Review of quality governance at Cwm Taf Morgannwg University Health Board

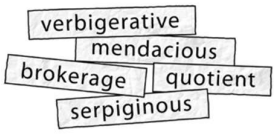
This report looks at if the Health Board knows its services are safe and good quality.

A Joint Review by

Healthcare Inspectorate Wales

Wales Audit Office

Easy Read version



There is a **Hard Words and Phrases** list at the end.

You can find out what words in **bold** mean.

Introduction and Background

Cwm Taf University Health Board was formed in 2009.

On the 1st of April 2019 the name changed to Cwm Taf Morgannwg University Health Board.

This is because they took over health care in the Bridgend County Borough Council area.

This includes the Princess of Wales Hospital.

In April 2019, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists published a very worrying report.

This report was about **maternity services** at the former Cwm Taf University Health Board.

It pointed out some serious worries about the service.

Many women had experiences that were unacceptable.

Because of that report, the Health Board's maternity services was placed into **Special Measures.**

This meant they would have to change the way they work to make these services better.

There were other worries in other parts of the Health Board.

Some of these were found when Health Inspectorate Wales and Wales Audit office looked at the services.

Because of all these things put together, Healthcare Inspectorate Wales and the Wales Audit Office had an urgent look into **quality governance arrangements** in the Health Board.

About this Review

The aim of this review was to look at whether Cwm Taf Morgannwg University Health Board's governance arrangements support services that are:

- High quality

- Safe

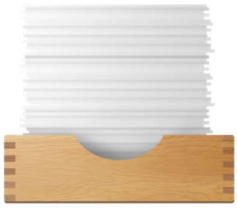
- Effective

We looked at how the Health Board was being run. We also looked at the Prince Charles and Royal Glamorgan Hospitals. What we did:

- We spoke to lots of staff and asked them to tell us about their work

- We spoke to staff working in the surgery and emergency departments

- Looking at what was being talked about at key meetings



- We read a lot of paperwork to do with quality of services

- We asked staff working in surgery, theatres and emergency departments to fill in a survey

What the report has found out is split into these groups:

- A focus on quality, patient safety and risk

- Leadership, **organisational scrutiny** and service plans for quality and patient safety

- Pointing out and managing **risk**

- How concerns are raised and what is done about them

- **Organisational culture** and learning

Here are the main things we found

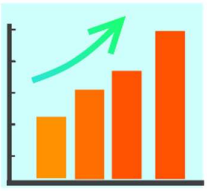
The Health Board has been good at doing work around money and meeting targets.

There hasn't been as much focus on the quality and safety of services.

We found a lot of the Health Board's governance arrangements were not working properly.

The Health Board was not good at knowing about the quality of its services.

This means problems may not be dealt with properly.



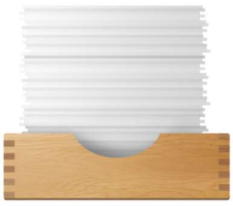
Urgent improvements are needed to sort out these problems.

This includes making it easier to openly talk about the quality and safety of patient care.

Leadership needs to be stronger with clear roles on quality for everyone.

The Medical Director and Clinical Director need clearer roles on quality of services.

The Health ~~Board's~~ has a committee that look at the quality and safety of services, but this didn't always work well.



This is because they didn't always receive the right information and sometimes the information they did receive was not clear.

The Health Board needs to get better at asking patients what they think of their care and use this information to help make services better.

Staff and managers need more time to focus on quality and patient safety issues.

There have been weaknesses for a long time with managing risk. This needs to change quickly.

The review team found some staff working in **high risk conditions**.

This had become normal and needs to change.

Routines around the reporting of incidents need to be stronger.

All staff need to be given more responsibility and power to respond to concerns and complaints.

The Health Board needs to get better at sharing learning across the organisation including from concerns and external reports.

The review also showed that some staff didn't feel like they could say if they were worried about something in work.

There needs to be clearer structures in how staff throughout the Health Board look at the quality and safety of services.

A new way of working called "The Values and Behaviours Framework" should help make this better.

Even though there are lots of problems with different things, there are some good changes happening that will help.

There is new leadership in the Health Board and they are starting to make the changes needed.

More staff have been brought in to make sure the right work is done and change happens more quickly.

The Health board are working hard on many of the issues in this report.

But this will be a big challenge and will take hard work to fix the problems.

Hard Words and Phrases

Special Measures

Extra help given to the Health Board to improve services and the way it runs.

Complaints

When someone tells you they think something is wrong.

Risk

The chances of things going wrong in patient's care.

Maternity Services

Care that someone has if they're having a baby

Surgical Services

The care someone has if they have an operation

Concerns

Worries that people raise with the Health Board when they are unhappy with their care.

Times when things go wrong with people's care.

Quality Governance Arrangements

A high standard of management

Organisational Scrutiny

A careful look into people's work in a job

Organisational Culture

The way people behave by habit in a job

Leadership

When someone is in charge and leads by example

Consistent

Stays the same

High Risk Conditions

When someone is around something that could be dangerous or hurt them

Incident

Something that has happened that could be important

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