Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) had previously articulated about the Health Board's quality governance and risk management arrangements. Our organisations had already signalled plans to examine these arrangements in more detail. Following the publication of the Royal Colleges' detailed findings, we took the decision that it was both timely and necessary to undertake that further work as a joint review. This is only the second time such a review has been undertaken, the previous one being at Betsi Cadwaladr University Health Board in 2013.

The findings we present in this report highlight a number of fundamental deficiencies in the Health Board's quality governance arrangements. Some of these can be, and indeed are being addressed fairly quickly. Others will take more time and will require changes to long established ways of working and thinking.

Whilst this report focuses on Cwm Taf Morgannwg University Health Board, we plan to undertake examinations of quality governance arrangements in other NHS organisations Wales in the near future. This report should be used as an opportunity for wider reflection and learning by the NHS in Wales, both within individual NHS organisations, and across the system as a whole.

Adrian Crompton
Auditor General for Wales

Kate Chamberlain
Chief Executive, Healthcare Inspectorate Wales

Acknowledgements

We are grateful to the Health Board for supporting the review. Particular thanks are due to Greg Dix, Gwenan Roberts, Lucy Timlin and Leanne Baylis for supporting the review in helping to arrange the fieldwork weeks and documents, and to Board members and directorate staff who made themselves available at short notice.

Introduction and background

Background

1 Cwm Taf University Health Board was established in 2009 and on 1 April 2019, it changed its name to Cwm Taf Morgannwg University Health Board having taken on responsibility for provision of healthcare services for the people of Bridgend County Borough Council area, including the Princess of Wales Hospital.

2 At the end of April 2019, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives published a highly critical report on maternity at the former Cwm Taf University Health Board. As a result of the Royal Colleges' report, the Health Board's maternity services were placed into special measures and the organisation was escalated to the status of 'targeted intervention' within the NHS Wales escalation and intervention framework[1].

3 During the Royal Colleges' review, it became apparent that a consultant midwife on secondment to the Health Board had produced an internal report highlighting many of the concerns subsequently reported by the Royal Colleges. However, the consultant midwife report had not been adequately considered by the Health Board and no immediate action was taken to address the concerns it identified. The Health Board's Chair has subsequently commissioned a separate independent review into the handling of the consultant midwife report and another related report by the Welsh Government's Delivery Unit into the management of concerns[2].

4 In addition to concerns around maternity services, a report by the Human Tissue Authority in 2018[3] identified concerns around mortuary service arrangements in the former Cwm Taf University Health Board. Inspections by Healthcare Inspectorate Wales also identified a range of concerns regarding mental health services, surgical services, maternity services and compliance with the Ionising Radiation (Medical Exposure) Regulations. Moreover, the 2018 Wales Audit Office structured assessment[4] report highlighted weaknesses in several aspects of the Health Board's quality governance arrangements.

5 Collectively, these concerns have prompted HIW and the WAO to undertake an urgent and more detailed examination of quality governance arrangements in the Health Board. The results of that examination are presented in this report.

1 The NHS Escalation and Intervention arrangements

2 In March 2019, the NHS Delivery Unit completed a report (unpublished) titled the **Management of concerns (Learning lessons and managing risk) and the supporting governance arrangements.**

3 The Human Tissue Authority report 2018

4 Cwm Taf University Health Board Structured Assessment 2018

6 As context to these findings, it should be acknowledged that the programme of work to implement the transfer of Bridgend services to the Health Board was extensive and absorbed a lot of senior leadership capacity. In addition, there has been a considerable amount of recent turnover with both the executive and independent member cadre on the Board and in August 2019, the Health Board's Chief Executive stood down.

About this review

7 The overarching objective of this review was to examine whether Cwm Taf Morgannwg University Health Board's governance arrangements supported the delivery of high quality, safe and effective services.

8 The review examined the Health Board's overall corporate arrangements for quality governance, together with the quality governance arrangements within the surgical services directorate. Our work focused predominantly on the Prince Charles and Royal Glamorgan Hospital sites and involved:

- Interviews with a range of independent members, executives, corporate and surgical directorate staff
- Drop in sessions with staff working within surgical directorate and emergency departments within Prince Charles and Royal Glamorgan Hospitals
- Observations of key meetings and committees
- Review of documentation in relation to quality governance
- Survey of staff working within surgery, theatres and emergency departments across the Health Board.

Further detail about our review approach can be found in Appendix 1. A terms of reference for the review can be found on HIW's and WAO's websites[5]. A summary of the results from our staff survey can be found in Appendix 2.

9 Our findings have been grouped under the following themes:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Directorate arrangements for quality and patient safety
- Identification and management of risk
- Management of concerns
- Organisational culture and learning.

5 The HIW/Wales Audit Office Joint Review of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board

Wales Audit Office: Working with others

10 The review team have maintained an ongoing dialogue with other interventions and external reviews underway at the Health Board; most notably, the work being carried out by the Independent Maternity Services Oversight Panel[6], the Delivery Unit[7], the Welsh Risk Pool[8], David Jenkins[9], and the independent review into the internal handling of a report prepared by a seconded consultant midwife announced in May 2019[10]. Given the latter, the review team have not considered the issues that are within the scope of the independent review.

6 The Written Statement: Final Terms of Reference for the Independent Maternity Services Oversight Panel

7 The NHS Delivery Unit provides professional support to the Welsh Government to monitor and manage performance and delivery across NHS Wales. In 2019, the Delivery Unit have been undertaking several pieces of work within Cwm Taf Morgannwg University Health Board, including work around maternity services, unscheduled and scheduled care, and the management of incidents.

8 The Welsh Risk Pool acts as a support function to NHS bodies in Wales. The team work with NHS colleagues to ensure that learning is in place following legal claims against health bodies. The Welsh Risk Pool have been recently undertaking work in Cwm Taf Morgannwg University Health Board in relation to the management of claims against the Health Board.

9 David Jenkins is an independent advisor to the Health Board to support the Board to improve its leadership and governance.

10 In May 2019, the Chair of the Health Board commissioned an independent review into the handling of a report by a seconded consultant midwife in September 2018, which raised a number of concerns about maternity services.

Summary of the main conclusions

11 Our review has highlighted a number of fundamental weaknesses in the Health Board's governance arrangements in respect of the quality of care and patient safety. We are concerned that these weaknesses are compromising the Health Board's ability to adequately identify and respond to problems that may arise with the quality and safety of patient care. Significant and urgent improvements are needed at both the directorate and corporate level to either strengthen or more fundamentally overhaul existing arrangements, organisational structures and roles. There is also a pressing need to tackle a number of issues associated with the culture of the Health Board in order to create a climate which supports open and informed debate on issues relating to the quality and safety of patient care.

12 The Health Board has a good track record of achieving financial balance, producing approvable integrated medium-term plans and meeting key performance measures. There has been strong and necessary attention on these issues within the Health Board, but there seems to have been less of an organisational focus on the quality and safety of services, evidenced by the absence of a clear vision and up-to-date strategy for quality and patient safety.

13 Leadership arrangements for quality and patient safety within the Health Board need to be strengthened and broadened. We identified the need for clarity of roles, responsibilities and accountability in relation to quality and patient safety within both the executive team and the directorates. The role of the Medical Director and Clinical Directors was particularly unclear in this respect.

14 We are particularly concerned about the ability of the Quality, Safety and Risk Committee (QSRC)[11] to scrutinise the information presented to it effectively due to a lack of analysis, triangulation and the volume of information the committee receives. Progress on the development and implementation of the new Quality and Patient Safety Governance Framework[12] has been slow and further work is needed to ensure this is fit for purpose. The quality and clarity of papers presented to the Board and its committees need to be improved to enable informed debate and appropriate scrutiny by independent members. In general terms, there has been insufficient focus and resource dedicated to gathering, analysing, monitoring and learning from patient experience across the Health Board.

11 The Cwm Taf University Health Board's Quality, Safety and Risk Committee

12 A document written by the Health Board which outlines their approach to ensuring the provision of safe and quality care, and the structures which are to be established both at a committee level as well as at a directorate level.

15 There was a lack of clarity and consistency in the governance structures in place at directorate level. The focus, scrutiny, format and transparency of Clinical Business Meetings (CBMs)[13] need improvement. We also found evidence of lack of capacity of both corporate and directorate staff to focus on the quality and patient safety agenda.

16 Previous work by both HIW and the WAO at the Health Board has identified the need to strengthen risk management arrangements. It was therefore disappointing to see that weaknesses still persist in this area and urgent work is now needed to ensure there are clear and comprehensive risk management systems at directorate and corporate level. At its most basic level, there needs to be greater clarity on where responsibility for the corporate risk register sits within the Health Board's governance structures, as current corporate documents are contradictory on this. More generally, there is a need to strengthen arrangements for the population and review of risk registers and the escalation of risks and to ensure there is greater ownership and understanding of risk registers and escalation arrangements at directorate level.

17 The review team found examples of normalisation/acceptance of working with high levels of risk. During our work, we needed to raise an immediate cause for concern in relation to this within the emergency departments at both Prince Charles and Royal Glamorgan Hospitals. Whilst the Health Board responded positively to the concerns we raised, this is an area that is going to need close ongoing review.

18 Concerns around incident reporting within the Health Board had been a key prompt for the review of maternity services by the Royal Colleges. Our findings, and those of others, point to a wider need to both review and strengthen the management of incidents, claims and complaints (concerns) within the Health Board. This needs to include a critical appraisal of how incidents are classified and reported and significant strengthening of the approaches to triangulate information from different sources to support better analysis of concerns and organisational learning.

19 The organisational culture within the Health Board, and its impact on quality governance, emerged as a strong theme from the review. Our staff survey revealed a mixed picture in relation to staff's confidence in raising concerns. Whilst some felt sufficiently empowered, other responses pointed to a culture of fear and blame and a reluctance to speak out because they felt nothing would be done. This points to a need for senior leadership in the Health Board to set the right tone for a culture of high-quality, compassionate and continually improving care. The new Values and Behaviours Framework that is being developed provides an opportunity to secure the improvements which are necessary.

13 Clinical Business Meetings are directorate meetings which report on directorate performance and service delivery.

20 A particular challenge facing the Health Board, is to move from an organisation that has traditionally been very centrally controlled to one where staff at an operational level are empowered to take responsibility for issues and improvement, especially in response to concerns and complaints. The Health Board must also strengthen its processes and procedures to identify and share learning from across the organisation, including from concerns and external reports. Currently, these arrangements are significantly underdeveloped.

21 Whilst the review has highlighted some significant concerns and the need for urgent action in a number of areas, there is cause for some optimism that the required improvements can be made. There is new leadership within the Health Board who have recognised the challenges and are demonstrating a willingness to make the changes needed. Additional capacity has been brought in to strengthen quality governance arrangements which should increase the pace of improvements. However, the scale of the challenge should not be underestimated and many of the improvements which are necessary cannot be achieved overnight. The Health Board is working to address many of the issues identified within this report but will need to demonstrate pace and resilience to address the fundamental challenges that remain.

22 The issues set out above are explored in more detail in the following sections of this report, together with our recommendations for the Health Board.

Detailed findings

Strategic focus on quality, patient safety and risk

The Health Board has not articulated its organisational vision for quality clearly. This means all levels in the organisation have struggled to articulate the quality priorities of the Health Board and demonstrate improvements. Key risk management documents appear to be out-of-date and the process for compiling the organisational risk register is unclear.

23 Documents such as the Integrated Medium-Term Plan (IMTP)[14] and the interim Quality Strategy do not provide explicit priorities for quality. The IMTP for 2019-2022 makes a commitment for the Health Board to achieve the vision articulated by the Welsh Government in 2018 through the 'A Healthier Wales' strategy[15]. The interim Quality Strategy developed in August 2018 was very high level and whilst it details the processes around quality and its importance, it did not set out the expectations for directorates in relation to quality and patient safety. Our review of the surgical directorates' IMTP mirrored this and did not identify targets by which success could be measured.

24 These findings support the consistent message from staff we spoke to that there has been an insufficient organisational focus on the quality of services compared to achieving financial and performance targets. Whilst it was acknowledged that the Health Board has maintained financial balance and produced an approvable IMTP, there must be an equal focus on the quality of services. The drive to meet financial targets needs to be balanced against the impact on the quality and outcomes of the service being delivered.

25 It is of note that until very recently, the internal annual 'accountability letters', which set out the organisation's expectations for its directorates, did not include any specific requirements in respect of quality of services. We understand that the accountability letter template has now been updated to include quality as a measure. Going forward, the aim is to include a quality schedule outlining the quality priorities for the directorates. This was being developed at the time of the review.

26 The Board Assurance Framework (BAF)[16] used by the Health Board is out-of-date, in that it does not reflect current IMTP priorities, and the arrangements it describes for oversight of key risks are different to what is set out in the Health Board's current Risk Management Strategy.

14 Integrated Medium Term Plans 3 Year Plans

15 In Brief – A Healthier Wales: our Plan for Health and Social Care

16 The Board Assurance Framework (BAF) is a tool that sets out the assurances required to know that control measures are effective and risks are being managed. Cwm Taf University Health Board: Board Assurance framework

27 The current BAF, which was prepared in 2017, states that whilst the Board will closely monitor its key risks, it will delegate risk monitoring to the Audit Committee[17]. However, the BAF had not been received by the Audit Committee since April 2017. Similarly, the Audit Committee has not received the corporate risk register since 2017.

28 The Health Board's Risk Management Strategy 2018-2023, states that the Quality Safety and Risk Committee (QSRC) oversees and monitors the BAF. However, whilst this committee has received the corporate risk register, it does not appear to have ever received the BAF. This would suggest a gap in the corporate arrangements to oversee the BAF and a general need to ensure that the BAF, the Risk Management Strategy and committee terms of reference are up-to-date and consistent. We are aware that the Health Board is reviewing the allocation of corporate risks to the QSRC, with a view to moving this back to the Audit Committee.

Leadership of quality and patient safety

Historically, the executive responsibility for quality and patient safety has sat with the Director of Nursing role, rather than being shared responsibility as in other health boards. Medical leadership in particular needs strengthening. Within many directorates, including surgical services, there are no dedicated leadership roles for quality and patient safety. The accountabilities and responsibilities for quality and patient safety within the directorates were unclear.

29 At the time of this review, responsibility for quality has sat with the Director of Nursing, Midwifery and Patient Care. From August 2018 until April 2019, there was a temporary Director of Nursing in post and there have been no Assistant Directors of Nursing to support the executive role. We found that the role of the Medical Director and Clinical Directors in respect of quality and patient safety was unclear. In other health boards, the responsibility for quality and patient safety is a shared responsibility between the Director of Nursing, Medical Director and Therapies Director. The Health Board has not had a Director of Therapies and Health Sciences for approximately two years, which should provide additional executive support for quality and patient safety. We also found the roles of the other executive directors and the Chief Operating Officer were ill defined in relation to quality and patient safety.

17 Cwm Taf University Health Board's Audit Committee: How we work

30 We found there has been a lack of strong senior leadership to set the right tone for a culture of high-quality, compassionate and continually improving care. Medical leadership was widely acknowledged to have been particularly lacking. Whilst there is positive working between clinicians at ward and clinical speciality levels, it was recognised that the quality of clinical leadership is variable and needs strengthening throughout the organisation. The Medical Leadership Forum[18] was cited as a key mechanism for providing medical leadership, but we found this meeting could be poorly attended and lacked clear focus.

31 In relation to leadership within the surgical directorate, greater clarity is needed regarding the roles and responsibility of the site-based Heads of Nursing and how they interact with the directorate structure. The Heads of Nursing have responsibility for quality and patient safety for a hospital site, but the Directorate Manager has responsibility for the surgical services across all hospital sites. This has led to ambiguity as to who is responsible for quality and patient safety. The scope of the Heads of Nursing roles also needs to be reviewed as they reported that they spend a significant amount of time managing estate issues, which limits their focus on patient and professional issues. In addition, staff and clinicians we interviewed were unclear about responsibilities and accountabilities for quality and patient safety within the directorate and the reporting arrangements. Interviewees also stated that the focus on quality and safety within specialities was variable.

Organisational scrutiny of quality and patient safety

A Quality and Patient Safety Governance Framework has been developed in response to recognised weaknesses in quality governance arrangements. However, implementation of the framework has been slow and operational awareness of it needs improving. There is a pressing need to improve the quality and breadth of management information on quality and patient safety matters, in order to support effective scrutiny at the Board and committees.

Effectiveness of the Quality Safety and Risk Committee

32 In 2016, the Health Board merged the Quality and Safety Committee and the Corporate Risk Committee (QSRC) with the intention of reducing duplication and improving effectiveness. Until recently the QSRC had met quarterly, unlike the Finance and Performance and Workforce Committee, which meets 10 times a year. These arrangements have recently changed so that QSRC also now meets monthly, although these arrangements are being kept under review.

18 The Medical Leadership Forum is a meeting for senior medical clinical leaders to discuss issues relating to workforce, clinical practice and quality and safety matters.

33 This QSRC was previously supported by the Quality Steering Group (QSG), which collated information from several sub-groups in order to support information flows to the QSRC. The QSG was also responsible for the preparation of the Annual Quality Statement[19]. However, as reported in the WAO 2018 structured assessment[20], the QSG met infrequently and its reports to the QSRC were sporadic and not compliant with the terms of reference. This QSG has now been disbanded, following the approval of the new Quality and Patient Safety Governance Framework.

34 The ability of the QSRC to properly discharge its function is hampered by the lack of a clear performance/quality dashboard to assist members to scrutinise information effectively. The Health Board has recently developed a draft quality dashboard, however, it is lacking in narrative, targets and interpretation of quality indicators. In addition, better triangulation of data across a range of sources (quantitative and qualitative) is needed to ensure the quality dashboard is fit for purpose and to support service improvement.

35 Currently, the QSRC receives exception reports from directorates on issues relating to risks, quality and patient safety. However, there is variability in what is reported by the directorates and what is to be escalated. Until very recently, there was no standard template for reporting, resulting in each area developing their own reporting frameworks. Due to the inconsistencies of information provided to the main committees, it was difficult to triangulate information and identify themes and trends. It is positive that the quality and consistency of the exception reports presented to the QSRC have improved recently. However, there is still a concern that the QSRC has insufficient time to scrutinise these properly due to the volume and length of papers they need to consider at each meeting. It is also unclear how issues raised within directorate exception reports are acted upon.

36 The Health Board also needs to ensure its management information covers the breadth of its new footprint as currently, there is a lack of visibility and oversight of quality and patient safety issues in the Princess of Wales Hospital in Bridgend.

19 The Annual Quality Statement is the mechanism for health boards to update its resident population and provides an opportunity to let the public know, in an open and honest way, how it is doing to ensure its services are addressing local need and meeting high standards. Annual Quality Statement 2018/2019 Guidance

20 Cwm Taf University Health Board Structured Assessment 2018

Development of quality and patient safety governance framework

37 We recognise the Health Board's recent commitment to place quality and patient safety at the heart of its planning and delivery of healthcare. As part of this, a Quality and Patient Safety Governance Framework was drafted in autumn 2018 and was approved in April 2019. This document sets out the expectations for clinical directorates in terms of their governance structures and establishes four sub-groups to support the work of the QSRC and replace the now defunct QSG. However, five months following the approval of the framework, only two of the sub-groups have had an initial meeting and the terms of reference for the four sub-groups are yet to be developed. Moreover, the resource requirements at a directorate level to implement the framework are yet to be finalised.

38 Whilst the framework represents a development on the previous arrangements, it does not set clear aims in relation to quality, such as zero tolerance to never events, no preventable deaths, or a focus on continuous quality improvement. There are also no clear measures of success nor quality targets to support scrutiny. The framework will need to be supported more effectively by a new Quality Strategy to replace the out-of-date interim strategy. The framework is also not referenced by other key Health Board governance documents. Currently, it sits as an isolated top down strategic document.

39 The framework notes that the role of data analysts, with access to software to support their function, is crucial in enabling data generation, analysis and triangulation of information from different sources. However, there are currently no plans in place to progress this which means that the Health Board continues to operate with insufficient business intelligence and analytical capacity.

40 Whilst we understand that some action has been taken by the Health Board to raise awareness of the new governance framework for quality and patient safety, many of the staff we spoke to at directorate level were not aware of this. We could not find any corporate information feeding to the directorates, the Medical Leadership Forum, or senior nurse meetings to highlight the new framework.

41 An interim programme director has been appointed and has commenced an engagement and implementation programme for the framework. This will include discussions with directorate staff, establishing a term of reference for each of the sub-groups, with the aim to complete the overall implementation work by December 2019. We also understand that the intention is to refresh the framework to align with the new Values and Behaviours Framework, once the latter has been developed.

Role of independent members

42 Independent members play a vital role in the oversight and scrutiny of Health Board performance, including the quality and safety of services. However, the deficiencies in the information presented to the Board and committees, highlighted earlier in the report, are compromising their ability to fully discharge their role.

43 Independent members reported that the volume, timeliness of receiving papers and presentation of information at Board and committees were a barrier to providing effective scrutiny. They felt that key messages and risks were not highlighted clearly and they had to rely on executives to draw attention to these. We are aware that executives and independent members recognise these issues and are currently working together to find ways to address this. This work needs to be undertaken in a timely way.

44 During interviews with independent members, many expressed concerns that they had not been sighted on the issues within maternity services through the information presented to them at committees and the Board. It was recognised there had been too much positive 'gloss' within the Health Board reporting and independent members had accepted information in good faith without detailed challenge. This has naturally affected the levels of trust within the organisation, although it was positive to note that despite this, the relationship between independent members and executives has remained largely positive and constructive.

45 Previously, independent members took part in regular visits to wards and other patient areas with executive staff. This provides independent members with an increased understanding of frontline services and gives staff an opportunity to raise any concerns directly with them. These visits also provide an opportunity for independent members to triangulate information presented at the QSRC against observations at ground level. For reasons which are not entirely clear, these 'walkarounds' have been in abeyance for some time, although we understand they have recently been reinstated.

46 During 2017-18, there was a significant change of independent members due to the terms of office concluding. The WAO 2018 structured assessment noted that the QSRC had an independent member vacancy for a significant part of 2018. It was acknowledged by Health Board staff that there has been a loss of experience, with a number of new less experienced independent members and little development provided for their role. Independent members confirmed they did not have a detailed induction which would have provided clarity about their responsibilities for governance and scrutiny.

Gathering patient experience

47 It was generally acknowledged by independent members and Health Board staff that improvement is needed around gathering meaningful patient experience across the organisation, including a greater focus and resource dedicated to this. Although patient stories are presented at QSRC and Board, independent members felt that patient experience information needed a higher profile. The Health Board has a patient experience plan which sets out a range of activities undertaken by the Health Board to gain a picture of patient experiences, with the aim of identifying issues and good practice. However, this plan lacks detailed actions, timeframes and outcome measures. Therefore, it is difficult for independent members to review progress against the plan. A review by Internal Audit[21], highlighted a lack of consistency in how patient experience information is reviewed and a risk that the Health Board is not gathering information across all areas.

48 Staff described issues around insufficient focus, a lack of capacity to support patient experience and the need to gather real-time patient feedback. During the review, we considered the resources within the Patient Advice and Liaison Service (PALS)[22] team. There were five Whole Time Equivalent (WTE) staff members at the Princess of Wales Hospital dedicated to the collection of patient experience, including unannounced visits and collection of real-time data, compared to 1.8 WTEs to cover both the Royal Glamorgan and Prince Charles Hospitals. This highlights the differences in resources allocated between the previous two Health Boards.

Use of clinical audit

49 Clinical audit is an important way of providing assurance about the quality and safety of services. The Health Board has a clinical audit plan and we were briefed on the range of clinical audit work that takes place within the surgical directorate and how this improved care. However, despite good work by local clinical teams, we found the Health Board is not effective at sharing areas of good practice and learning across the organisation. In addition, oversight of the range of audit and improvement activity taking place needs improvement. Whilst the Audit Committee received the clinical audit plan, there is insufficient visibility and oversight of the range of audit and improvement activity at corporate level.

21 The Internal audit patient experience report March 2018

22 The Patient Advice and Liaison Service (PALS) acts as a point of contact for patients and staff wishing to get advice and information about services, listens to concerns and helps find ways of resolving them. The PALS also has a responsibility to gather patient feedback and provide reports to Health Board committees. Cwm Taf University Health Board: Concerns and Complaints

Directorate arrangements for quality and patient safety

There are variable arrangements in place to support quality and patient safety at directorate level. The role of the Clinical Business Meetings in relation to quality and patient safety is unclear and needs strengthening.

Directorate arrangements to support quality and patient safety

50 Our work and an internal review[23] of directorate governance arrangements, undertaken by the office of the Chief Operating Officer, highlighted there were variable directorate governance structures. Responsibility for the structures which sit within the directorates has previously not been prescribed by the Health Board, until the development of the new Quality and Patient Safety Governance Framework. This led to inconsistent and varied structures across directorates and a lack of clarity around the flow of information from the directorates to the corporate and executive teams. Additionally, there has been a lack of corporate support on quality governance, leaving directorates short on capacity in this area.

51 Without a clear directorate governance structure operating effectively, there is a risk that issues are not being effectively captured and fed through the Health Board's governance structure. The Health Board has identified through the implementation of the Quality and Patient Safety Governance Framework that additional resources will be needed at both corporate and directorate level.

52 A large number of interviewees described a lack of capacity of both corporate and directorate staff to focus on the quality and patient safety agenda. Many felt that the Directorate Managers did not have the time to consider quality and safety as a priority and there was a lack of leadership training to support staff who had responsibility for oversight of quality and patient safety. Whilst detailed analysis of workforce trends within the Health Board was beyond the scope of this review, the staff we spoke to frequently described middle management as being 'too lean', with capacity and capability at this level having been eroded over time.

53 The surgical directorate has its own QSRC which is scheduled to meet monthly. However, the review found only three of the seven meetings planned in 2018-19 went ahead. In our observation of one of these meetings, we found attendance was poor and with the exception of the chair, there were no other medical consultants present. The infrequency of these meetings and poor attendance call into question the robustness of this committee and its role in quality and patient safety.

23 The internal review (unpublished) considered the directorates' and localities' governance arrangements for quality and patient safety.

54 It is positive that we are starting to see directorates highlight the need for more governance resources within their exception reports to corporate QSRC. The IMTP for the surgical directorate has also identified a governance lead as an additional requirement for the directorate, although the request for the resources is yet to be considered.

Effectiveness of clinical business meetings

55 Clinical Business Meetings (CBMs) are directorate meetings which are chaired by the Chief Operating Officer and are seen as the business link between the directorate management team, including clinical management and the executive team. The CBMs report on directorate performance and monitoring of IMTP delivery. Within the surgical directorate, we found that whilst the CBMs received some information on incidents and complaints, the focus has predominantly been on finance and performance. Information presented lacked detail as to what actions were being taken or lessons learnt from the concerns being received. However, recently the Heads of Nursing have developed an improved patient experience and quality report which has a greater focus on learning and actions.

56 We found CBM action logs to be high level, which makes it difficult to understand the actions. Issues identified as needing action do not appear to be followed up. This is compounded by the variability in quality governance resources within directorates, a lack of escalation mechanisms and quality priorities at corporate and directorate level.

57 Whilst the CBM process should review the directorate risk registers and feed through to the executive management board, there is little formal evidence of this happening in practice. This arrangement is also not mentioned within the current Risk Management Strategy.

58 Staff we spoke with were unclear about whether the CBM had the authority to make decisions and if a decision was made, where this was escalated for approval. We found the there is a lack of clarity about which committees the CBMs reported to. It is understood that currently, CBMs only report to the executive management board. When matters are reported, staff felt they received very little information back from executives. This was a source of frustration for staff.

Identification and management of risk

There is an urgent need for the Health Board to strengthen its arrangements for the identification and management of risk at directorate level. The Health Board needs to clarify where responsibility for oversight of the corporate risk register sits within the organisation. The Board also needs to clearly articulate its risk appetite around quality and patient safety.

59 HIW's 2012 governance review[24] identified the need for improvements in risk management within the Health Board. It was therefore disappointing to find in this review, that there were still a number of weaknesses in the Health Board's processes for identifying and managing risk.

60 As stated earlier in this report, there is a lack of clarity at a corporate level in relation to the oversight of risk and monitoring of the BAF. Whilst the QSRC now receives the full organisational risk register, there is no other forum for consideration of risk within the Health Board. Historically, there was a risk management group, but this has not met for some time.

61 At directorate level, many staff were unclear about where responsibility for the directorate risk register sat and how issues were escalated. There was no clear process for the identification or scoring of risk within the directorate. From our interviews with staff, it was clear that risk registers were not up-to-date.

62 Within surgical services, we found the directorate risk register was poorly developed. Although risks were identified, there were no mitigating actions, responsible person or timescales recorded. It is unclear how and where the directorate risk log is reported or how it links with the corporate risk register. This issue was reported by a number of staff. There was also a lack of confidence that risks from the directorate would be escalated and if they were escalated, that they would be acted upon.

63 Organisationally, there is no cross checking to ensure there is a completed risk register for all areas of the organisation. Risk processes appeared to be reactive rather than proactive. There was also a lack of risk management training in place for staff.

24 A Review of Governance Arrangements at Cwm Taf Health Board

64 Through our work, we found examples of normalisation/acceptance of working with high levels of risk. During the review, our visits to the emergency departments at the Prince Charles and Royal Glamorgan Hospitals found that it was becoming normal for these departments to be working with high levels of risk. In speaking to a range of emergency department staff, we found consistent themes and areas of concern which we felt could pose an immediate risk to the safety of patients. These practices had become normalised and we were extremely concerned to hear that staff across both sites consistently describing operating at a high level of risk and feeling that practice was unsafe. Staff said they had repeatedly raised these issues and now felt they could do no more to escalate their concerns. These issues centred on nurse and doctor staffing levels, safety and dignity of managing patients in corridors, the arrangements for accepting diverted ambulances from other areas, the impact of service changes and staff morale/support. As a result, we raised this immediately with the Health Board and were given assurance that urgent remedial actions were taken to ensure patient safety.

Management of concerns

There is little evidence of triangulation of information in relation to incidents, claims and complaints (concerns) at a directorate or corporate level. Importantly, there is also no formal process for learning from concerns. The arrangements for reporting patient safety and non-patient safety incidents need to be reviewed.

65 DATIX is a database used throughout Wales to record, monitor and create reports relating to incidents, claims and complaints. The Health Board currently categorises information from DATIX into two areas, 'patient safety' and 'non-patient safety'. In other health boards, all incidents are reported as relating to patient safety because it is felt that all reported incidents relate to the provision of safe and effective care. Therefore, there is a risk that key information relating to patient safety is not being analysed if it is reported as 'non-patient safety'. For example, under these arrangements low staffing levels are reported as 'non-patient safety', however, low staffing can have a direct impact on the quality and safety of care. In relation to patients, falls that do not result in an injury are reported as 'non-patient safety' incidents. This is a missed opportunity to link falls rates across areas to identify trends and themes to prevent future falls occurring.

66 During our work and previous HIW inspections[25], staff stated they have been discouraged from reporting or 'over using' DATIX. However, this is at odds with the results from our survey of staff in which 78% of respondents felt they were encouraged to report errors, near misses or incidents. It was also encouraging that over half of staff responding to the survey felt that action is taken when errors, near misses or incidents are reported. Over half of staff also said that the learning from these errors, near misses and incidents is shared.

67 During our staff drop in sessions, staff were generally positive about the DATIX system however, many felt that matters such as low staffing levels were reported but nothing was done to address these issues and no feedback was provided.

68 Staff reported that using DATIX can be seen as a role for nurses rather than medical staff. Training in the use of DATIX is limited with many staff reporting that they had not received training. Of those who had received training, this had focused upon the completion of a DATIX form rather than in running reports, monitoring progress with incidents or reviewing themes and trends.

69 There does not appear to be a process to support the development of the DATIX system and its use as a learning tool. Staff from the Princess of Wales Hospital were critical of the DATIX process within the Health Board and expressed concerns that they did not feel that the organisation was listening or willing to learn from their own experiences following the 2014 Andrews report **Trusted to Care**[26].

70 For those providing investigation training within the directorates, it was reported that some staff were resistant to being trained. This lack of engagement was also commented on by the Welsh Risk Pool when they offered to provide incident and investigation training. We would support the recommendation from the Delivery Unit that the organisation should consider how they ensure that all staff involved in undertaking reviews and investigations have the right skills and support.

25 The unannounced hospital inspection of Royal Glamorgan Hospital Wards 12 and 19 March 2018

The unannounced inspection of Royal Glamorgan Hospital Maternity Services October 2018

26 The 2014 Professor Andrews report was commissioned by the Minister for Health and Social Services following raised concerns about patient care in the Princess of Wales and Neath Port Talbot Hospitals. The review focused on the quality of care for older people at these hospitals and highlighted a number of serious concerns.

The Trusted to Care report

71 We could not be assured that there is a systematic review of concerns to identify themes and trends over time and actions needed to improve care. This is because the accountability and responsibility of the different DATIX reports produced and how these are reviewed at different meetings are unclear. There is a little real-time data and an unclear reporting framework. There is little evidence triangulation of information in relation to concerns at a directorate or corporate level. Importantly, there is also no formal process to learn from concerns at a directorate or corporate level.

72 Staff at both corporate and operational level reported they had limited capacity to review concerns. Following a serious incident, there is good clinical engagement in the investigation process, but no dedicated directorate capacity to work with the corporate improvement manager. The corporate improvement manager will co-ordinate the pulling together of the incident report, but the responsibility for the development and monitoring of action plans sits within the directorate. In not owning the report, there is a risk the directorate team may not take sufficient ownership of improvement actions from this.

73 Currently, the model for complaints management is for the directorate to provide statements from staff and information for the corporate concerns team to pull together the complaint response. Often, the directorate does not get to see the final response. This results in a lack of ownership at local level and a lack of actions to make systemic improvements following complaints.

Organisational culture and learning

The organisation did not set the right culture at corporate and executive level to ensure adequate focus and attention were given to quality and patient safety. There is a lack of formal systems to identify and share learning across the organisation. There is currently no Values and Behaviours Framework in place within the Health Board. In relation to the raising of concerns, we received mixed feedback from staff within the surgical directorate. It was worrying that a proportion of staff, who responded to our survey, reported that they had experienced harassment, bullying or abuse. Several staff we spoke to felt that historically, poor behaviours had not been tackled.

Culture within the organisation

74 Every organisation has its own particular culture, which is often shaped by the cultures which existed in its predecessor bodies and by the experiences and challenges that the organisation has been through. The culture within the former Cwm Taf University Health Board can be described as one in which there was a high degree of central or corporate control. This may, in part, be a legacy from the period when the Health Board was in 'turnaround' in response to concerns about its financial management. Whilst a strong central approach may be appropriate for an organisation in difficulty, adjustments are necessary as the organisation returns to more routine arrangements. Without such adjustments, there is a risk that staff within the organisation will not be empowered to take responsibility for service oversight and improvement. Within Cwm Taf Morgannwg University Health Board, there are a number of functions which are handled at the corporate level rather than within the directorates, such as safeguarding, infection control, and concerns. This results in a lack of ownership around these areas at directorate level.

75 During the review, several of the staff we spoke to referred to the phrase 'the Cwm Taf way' to describe what has clearly been a particular way of doing business within the Health Board. Following the transfer of services from the Bridgend area, the Health Board has the opportunity to develop a fresh and positive culture. It is encouraging that work has begun to develop and launch a Values and Behaviour Framework. However, the challenge in changing the culture of the organisation should not be underestimated and particular attention needs to be given to the integration of Bridgend services. Staff in the Princess of Wales Hospital told us that the transition had not been a positive experience with staff feeling that the hospital had been 'taken over' with little engagement with clinical teams to understand how the hospital operates.

Culture around raising concerns

76 Our work revealed a mixed picture in relation to the culture around raising concerns amongst staff. Half of staff who completed our survey agreed that patient facing staff were empowered to speak up and act when poor care was identified. Feedback from consultants we spoke with was generally positive around their confidence to raise concerns and escalate these directly with the executive team if necessary. We were told of the positive work being undertaken by Heads of Nursing and senior nurses to empower nursing staff. Most of the ward staff we spoke with were positive about the ward managers.

77 In some areas, there still appears to be a culture of fear and blame relating to the reporting of incidents. Of the staff who completed our survey, one quarter of staff felt the organisation blames or punishes people who are involved in errors, near misses or incidents. This was particularly felt by nursing staff at the Prince Charles and Royal Glamorgan Hospitals.

78 There is also a reluctance for some staff to speak out because of a lack of confidence that concerns would be acted upon. Nearly half of staff responding to our survey felt that managers would not act on feedback from staff. A report by Internal Audit in 2018[27], issued a limited assurance on the arrangements for staff to raise concerns.

79 At directorate level, many staff we spoke with raised concerns about low clinical staffing levels and high use of bank, agency and locum staff. HIW has also previously identified issues around staffing in its inspections within the Health Board[28]. This led to stress amongst ward staff. Some staff, in Prince Charles Hospital in particular, stated they constantly worried about staffing as they did not have time to do a good job and were distressed by this. Within the emergency departments, several staff members told us they experienced high levels of anxiety about coming into work due to the pressures and concerns about patient safety they would encounter. Staff consistently told us that they have raised concerns with managers and whilst some felt that managers had listened to them, there was a lack of timely action being taken as a result. We raised this with the Health Board and were provided with assurance that these matters would be urgently addressed.

27 The Internal audit report raising concerns

28 The unannounced hospital inspection of Royal Glamorgan Hospital Wards 12 and 19 March 2018

The unannounced hospital inspection of Surgical Services: Trauma and Orthopaedic Care at the Royal Glamorgan Hospital September 2018

The unannounced inspection of Royal Glamorgan Hospital Maternity Services October 2018

Experience of harassment, bullying or abuse

80 Over one third of staff who completed our survey said they had personally experienced harassment, bullying or abuse at work from managers and team leaders or other colleagues in the last 12 months. Of these staff, the responses were relatively even across Prince Charles, Royal Glamorgan and Princess of Wales Hospitals, with the Royal Glamorgan Hospital having the highest number of staff reporting these issues. Across the professions, 41% of nursing staff and 32% of medical staff across the three sites said they had experienced bullying. From the staff we spoke to, there was a commonly held view that historically poor behaviours and cultures have not been challenged, with an unwillingness from senior managers to tackle this. This was also highlighted within the Royal Colleges' maternity report. Of the staff who completed our survey, 42% said they felt the organisation would not take effective action if staff were bullied, harassed or abused by other members of staff. Of these figures, almost half of nursing staff said they did not feel the organisation would take effective action to address bullying. However, this was less apparent with medical staff, with only 23% of staff reporting that this would not be addressed.

81 The Health Board have recognised the issues around bullying and have taken positive steps to address this through an anti-bullying group chaired by an independent member, but it is too early to consider the impact of this initiative.

Approach to organisational learning

82 As part of effective quality governance, organisations need to ensure they are listening and learning through a range of sources, internal and external, to support the delivery of safe and effective care. This is an area where the Health Board needs to make significant improvements.

83 We found that opportunities for learning from the Bridgend transfer have not been taken. For example, the Princess of Wales Hospital staff felt there had been little consideration of the benefits of the Friends and Family Test[29] and the learning gained following the Andrews report.

29 The NHS Friends and Family Test was created to help services/organisations understand whether their patients are happy with the service provided, or where improvements are needed. Patients are invited to complete an anonymous survey after their treatment or are discharged from a service. The main question is in relation to whether patients would recommend services to their friends and family.

84 In respect to learning from external reports, the Health Board did not take the opportunity to clearly disseminate and share learning from the Royal Colleges' report on maternity services. Many staff we spoke with had not read this report or, if they had, did not think it had relevance within the surgical directorate or consider what learning could be taken from it. Whilst the Medical Director and assistant Medical Director confirmed that formal communication regarding the Royal Colleges' report had been sent to staff and discussed at Medical Leadership Forums, we could find no evidence within the agendas/minutes to confirm this. This is particularly disappointing given the seriousness of the findings from this report.

85 There has been a lack of visibility of HIW reports in Board and QSRC. More specifically, it was disappointing that many of the staff we interviewed within the surgical services directorate were not aware of HIW's previous surgical services inspections or the findings[30].

86 HIW has also identified a lack of learning following a series of inspections within Royal Glamorgan Hospital mental health services from 2015-2018[31]. This was formally raised with the Health Board in August 2018. It was apparent that the pattern of findings and gravity of the issues across inspections had not been fully recognised, either by the mental health service, or by the Health Board itself. Given the Health Board committed to ensuring wider learning from these matters, it was disappointing that insufficient progress has been made during HIW's subsequent follow-up inspection in July 2019.

87 More positively, however, HIW's follow-up inspection of Royal Glamorgan Hospital maternity services in September 2019[32] showed that significant improvements had been made. Patients and staff also reported their satisfaction with the maternity service.

30 HIW conducted a pilot surgical services inspection in the Prince Charles Hospital in 2017 (unpublished) and a full inspection of the Royal Glamorgan Hospital in 2018 The unannounced hospital inspection of Surgical Services: Trauma and Orthopaedic Care at the Royal Glamorgan Hospital September 2018

31 The unannounced mental health and learning disability inspection of Royal Glamorgan Mental Health Unit October 2015

The unannounced mental health and learning disability inspection of Royal Glamorgan Mental Health Unit July 2016

The unannounced mental health follow up inspection of Royal Glamorgan: Seren Ward and Enhanced Care Unit January 2017

The unannounced NHS Mental Health Service inspection of Royal Glamorgan Hospital Audit Mental Health admission ward, Wards 21, 22 and Psychiatric Intensive Care Unit January 2018

The unannounced mental health follow up inspection of Royal Glamorgan Hospital: Seren and St David's wards June 2018

The unannounced NHS Mental Health Service inspection of Royal Glamorgan Hospital Audit Mental Health admission ward, Wards 21, 22 and Psychiatric Intensive Care Unit July 2019

32 HIW's inspection report of Royal Glamorgan Hospital maternity services in September 2019 is due to be published in December 2019 on HIW's website Link to publications about Royal Glamorgan Hospital on HIW's website

88 The Health Board has recognised that it needs to introduce a process for learning from external reports. There is now a standing agenda item in QSRC to cover external reviews. What is less certain, is whether the QSRC will have the capacity to collate and track all recommendations from a range of external reports, in order to monitor actions and share learning. As part of the new Quality and Patient Safety Governance Framework, the proposed learning sub-group has been identified as the place that learning will be shared across the Health Board. However, the scope and terms of reference for this group have yet to be confirmed.

Recent organisational developments

89 Over the last six months, the Health Board has made a number of new appointments, including a new interim Chief Executive, interim Board Secretary and interim Director of Workforce and Organisational Development. The Health Board has also recently appointed a substantive Executive Director of Nursing, Midwifery and Patient Care, Medical Director and Director of Therapies and Health Sciences. This provides opportunities for the Health Board to introduce new ways of working with a greater focus on quality and patient safety. It should also enable clear leadership, visibility and decision making to drive the organisation forward.

90 During this review, we have seen the Health Board behave with openness and transparency with external review bodies. The development of a Values and Behaviours Framework will help to reinforce and embed a positive working culture within the organisation.

91 We are aware of ongoing work and consultation on a new organisational structure. This should help to clarify roles and responsibilities in relation to quality and patient safety. The Health Board has recognised that the structures around quality and patient safety need to change. Recently, the Health Board has assigned additional capacity to support the implementation of the Quality and Patient Safety Governance Framework. However, further work is needed to strengthen this and link it with the development of a new Quality Strategy.

92 Resources to support the focus on quality and patient safety need to be allocated at both corporate and directorate level. Additional capacity has been brought into maternity services and there is positive evidence of improvement following HIW's maternity inspection of the Royal Glamorgan Hospital in September 2019.

93 The Health Board recognised that more work is needed to develop the Board, including how the executive team work together, and with the independent members in terms of scrutiny, decision making and ensuring sufficient focus on quality. A Board development programme has been agreed, with the first session being held in September 2019.

94 Whilst the developments are positive, the scale of the challenges to improve quality and patient safety governance is not to be underestimated and will require focused and sustained commitment by the Health Board. We hope the recommendations within this report will help the Health Board to make the necessary changes.

Recommendations

Issues for the Health Board

95 This review has identified a number of recommendations that the Health Board must act upon. We have identified the need for action at the corporate and directorate level. Whilst the latter has been informed by our examination of arrangements in the surgical directorate, our wider fieldwork indicates that they are likely to be relevant across all directorates. These recommendations need to be considered in line with those made by other bodies, including the work being carried out by the Independent Maternity Services Oversight Panel, the Delivery Unit, the Welsh Risk Pool, David Jenkins, and the independent review into the handling of the report by a seconded consultant midwife.

Recommendations to improve the strategic focus on quality, patient safety and risk

1. The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.

2. The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically:

    I. The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities

    II. The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety Governance Framework and any changes to the management of risk within the Health Board

    III. The Quality and Patient Safety Governance Framework must support the priorities set out in the Quality Strategy and align to the Values and Behaviours Framework

    IV. Terms of reference for the relevant committees, including the Audit Committee, QSRC, and CBMs, reflect the latest governance arrangements cited within the relevant strategies and frameworks.

Recommendations for leadership of quality and patient safety

3. Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:

    I. Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety

    II. Clarify the roles, responsibilities, accountability and governance in relation to quality and patient safety within the directorates

    III. Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.

Recommendations for organisational scrutiny of quality and patient safety

4. The roles and function of the QSRC need to be reviewed to ensure it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include the following:

    I. Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively

    II. Improvements to the content, analysis, clarity and transparency of information presented to QSRC

    III. Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications and training.

5. Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.

6. There needs to be sufficient focus and resources given to gathering, analysing, monitoring and learning from patient experience across the Health Board. This must include use of real-time patient feedback.

7. There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.

Recommendations to improve the arrangements for quality and patient safety at directorate level

8. The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.

9. The form and function of the directorate governance committees and CBMs must be reviewed to ensure there is:

    I. Clear remit, appropriate membership and frequency of these meetings

    II. Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions

    III. Clarity of the role and decision making powers of the CBMs.

Recommendations to improve the identification and management of risk

10. The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.

Recommendations to improve the management of incidents, concerns and complaints

11. The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.

12. The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning.

Recommendations for organisational culture and learning

13. The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation.

14. The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales Hospital.

Wider issues for NHS Wales

96 We hope that other health boards will reflect on the findings presented in this report and seek to assure themselves that any relevant issues are being addressed appropriately and in a timely manner within their own organisations.

97 The Welsh Government will no doubt also want to reflect on the issues raised in this report and give consideration to how they will gain assurances on the robustness of quality governance arrangements across other NHS bodies. Through the development of the new Health and Social Care (Quality and Engagement) (Wales) Bill[33] with its emphasis on quality, the Welsh Government also has an opportunity to consider its role in monitoring the effectiveness of NHS bodies in relation to quality and patient safety.

33 The Health and Social Care (Quality and Engagement) (Wales) Bill: summary

Appendix 1 – review approach

98 This review sought to address the following overall question: Do Cwm Taf Morgannwg University Health Board's governance arrangements support delivery of high quality, safe and effective services? To answer this question we considered the following key lines of enquiry:

- Is the quality and safety of services understood at an operational level, with concerns adequately acted upon?
- Is the quality and safety of services understood at the corporate level, with concerns adequately acted upon?
- Does the organisation promote an open, listening and learning culture to support the delivery of high quality, safe and effective services?

99 To test these arrangements, we looked at the Health Board's overall corporate arrangements for quality governance arrangements, which included consideration of governance processes for managing and learning from concerns and incidents. We also examined arrangements within the surgical services directorate, from ward to Board, focusing on the Prince Charles and Royal Glamorgan Hospital sites. Given the known pressures on unscheduled care services (which are not unique to Cwm Taf Morgannwg University Health Board), we included visits to the emergency departments at both hospitals.

100 In selecting the surgical services directorate for review, we considered a number of factors. Maternity services are currently under considerable scrutiny by the Welsh Government, the Independent Maternity Oversight Panel and the Delivery Unit. We therefore felt that it would be pertinent to determine whether concerns in relation to quality governance existed in other areas. We also needed a discrete area within the Health Board to explore directorate and corporate quality governance arrangements in sufficient detail. The surgical directorate met this criterion. In addition, maternity services were previously managed within the surgical directorate and, given the concerns within those services, we felt that quality governance within the surgical directorate would be worthy of closer examination.

101 Fieldwork for our review was conducted between July and August 2019. This included the following:

- **Interviews:** We conducted over 60 interviews with all independent members, executives, and a range of corporate and surgical directorate staff.
- **Drop in sessions:** On 23 and 24 July 2019, we held drop in sessions for staff working in surgery, theatres and emergency departments in the Royal Glamorgan and Prince Charles Hospitals. We spoke to a range of over 35 staff during our sessions.
- **Observations:** We observed various operational meetings within the Health Board, including at directorate/speciality level. This included observations at Quality, Safety and Risk Committee and Board meetings during our fieldwork.
- **Documentation review:** We considered over 300 documents in relation to quality governance, including strategies, frameworks, and the terms of reference for various committees and groups, meeting minutes and papers, amongst others.
- **Staff survey:** Between July and August 2019, we conducted a staff survey of those working within surgery, theatres and emergency departments across the Prince Charles, Royal Glamorgan and Princess of Wales Hospitals. We received a total of 121 responses. A summary of the survey responses can be found in Appendix 2.

Appendix 2 – staff survey: surgical, theatres and emergency departments

102 Alongside the fieldwork for this review, we conducted a staff survey of those working within surgery, theatres and emergency departments across the Prince Charles, Royal Glamorgan and Princess of Wales Hospitals. We received a total of 121 responses. This survey was intended to capture a snapshot of staff views at the time of our work and in the areas of the Health Board where we were undertaking fieldwork. It should not therefore be interpreted as representative of all staff opinions across the organisation. Nonetheless, we expect the Health Board to use the feedback from this survey to inform the improvements it needs to make in its overall approach to quality governance including the introduction of the new Values and Behaviour Framework.

Please indicate the hospital site you work at

			Response Percent	Response Total
1	Royal Glamorgan		31.53%	35
2	Prince Charles		23.42%	26
3	Princess of Wales		45.05%	50
			answered	111
			skipped	10

Please indicate your area of work

			Response Percent	**Response Total**
1	Surgery		31.48%	17
2	Theatres		31.48%	17
3	Emergency department		37.04%	20
			answered	54
			skipped	67

Job role				
			Response Percent	Response Total
1	Nursing		52.99%	62
2	Medical		16.24%	19
3	Theatre		1.71%	2
4	Therapy		3.42%	4
5	Administrative		8.55%	10
6	Housekeeping		3.42%	4
7	Healthcare support		6.84%	8
8	Management		5.13%	6
9	Other (please specify):		4.27%	5
			answered	117
			skipped	4

Delivery of safe and effective care						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Response Total
1. I am satisfied with the quality of care I give to patients	37.3% (44)	28.8% (34)	12.7% (15)	12.7% (15)	8.5% (10)	118
2. I am satisfied with the quality of care my colleagues provide to patients	28.2% (33)	34.2% (40)	16.2% (19)	15.4% (18)	6.0% (7)	117
3. There are enough staff within my area to support delivery of safe and effective care	9.4% (11)	10.3% (12)	12.8% (15)	25.6% (30)	41.9% (49)	117
4. Patients and/ or their relatives are involved in decisions about their care	27.6% (32)	42.2% (49)	25.0% (29)	5.2% (6)	0.0% (0)	116
5. Communication between senior management and staff is effective	6.0% (7)	24.8% (29)	13.7% (16)	24.8% (29)	30.8% (36)	117
6. The patient environment in my area supports safe and effective care	18.8% (22)	23.9% (28)	16.2% (19)	17.9% (21)	23.1% (27)	117
					answered	117
					skipped	4

1. I am satisfied with the quality of care I give to patients			Response Percent	Response Total
1	Strongly agree		37.3%	44
2	Agree		28.8%	34
3	Neither agree nor disagree		12.7%	15
4	Disagree		12.7%	15
5	Strongly disagree		8.5%	10
			answered	118

2. I am satisfied with the quality of care my colleagues provide to patients			Response Percent	Response Total
1	Strongly agree		28.2%	33
2	Agree		34.2%	40
3	Neither agree nor disagree		16.2%	19
4	Disagree		15.4%	18
5	Strongly disagree		6.0%	7
			answered	117

3. There are enough staff within my area to support delivery of safe and effective care			Response Percent	Response Total
1	Strongly agree		9.4%	11
2	Agree		10.3%	12
3	Neither agree nor disagree		12.8%	15
4	Disagree		25.6%	30
5	Strongly disagree		41.9%	49
			answered	117

4. Patients and/or their relatives are involved in decisions about their care			Response Percent	Response Total
1	Strongly agree		27.6%	32
2	Agree		42.2%	49
3	Neither agree nor disagree		25.0%	29
4	Disagree		5.2%	6
5	Strongly disagree		0.0%	0
			answered	116

5. Communication between senior management and staff is effective			Response Percent	Response Total
1	Strongly agree		6.0%	7
2	Agree		24.8%	29
3	Neither agree nor disagree		13.7%	16
4	Disagree		24.8%	29
5	Strongly disagree		30.8%	36
			answered	117

6. The patient environment in my area supports safe and effective care			Response Percent	Response Total
1	Strongly agree		18.8%	22
2	Agree		23.9%	28
3	Neither agree nor disagree		16.2%	19
4	Disagree		17.9%	21
5	Strongly disagree		23.1%	27
			answered	117

Organisational culture						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Response Total
7. The directorate encourages teamwork	11.9% (14)	30.5% (36)	23.7% (28)	19.5% (23)	14.4% (17)	118
8. Patient facing staff are sufficiently empowered to speak up and take action when poor care is identified	13.8% (16)	42.2% (49)	19.0% (22)	18.1% (21)	6.9% (8)	116
9. There is a culture of openness and learning within the directorate that supports staff to identify and solve problems	14.3% (17)	25.2% (30)	16.8% (20)	21.8% (26)	21.8% (26)	119
10. Managers act on staff feedback	10.2% (12)	16.1% (19)	24.6% (29)	24.6% (29)	24.6% (29)	118
11. Managers act on patient feedback	13.9% (16)	35.7% (41)	32.2% (37)	8.7% (10)	9.6% (11)	115
12. I have personally experienced harassment, bullying or abuse at work from managers/ line managers/team leaders or other colleagues in the last 12 months	25.2% (30)	12.6% (15)	15.1% (18)	19.3% (23)	27.7% (33)	119
13. My organisation takes effective action if staff are bullied, harassed or abused by other members of staff	7.6% (9)	16.1% (19)	33.9% (40)	20.3% (24)	22.0% (26)	118
					answered	118
					skipped	3

7. The directorate encourages teamwork			Response Percent	Response Total
1	Strongly agree		11.9%	14
2	Agree		30.5%	36
3	Neither agree nor disagree		23.7%	28
4	Disagree		19.5%	23
5	Strongly disagree		14.4%	17
			answered	118

8. Patient facing staff are sufficiently empowered to speak up and take action when poor care is identified			Response Percent	Response Total
1	Strongly agree		13.8%	16
2	Agree		42.2%	49
3	Neither agree nor disagree		19.0%	22
4	Disagree		18.1%	21
5	Strongly disagree		6.9%	8
			answered	116

9. There is a culture of openness and learning within the directorate that supports staff to identify and solve problems			Response Percent	Response Total
1	Strongly agree		14.3%	17
2	Agree		25.2%	30
3	Neither agree nor disagree		16.8%	20
4	Disagree		21.8%	26
5	Strongly disagree		21.8%	26
			answered	119

10. Managers act on staff feedback			Response Percent	Response Total
1	Strongly agree		10.2%	12
2	Agree		16.1%	19
3	Neither agree nor disagree		24.6%	29
4	Disagree		24.6%	29
5	Strongly disagree		24.6%	29
			answered	118

11. Managers act on patient feedback			Response Percent	Response Total
1	Strongly agree		13.9%	16
2	Agree		35.7%	41
3	Neither agree nor disagree		32.2%	37
4	Disagree		8.7%	10
5	Strongly disagree		9.6%	11
			answered	115

12. I have personally experienced harassment, bullying or abuse at work from managers/line managers/team leaders or other colleagues in the last 12 months			Response Percent	Response Total
1	Strongly agree		25.2%	30
2	Agree		12.6%	15
3	Neither agree nor disagree		15.1%	18
4	Disagree		19.3%	23
5	Strongly disagree		27.7%	33
			answered	119

13. My organisation takes effective action if staff are bullied, harassed or abused by other members of staff			Response Percent	Response Total
1	Strongly agree		7.6%	9
2	Agree		16.1%	19
3	Neither agree nor disagree		33.9%	40
4	Disagree		20.3%	24
5	Strongly disagree		22.0%	26
			answered	118

Incidents and concerns						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Response Total
14. Staff are encouraged to report errors, near misses or incidents	37.8% (45)	40.3% (48)	10.1% (12)	9.2% (11)	2.5% (3)	119
15. My organisation blames or punishes people who are involved in errors, near misses or incidents	10.2% (12)	24.6% (29)	28.8% (34)	24.6% (29)	11.9% (14)	118
16. When errors, near misses or incidents are reported, action is taken to ensure that they do not happen again	16.1% (19)	43.2% (51)	26.3% (31)	14.4% (17)	0.0% (0)	118
17. Learning from errors, near misses and incidents that happen is shared with staff	15.1% (18)	37.0% (44)	26.9% (32)	13.4% (16)	7.6% (9)	119
					answered	118
					skipped	3

14. Staff are encouraged to report errors, near misses or incidents			Response Percent	Response Total
1	Strongly agree		37.8%	45
2	Agree		40.3%	48
3	Neither agree nor disagree		10.1%	12
4	Disagree		9.2%	11
5	Strongly disagree		2.5%	3
			answered	119

15. My organisation blames or punishes people who are involved in errors, near misses or incidents			Response Percent	Response Total
1	Strongly agree		10.2%	12
2	Agree		24.6%	29
3	Neither agree nor disagree		28.8%	34
4	Disagree		24.6%	29
5	Strongly disagree		11.9%	14
			answered	118

16. When errors, near misses or incidents are reported, action is taken to ensure that they do not happen again			Response Percent	Response Total
1	Strongly agree		16.1%	19
2	Agree		43.2%	51
3	Neither agree nor disagree		26.3%	31
4	Disagree		14.4%	17
5	Strongly disagree		0.0%	0
			answered	118

17. Learning from errors, near misses and incidents that happen is shared with staff			Response Percent	Response Total
1	Strongly agree		15.1%	18
2	Agree		37.0%	44
3	Neither agree nor disagree		26.9%	32
4	Disagree		13.4%	16
5	Strongly disagree		7.6%	9
			answered	119

Training						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Response Total
18. I am able to attend statutory and mandatory training	22.9% (27)	43.2% (51)	14.4% (17)	11.9% (14)	7.6% (9)	118
19. I am able to attend training to support my professional development	23.1% (27)	40.2% (47)	12.8% (15)	12.8% (15)	11.1% (13)	117
20. I am able to attend multi-disciplinary training relevant to my practice	19.8% (23)	35.3% (41)	19.0% (22)	14.7% (17)	11.2% (13)	116
21. I have had an appraisal or performance and development review of my work in the last 12 months	40.0% (46)	34.8% (40)	2.6% (3)	15.7% (18)	7.0% (8)	115
22. The induction arrangements for new and temporary staff support safe and effective care	11.2% (13)	34.5% (40)	25.0% (29)	17.2% (20)	12.1% (14)	116
					answered	117
					skipped	4

18. I am able to attend statutory and mandatory training			Response Percent	Response Total
1	Strongly agree		22.9%	27
2	Agree		43.2%	51
3	Neither agree nor disagree		14.4%	17
4	Disagree		11.9%	14
5	Strongly disagree		7.6%	9
			answered	118

19. I am able to attend training to support my professional development			Response Percent	Response Total
1	Strongly agree		23.1%	27
2	Agree		40.2%	47
3	Neither agree nor disagree		12.8%	15
4	Disagree		12.8%	15
5	Strongly disagree		11.1%	13
			answered	117

20. I am able to attend multi-disciplinary training relevant to my practice			Response Percent	Response Total
1	Strongly agree		19.8%	23
2	Agree		35.3%	41
3	Neither agree nor disagree		19.0%	22
4	Disagree		14.7%	17
5	Strongly disagree		11.2%	13
			answered	116

21. I have had an appraisal or performance and development review of my work in the last 12 months			Response Percent	Response Total
1	Strongly agree		40.0%	46
2	Agree		34.8%	40
3	Neither agree nor disagree		2.6%	3
4	Disagree		15.7%	18
5	Strongly disagree		7.0%	8
			answered	115

22. The induction arrangements for new and temporary staff support safe and effective care			Response Percent	Response Total
1	Strongly agree		11.2%	13
2	Agree		34.5%	40
3	Neither agree nor disagree		25.0%	29
4	Disagree		17.2%	20
5	Strongly disagree		12.1%	14
			answered	116

Appendix 3 – review team

103 The review team comprised of:

- Erica Hawes
- Sara Utley
- Jane Dale
- Gabby Smith
- Carol Moseley
- Rhys Jones

104 The team worked under the direction of Alun Jones, HIW and Dave Thomas, WAO

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Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: 0041/19

Chairs and Chief Executives
NHS Wales' organisations

19 November 2019

Dear colleagues,

All Wales Self-Assessment of Quality Governance Arrangements

The HIW/WAO Review of Quality Governance Arrangements within Cwm Taf Morgannwg Health Board was published on 19 November. The report highlights a number of fundamental deficiencies in the health board's quality governance arrangements. It is concerning that some of the findings echo failings identified in governance reviews previously undertaken both within Wales and across the UK. It is essential NHS Wales and individual organisations reflect and learn from review findings and assure themselves that any relevant issues are being addressed within their own organisations.

The Cwm Taf Morgannwg Health Board review includes 14 recommendations for the health board to act on. To gain assurance on the robustness of quality governance arrangements across all NHS bodies I am requiring you to undertake a self-assessment against the review recommendations within your own organisation.

I expect you to self-assess your position against each recommendation to provide a current level of assurance, outline any required action and set out how you will undertake future and on-going reviews to ensure delivery on actions and learning is embedded. Whilst the report focuses on quality governance the themes and required action could be equally applicable to other areas of governance. When undertaking the assessment you should also be satisfied of the ongoing capacity and capability to deliver the quality and corporate governance functions.

To aid this work and ensure a consistent approach a self-assessment pro-forma is attached for you to complete. This work will need to be completed and the form, including any supporting information, should be submitted to my officials by 7 January 2020.

This is an important exercise to assure yourselves and the Welsh Government that your organisation is carrying out its responsibilities in a way that fulfils its duty to ensure the quality and safety of healthcare and has robust standards of governance in line with the recently updated model standing orders.

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Yours sincerely,

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

c.c. Board Secretaries

All-Wales Self-Assessments of Current Quality Governance Arrangements

Following publication of the Healthcare Inspectorate Wales and the Wales Audit Office report titled '*A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board*', the Minister for Health and Social Services has requested that all health boards and NHS Trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment should include a narrative of current arrangements and the current level of assurance: ***high***, ***medium*** *or* ***low***. Whilst reference is made to specific documents in the main report and in the recommendations listed below, each organisation should demonstrate how they are discharging the requirements rather than adhering rigidly to the need to have documentation with the same titles.

Completed pro forms should be submitted to Janet Davies no later than **7 January 2020**. If you have queries do get in touch.

Recommendations	***Self-Assessment***	***Plan for future action/review***
Strategic focus on quality, patient safety and risk		
1. *Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.*	Trust Board approved the 2016-19 Quality Strategy in March 2016 and the Health & Care Standards and Commissioning Core Requirements are aligned throughout the strategy as a control framework to operate in. The Quality Strategy is currently under review ensuring it is aligned to reflect the new Health & Social Care (Quality & Engagement) (Wales) Bill and its duties of quality and candour and the citizen voice. This is due to	The quality principles will form part of other strategies such as the Clinical Strategy. The quality priorities will be articulated, reported and monitored in all relevant

	be approved at Quality, Patient Experience & Safety Committee in May 2020. We are committed to 'Healthier Wales' ambitions and the quadruple aim. To ensure that, as a Trust, we are providing care that is: • Safe - avoiding harm • Effective - evidence based and appropriate • Patient-centred - respectful and responsive to individual needs and wishes • Timely – at the right time • Efficient - avoiding waste • Equitable – an equal chance of the same outcome regardless of geography, socioeconomic status etc. Expectations for directorates in relation to quality and patient safety will be implicit within the strategy and subsequent Local Delivery Plans. The Trust IMTP deliverables for Quality are; • Health and Social Care (Quality and Engagement) (Wales) Bill;	Directorate Local Delivery Plans and aligned to the priorities in the IMTP. Our revised Quality Strategy will reflect the Quality Cycle (Quality Management System) to include quality planning, quality improvement, quality control and quality assurance. We will self-assess the strategy and seek peer review to inform our action for quality plan. The revised Quality Strategy will describe how we operate and create the conditions for all parts of the service to deliver 'quality at the heart of all we do'.

	• Implement relevant learning from the Cwm Taf Morgannwg UHB Maternity services review; • Implementation of the older people's framework with a focus on level 2 falls; • Implementation of the Mental Health and Dementia Improvement Plan. *Current level of assurance: High*	
2. *The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically:* ***i.*** *The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.*	The Trust's BAF was first introduced in September 2017 and has undergone a series of updates to ensure alignment to the strategic themes and actions as described across several iterations of the IMTP. The BAF is presented to each Trust Board meeting for monitoring, oversight and scrutiny.	Committee Assurance Frameworks are under development which will sit under the overarching Board Assurance Framework. These reflect current strategies, for example, delivery of the People & Culture Strategy and associated Corporate Risks. The Trust will explore the potential for driving Committee Agenda setting through the CAFs as well using

		A Board Development Session took place in October 2019 to test out a range of new developments to further embed the BAF across the organisation as an effective assurance tool which include: • The development of Committee Assurance Frameworks (CAF); • The potential to distinguish these from the higher level strategy Board Assurance Framework (BAF). Whilst the Corporate Risks are aligned to the Strategic Themes on the BAF and are received by the Trust Board, the Audit Committee receive the BAF and have oversight of the Corporate Risk Register for scrutiny and challenge at each meeting.	these as a tool to review and challenge levels of assurance on a range of other areas; for example, compliance with Legislation, delivery against Trust Strategies and monitoring against Commissioning Intentions; this list is not exhaustive. Further actions for 20/21 include ensuring that the BAF becomes an integral part of the assurance framework embedded in Board Agendas.
ii.	*The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the management of risk within the organisation.*	The Trust's Risk Management Strategy (2019-2021) was revised and approved by the Board during 2018-19. The revised strategy, which took into account recent audit recommendations, sets out how the Trust aims to, through incremental steps, become 'risk enabled' by 2021. The Strategy also set	Both the risk management and BAF processes have evolved and developed considerably during 2018/19 and 2019/20 and the Risk Management Strategy will need to be reviewed during 2020 to ensure the Strategy reflects these developments and fully describes the current processes.

	out a number key developments that would and has taken place over the intervening period. These include: • Embedding of the Risk Management Development Group. • Development of an electronic risk register (DATIX) • A revised and strengthened process for agreeing and managing risks within the Trust. • Revised risk management guidance document. The BAF, which fully reflects the strategic priorities as set out in the Trust's IMTP, has also evolved and expanded over the same period and further developments are planned before the end of the financial year. The BAF fully integrates with the risk management processes with corporates risks identified by strategic aims and married with assurances.	

		An Internal Audit review of the Trust's risk management processes was carried in April 2019 and concluded that the Trust can take reasonable assurance from the processes and controls in place.	
iii.	*The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework.*	The Trust Board approved the Quality Strategy (2016-19) in March 2016. The Strategy will be reviewed and updated in 2019/20 to ensure it aligns with the new Health & Social Care (Quality and Engagement) (Wales) Bill. The Commissioning and Quality Delivery Framework was introduced in 2015 which saw the introduction of a five-step ambulance care pathway. The framework, which sets out core requirements, involves working closely with the Commissioner to ensure that it translate into demonstrable service improvements, with a focus on the patient experience within the care pathway. Priorities are set in Local Delivery Plans and in the Trust's IMTP. The trust has also established a Quality Improvement Network (WIIN) to enable staff to make improvements by building capability	

		and confidence with QI techniques. This is consistent with the Trust's vision and behaviours. The governance structures support regular monitoring of priorities, quality standards and requirements which is overseen by the Quality Steering Group. Regular reporting through to Senior Management Groups, Committee and to Board is also clearly defined.	
iv.	*Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks.*	The Audit Committee has responsibility for ensuring the adequacy of the Trust's governance and assurance arrangements, which includes risk management and internal control. These arrangements are clearly set out in the Audit Committees Terms of Reference which were reviewed and approved by the Board in March 2019. The Corporate Risk Register is presented at each and every Audit Committee Meeting and Corporate Risks are reported Quarterly to the Board via the BAF.	

	Processes are supported by a Risk Management Development Group and a Deputy Director Group who identify, discuss and assess risks and recommend scores and mitigations to the Executive Team. *Current level of assurance: Medium*	
Leadership of quality and patient safety		
3. *There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:* ***i.*** *The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined*	Whilst quality and patient safety responsibility and leadership sits within the Executive Director of Quality, Safety and Patient Experience portfolio the agenda is shared across the executive management team and embedded across the organisation structures. This is in addition to cross directorate leadership, work streams and accountability particularly with the Medical & Clinical Directorate.	*CEO priorities and objective setting through PADR – does this include quality for every Director?*

	The accountabilities and responsibilities for quality and patient safety within each directorate are clear; however, Directorates work in collaboration to understand these – for example PTR. The portfolios of Directors are clearly defined (e.g. Medical/Clinical Directorate are responsible for mortality reviews which are reported through to the Quality Committee. The Quality Strategy does not implicitly describe Executive Leads and responsibilities; however, the Quality Assurance/governance framework clearly applies to the whole organisation and not simply the QS&PE Directorate. The Trust is represented on the Medical & Nurse Director Peer Groups in NHS Wales and the sub groups of AACE. Medical Director is a member of the Unscheduled Care Board and the Nurse Director is part of the National Quality & Safety Forum. Representatives from both the Quality and Medical Directorates attend the Assistant	

	Directors Leadership Team and Executive Management Team meetings as well as the Quality, Patient Experience & Safety Committee.	
ii. *The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear*	Directors are held to account through Quality, Patient Experience & Safety Committee and Trust Board. Responsibilities and accountability are clearly defined and demonstrated through well-established Quality and Medical & Clinical Directorate organisational structures and reporting arrangements. Through the Trust's IMTP as Executive Sponsors aligned to Strategic Objectives and administered through Local Delivery Plans. The Trust Quality Steering Group (sub group of QuEST), which meets quarterly, is clearly described as providing assurance on quality, governance, improvement and learning within the context of the Trust Strategic Objectives, IMTP, Quality and Risk Management Strategies.	

		The Patient Safety and Experience, Learning and Monitoring Group is key to placing patient safety at the heart of services. The cross directorate membership is critical to this. The Team Leader Development Programme focusses on compassionate leadership in addition to positive risk management processes and developing a learning rather than blame culture.	
iii.	*There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.*	There are clear structures in the Medical Directorate and Patient Safety, Concerns and Learning teams in the Quality Directorate which is central to quality and patient safety. There is also positive collaboration with patient safety teams in partner organisations (e.g. joint investigation frameworks). Represented through collective groups and the sharing of responsibilities such as at Assistant Director Leadership Team and Executive Management Team. Capacity and support through deputising arrangements:	

	• Assistant Director of Quality & Nursing • Assistant Director Quality, Governance and Assurance • Assistant Medical Director • Assistant Director of Paramedicine • Assistant Director of Research, Audit & Service Improvement *Current level of assurance: High*	
Organisational scrutiny of quality and patient safety		
4. *The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of*	The Terms of Reference for the Quality, Patient Experience and Safety (QuESt) Committee were reviewed and approved by Trust Board in March 2019. This followed an extensive review by a Board Working Group which looked at the portfolio, workloads, membership and frequency of meetings for all the Board Committees. The Committee continues to meet quarterly with full agendas. Papers are issued 7 days in advance of meetings.	

quality and patient safety across the whole organisation.	The quarterly Quality Assurance report is the mechanism for reporting quality and patient safety, aligned to the health and care standards. The Committee is supported by the Quality Steering Group and associated Sub-groups which brings together all matters relating to quality and safety and reports directly into the Committee. The Committee receive regular quality reports as well as relevant audit reports and other reports from external assessors and regulators. The Committee also regularly receives information on incidences, concerns and patient stories. *Current level of assurance: High*	
5. *Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can*	The Trust has a comprehensive programme of induction and ongoing development. On appointment, new NEDs follow a programme of introduction and familiarisation, after which they are matched with a Health Board area and are encouraged to engage with their	The Board has been operating for most of the year with 3 NED vacancies. Whilst one post has been covered on an interim basis, this has nevertheless put a strain on the existing NEDs time commitment and their ability to undertake all activities. The vacancies will be filled from

effectively scrutinise the information presented to them.	Health Board peers, visit and meet with WAST staff, go on ride-outs and attend staff and other official events. NEDs are also paired with an appropriate Executive, whom they meet regularly and are kept up to date with specific and corporate developments. These are an important part of triangulation. NEDs also attend regular Board Development Days (approximately 6 a year) which are used for training (e.g. safeguarding, Health & Safety, corporate manslaughter), strategic thinking and external engagement. A specific programme of Board and senior management development is being designed and is planned to begin when Board and senior appointments have been made early in 2020. *Current level of assurance: Medium*	January 2020 and this will be an opportunity to further test induction programmes and review matching and pairing arrangements.
6. *There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This*	<u>General Engagement</u> The Patient Experience & Community Involvement Team (PECI) have developed and use a continuous engagement model to	The Trust has started to have closer working with the local health board to share experiences and learn/implement lessons to improve experiences and outcomes of

must include use of real-time user/ patient feedback.	engage with the public, patients, service users across Wales and all protected characteristics. The team coordinate regular engagement activities across a wide range of communities across Wales to capture evidence in relation to engaging people, gathering and utilising patient experience information. We do this survey forms, feedback forms/cards, film recordings. Every year we follow up on the engagement activities by going back into communities/groups and talking about what we have done with their feedback and to see whether there have been any positive experiences. In addition, the team work in partnership with local agencies/organisations to host 'come and meet' events to talk about the Trust services, listen to people's experiences and expectations also. This is all part of our continuous engagement model. PECI has a 'Have your Say' facility accessible through the Trust website for people to email their feedback and experiences direct to the	patients/service users. This will continue and be strengthened. The Team want to capture more patient stories and nurture/foster a more robust method for the sharing of stories across the continuum of care (from 999 through to health board services and vice versa).

	team. We also have a dedicated twitter account to share information, announce local events and request for experience information (@WelshAmbPIH) The team have coproduced sets of 'promises' to older people and children that we use to measure experiences their experiences against. PECI also have a 'network' for people to sign up to and receive monthly updates on what is happening within the Trust, how we have acted on people's feedback, any consultations that are happening as well as health campaigns the Trust are promoting. Quarterly PECI highlight reports are submitted to QUEST committee as well as a patient story. Patient stories presented to QUEST committee are tracked using a driver diagram 'patient story tracker' to monitor improvements. Executive and Non-Executive Director visits to Health Board Quality Committees to present on Serious Adverse Incidents. The	

	Chief Executive Officer and Chair meeting with respective colleagues across NHS Wales. There is also proactive social media activity within the Trust which allows for direct communication with patients, the public and stakeholders. During 2020 we will be implementing the 'one for wales' concerns management system, which includes a service user feedback system. Through our continuous engagement model there has been regular engagement with communities, voluntary, local authority and health board colleagues are planned in the diary. These events have included engaging the public on the number of vehicles available in the area and how we utilise resources. We have been regular visitors at the Royal Glamorgan Hospital to engage with visitors there on their experiences/expectations. <u>Carers</u>	

	There has been a number of events in particular that have contributed to key work namely: Engaging Carers Event (held in Merthyr Tydfil) to listen to the views and experiences of Carers and their experiences/expectations of the Welsh Ambulance Services NHS Trust. Our online Carers Experience Survey continues to run until 31st December 2019. We have been actively promoting the survey across Cwm Taf. We have taken one of the stories and are working with the Carers Coordinator at Cwm Taf Health Board and Head of Primary Care for Cwm Taf/Merthyr, with a meeting planned in Prince Charles Hospital shortly to work through the learning and ensure lessons are implemented to improve experiences of Carers. <u>Mental Health</u> We have delivered engagement activities to create a mental health information leaflet. We have been working in partnership with Valley Steps Organisation to include a Launch Event for the new Welsh Ambulance Services Trust Mental Health Support Leaflet at a Cwm Taf World Mental Health Day Event	

	in Coleg Y Cymoedd, Nantgarw. We have continued to play an active role within Rhondda Cynon Taff and Merthyr Mental Health Forum, which celebrated the joint achievement of the new Welsh Ambulance Services Trust Mental Health Support Leaflet in its Annual General Meeting during this quarter. <u>Children/Young People</u> We engaged with a number of school children (355 children) in the delivery of Shoctober and captured feedback from children on their knowledge and experiences of emergency services. **What are people saying? – some examples** • *"Absolutely brilliant extremely caring and calming and knowledgeable made me feel safe answered all my questions and family were reassured a nice experience at a scary time"* • *"Fantastic service even though there was only 1 ambulance on duty for my area of Miskin Pontyclun at 6am on a Sunday morning. Thank you so much all my neighbours were away family on holiday*	

	so quite frightening at 77 yrs old. ..Dr suggested I was admitted. The team were wonderful" **Themes:** consistent themes identified from across Cwm Taf through our continuous engagement have included: • People expect calmness, reassurance sense of humour, professionalism and understanding when ringing 999 *Current level of assurance: High*	
7. *There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.*	The Quality, Patient Experience & Safety Committee ensures that there is an effective annual Clinical Audit Programme, clinical audits, action trackers and improvements which are taken to the Medical & Clinical Services directorate (M&CSD) meeting for ongoing monitoring and review of the actions. Findings from clinical audits are summarised into clinical notices and are shared with Clinical Team Leaders, Clinical Leads and also made available on the intranet along with	We have developed an ePCR business case which is currently with Welsh Government for scrutiny. From March 2021, the contract on our current digipen system will expire and we are keen to replace with an electronic patient care record that will better support effective clinical audit and improvement. We are also working to develop WIIN further by expanding our links with external partners and looking for further opportunities to spread and scale clinical improvements across our service.

	completed audits and the Clinical Audit Programme. Learning from clinical improvements are discussed at M&CSD, The WAST Improvement & Innovation Network (WIIN) Steering Group and the Assistant Directors Leadership Team (ADLT). Clinical Indicators are reported on for specific conditions to monitor clinical performance and are available on the Intranet. These help to improve performance and contribute to improvement plans. The Trust also participates in national clinical audit and improvement networks to share learning opportunities and good practice. To note: A reasonable level of assurance was provided for a follow up of Clinical Audit arrangements in 2018/19. The department has worked towards implementing the remaining recommendations and is therefore confident of achieving a high level of assurance.	We are exploring an electronic audit tool that will support clinical audits such as medicines management/IPC

	Current level of assurance: Medium	
Arrangements for quality and patient safety at directorate level		
8. *The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.*	The Quality Steering group and its related sub-groups oversee all matters relating to quality and ensure regular reporting through to the Quality Committee. This includes the quarterly Assurance Report which receives wide circulation across the Trust. Representatives from both the Quality and Medical Directorates attend collective groups such as the Assistant Directors Leadership Team and Executive Management Team meetings as well as the Quality Steering Group, Patient Safety, Learning & Monitoring Group and the Quality, Patient Experience & Safety Committee. The organisation's focus and accountability regarding quality and patient safety is demonstrated through well-established Quality and Medical & Clinical Directorate governance structures and reporting arrangements through the Quality Steering Group to the Executive Management Team,	

	Quality, Patient Experience & Safety Committee and Trust Board. This is in addition to delivery of the Trust's IMTP and Local Delivery Plans. The Trust continues to development quality measures across all directorates as well as Qliksense, which is a tool for generating a variety of different reports. Route Cause Analysis/Serious Incident Investigation Training has been implemented for key individuals across the Trust. *Current level of assurance: Medium*	
9. *The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have:* ***i.*** *Clear remits, appropriate membership and are held at appropriate frequently.*	The Quality, Safety & Patient Experience Directorate has a clearly set out governance structures, with define reporting routes. Each group, such as the Quality Steering Group and its sub-groups, have clear terms of reference which sets out remit, membership, outputs and reporting arrangements.	Structures, including the Quality Steering Group and associated sub-groups will be reviewed in-line with the introduction of the Health & Care Quality and Engagement (Wales) Bill.

ii. *Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.*	Reporting routes through to the Executive Management Team and to the Quality Committee is also clearly defined. The Quality Assurance Report; Quality and Performance Report and Integrated Highlight Report are scrutinised by the Committee.	
iii. *Clarity of the role and decision making powers of the committees.*	The Quality Committee is supported by the Quality Steering Group which oversees the Divisional/Directorate Groups and ensures the Committee receives relevant, timely information on all matters relating to quality and safety including concerns, incidents, Health & Safety and related risks. *Current level of assurance: Medium*	
Identification and management of risk		
10. *The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at*	The management of risk systems is the responsibility of the Quality, Safety & Patient Experience (QS&PE) Directorate. The Trust recognises that managers across the organisation are responsible for owning and managing their own risks. The QS&PE Directorate chair's the Risk Management	The revised Risk Management Strategy and guidance document will be published in quarter 4 of 2019/20.

directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.	Development Group, which consists of risk leads from all parts of the Trust, where risks are discussed and assessed. The Assistant Directors Leadership Team (A Senior Management Team), oversee the mitigation of risks and advise on scoring and controls and makes recommendations to the Executive Management Team on such matters. Risks are regularly reported through to EMT, Committees and, via the BAF, to Board. The Audit Committee continues to receive the Corporate Risk Register at each and every meeting. Considerable work has taken place throughout 2019/20 to introduce electronic risk registers (DATIX) where individual Directors are responsible for entering and managing their own risks and identifying those that need to be escalated as appropriate. The Once for Wales module to the DATIX system will be introduced shortly which will	

	further enhance functionality and improve the reporting and identification of staff concerns. *Current level of assurance: Medium*	
Management of incidents, concerns and complaints		
11. *The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.*	Quarterly incident reporting through the Quality Assurance Report. This is broken down by non-patient safety and patient safety incidents. Using Datix to report all incidents whether clinical or non-patient safety is actively promoted on the QS&PE Clinical Team Leader Programme and the Trust actively encourages staff to report adverse incidents, Near-misses and Hazards. The oversight and governance of Datix lies with the Director of Quality and Nursing who also has Executive oversight of: ○ *Patient Safety Incidents* ○ *Health and Safety Incidents* ○ *Complaints* ○ *Claims*	

	○ *Compliments* ○ *Ombudsman Reviews* ○ *Inquests* This triangulation of concerns come together a various stages by Corporate, Directorate and Operational level. *Corporately reporting to:* • Board • QuEST • Health & Safety Committee • Patient Safety, Learning and Monitoring Group. *Directorate:* • Quality and Safety Directorate Group Meetings. • Quality Assurance Report *Operationally:* • Weekly Patient Safety Meetings • Weekly Serious Case Incident Forum • Monthly Complex Case Forum • Patient Safety Integrated Highlight Report • Quality & Performance Report	

	Daily Surveillance: • Patient Safety Team reviews all patient safety incidents on a daily basis. • Health & Safety Team review all non-patient incidents on a daily basis. The Trust has appointed a full-time Datix administrator who is responsible for the upkeep and daily management of the database and providing reports to several committees. *Current level of assurance: Medium*	
12. *The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.*	Route Cause Analysis/Serious Incident Investigation Training has been implemented for key individuals across the Trust. The Head of Patient Safety, Concerns and Learning is developing a Training Plan for staff to include empathy and customer care. The Patient Safety Team undertook a benchmarking visit with South West Ambulance Services Trust to further develop the accountability maturity in relation to	This training will be implemented for all newly appointed Duty Control Managers. We will implement Welsh Government training resources to support the introduction of the Health & Social Care (Quality and Engagement) (Wales) Bill.

	incident reporting, escalation of concerns and review of Datix. CCC has recently appointed 4 Investigation Supporting Officers on a permanent basis who will have the necessary skills to conduct an investigation. All new staff receive training in patient safety which includes being open and honest. The requirement to reflect when things go wrong and to be objective and learn from incidents. *Current level of assurance: Medium*	
Organisational culture and learning		
13. *The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.*	Within WAST we have a well-established purpose, vision and behaviours framework that was developed with a high level of staff input from across the organisation. Since the development of these Trust 'Behaviours' over 5 years ago they have been a key component of the corporate induction or 'Welcome Day', included in leadership and management development courses along with being	

	explored within individual teams as part of team training and development days. Compliance with Trust behaviours forms part of the annual appraisal template. The Trust has recognised that they are due a 'refresh' and this is being looked at as part of the work going forward into 2020. Internal Audit undertook a review of Raising Concerns, received by the Audit Committee at its December 2019 meeting. This received a reasonable assurance rating and advised that a high percentage of staff knew how to raise concerns and understood the process to do so. The All Wales Whistleblowing Policy has recently been reviewed which provided a good opportunity to test and consult on the local procedures against the all Wales framework. *Current level of assurance: Medium*	It was recommended that a dedicated area be established on the intranet and there are future plans to have a nominated NED champion for raising concerns.

14. *The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.*	Priorities for learning and improvement are set by the Strategic Education Group and the Quality Steering Group (sub group of the Quality, Patient Experience & Safety Committee) whose remit is to: • Provide specialist and expert advice to the Trust in relation to issues of quality, governance ,organisational learning and patient and staff feedback; • Promote evidence based practice that will improve patient and staff safety; • Act as the point of reference for quality improvement and quality governance related issues for the Trust, promoting a consistency of approach between Directorates and working in partnership; • Share learning and monitor action plans from Healthcare Inspectorate Wales, significant adverse events including Serious Incidents, independent enquiries, serious case reviews, complaints and Coroners' Regulation 28 letters; • Develop a suite of Quality metrics relevant to the remit of the group;	

	• Provide information and advice on emerging legislation, policy and guidance; • Set the Quality direction and priorities for the Trust; • Monitor the Trust Quality agenda, Quality Data intelligence programme and subgroup annual work plans; • Inform the development of the Trust Annual Quality Statement; • Lead on and provide advice to specific quality improvement projects to support the Trust IMPT; • Inform the Trust Risk Register, Internal Audit programme, research and development, and Clinical Audit and Effectiveness programme and organisational learning system; • Receive reports on Clinical audit where necessary and identify any issues that may have an impact on either patient or non-patient safety and draw up appropriate action plans; • Commission internal audit reports on the efficacy of actions taken arising from lessons learned in high level action plans resulting from Serious	

	Adverse Incidents, Coroners Regulation 28 reports, Public Service Ombudsman for Wales (PSOW) reports, patient experience surveys, claims and other sources of information or intelligence identified. The governance structures within the Medical & Clinical Services and Quality, Safety and Patient Experience Directorates include groups such as the Redress Panel, one which considers PTR, Complaints, Claims and Incidents, a SCIF and Serious Adverse Incidents Panel, Mortality Review Group, Clinical Pathways in addition to WAST Improvement and Innovation Network. The Patient Safety and Experience, Learning and Monitoring Group is key to placing patient safety at the heart of services. The cross directorate membership is critical to this. The Quality Steering Group receives and considers external reports from across NHS Wales and benchmarks current practice and performance. Recent examples of this include:	

	• Amber Review • Demand and Capacity Review • Carter Review • Cwm Taf Maternity Services Review • Learning from CQC reports on other UK ambulances services *Current level of assurance: High*	