Safety Efficiency Effectiveness	Issue No	Identified Issue	Recommendation No	Recommendation	Action No	Action Required	Current Position (Where applicable)	Target Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence	Link to Action Plan	RCOG Recommendations
SAFETY ○ SAFETY ○ SAFETY	1	Learning from both external and internal practice to inform, embed and enable change	1.1	Develop a service that is underpinned with professional standards to ensure professional body expectations	1.1.1	Evaluation by Senior Team of RCOG and RCM standards against current service to be completed and presented at the assurance group	scoping exercise currently being undertaken	07/12/2018	Director of Nursing/ Midwifery Medical Director	G	Full analysis on performance against professional body standards.	X:\Waiting_List\ SURGICAL DIRECTORATE\	Themes on training included in the **HIW Response** (pp 8 - 11). Mentoring, training and appt'ment of Clinical Supervisor of Midwives.	
					1.1.2	Ensure that professional body expectations of service provision are met and service is compliant against standards.	Review completed. Immediate action plan being delivered pending formal report. RCOG report published with significant recommendations	31/05/2019	Medical Director Head of Midwifery	R	Service compliant and monitored against RCOG standards Ensuring the service delivered to women and babies is safe and effective. HIW completion of actions	Score card and completion of action plan. RCOG standards X:\Waiting_List\ SURGICAL DIRECTORATE\	Themes on training included in the **HIW Response** (pp 8 - 11). Mentoring, training and appt'ment of Clinical Supervisor of Midwives. HIW plan mentions attendance at the Royal College of Midwives training on Labour Ward leadership in Dublin.	
			1.2	The strategic and operational action plans aim to implement the **MBRRACE (2018) recommendations.**	1.2.1	Adequate staffing and resources to support safe care, particularly on the delivery suite, needs to be addressed	See: Action 3	01/07/2019	Head of Midwifery Clinical Director	B	Completion of actions 2	Assurance group monitoring on a weekly basis Workforce Scorecard is being developed.	Consultant Midwife report	
					1.2.2	Women with previous caesarean sections must have clear discussions about their birth plan so they can make informed decisions	See: Action 16	01/07/2019	Consultant Midwife Lead for Labour ward	R	Completion of actions 11	Audit to be undertaken in Q1/2 2019/20	No specific evidence in plans other than this one.	
					1.2.3	National guidance should be developed around managing the early stage of labour	Engaged with all National groups. Consultant Midwife leads on guidance of all Wales midwifery led guidance	01/07/2018	Clinical Director Head of Midwifery/ consultant Midwife	G	Influence national guidance for service delivery and change	Consultant Midwife input into all Wales Guidance.		
					1.2.4	improvements in training for fetal monitoring and situational awareness are required for staff caring for women in labour	See: Action 17 moving to FIGO 1st April 2019	01/07/2019	Clinical Director Head ofMidwifery	B	Completion of actions 12 &15	Training compliance rates		
					1.2.5	All families must be offered consent for post-mortem material provided to support the decision	Continuous work with pathology directorate as part of the HTA	07/01/2019	Clinical Director Head of Midwifery	G	Support and consent process offered to all families	Audit to be undertaken re:compliance of offer. Audit plan 2019/20 HTA Report to be added	Consultant Midwife report	
					1.2.6	Units should adopt the national Perinatal Mortality Review Tool and put aside time for training so that review can be carried out robustly	Completed November 2018	08/03/2019	Clinical Director Lead Governance Midwife	G	To ensure that learning takes place to avoid incidents and reduce risk. Providing a safe service to the women and families	**Insert Tool** ZA		
			1.3	Ensure that there is learning from internal incidents recorded by implementing a feedback loop	1.3.1	Development of weekly multidisciplinary reflection sessions led by obstetricians. Linked to Governance arrangements below. Scoping requirements with a work stream and lead appointed Reflection meetings have commenced in the Tirion birthing centre Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.	Feedback taken from staff engagement events and will be addressed through new Governance and Quality framework.	01/08/2019	Labour ward Lead consultant	A	Functional MDT that works effectively to ensure safe care for women and their families. Embedded process in to the service	Discuss with Governance Midwife for evidence inc frequency and attendance of meetings	Consultant Midwife report Need for MDT is mentioned in the HIW Report (pp 10 - 11). Datex is also mentioned at page 8 as an important area for training.	7.2
					1.3.2	Monitor and present situation on a weekly basis to senior team	Weekly assurance meetings established with information presented	17/10/2018	Directorate Manager Governance Lead Midwife/ Head of Midwifery	G	Functional MDT that works effectively to ensure safe care for women and their families. Embedded process in to the service	Meetings in diaries and minutes produced		
					1.3.3	Close feedback loop with individual who raised concern.	Manual email to be sent until an automatic reply can be made.	01/03/2019	Governance lead Midwife Senior Midwives	G	To increase communication within the teams.			
			1.4	An effective monitoring process will be embedded into the service	1.4.1	Development of a dashboard to include the present maternity performance targets	Dashboard updated and published on sharepoint Continuous improvements and updates being made.	03/12/2018	IT programmer Deputy Head of Midwifery	G	To ensure continuous monitoring of the service maintaining a safe, efficient and effective service for women and babies.	http://ctuhb-intranet/dir/PI/PB/_layouts/15/WopiFrame.aspx?sourcedoc={C048CCBB-C5F0-45F7-90E3-4224E2ADA3AE}&file=J7087%20Maternity%20Dashboard.xlsx&action=default&DefaultItemOpen=1		
					1.4.2	Required targets for maternity need to be agreed and monitored on a weekly basis	Targets added on current dashboard. They need to be agreed by Clinical Leads	03/12/2018	Deputy Head of Midwifery Directorate Manager	G	To ensure continuous monitoring of the service maintaining a safe, efficient and effective service for women and babies.	As above		
			1.5	Agree a comprehensive programme of Audit over the next 12 months	1.5	Audit lead to work with Audit Midwife for full rolling programme of audit to include national audits. Agree jointly owned neonatal and maternity services audits of neonatal service data including - neonatal outcome data, - perinatal deaths, - transfer of term babies to SCBU, - babies sent for cooling, - Each Baby Counts reporting, - MBRRACE reporting, - breast feeding rates, - skin to skin care after birth, - neonatal infection, - Baby Friendly accreditation Bliss baby charter accreditation	Leads appointed	01/07/2019	Lead Consultant Lead Midwife	A	Full rolling programme of Audit for the directorate, that feeds into the Governance structure and programme of improvement.	Insert Audit programme from assuranse group		7.1

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SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFE			1.6	Ensure external expert facilitation to allow a full review of working practice to ensure: - patient safety is considered at all stages of service delivery, - a full review of roles and responsibilities within the obstetric team, - the development and implementation of guidelines, - an appropriately trained and supported system for clinical leadership, - a long term plan and strategy for the service, - there is a programme of cultural development to allow true multi-disciplinary working.	1.6	Welsh Government introduction of an oversight panel	Members being appointed	01/06/2019	Welsh Government	A	Assurances to oversight panel			7.8 & 7.26
			1.7	Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through: - appropriate training to key staff members, - making investigations multidisciplinary and including external assessors.	1.7	Agree a process for identification of SI's Standard Operation Process to be written and agreed	Senior Midwifery with the Clinical Director review potential serious incidents and once confirmed call a stratergy meeting with the patient safety meeting	01/07/2019	Interim Risk Midwife Lead Consultant for Risk	A	Timely identification and reporting of SUI's			7.19
	2	Midwifery staffing needs to be safe, effective, efficient and sustainable	2.1	Robust recruitment and retention of midwifery staff	2.1.1	Rolling programme for recruitment for midwives. With development of a staffing score card.	Funded Establishment: 148.88 WTE	30/05/2019	Head of Midwifery Human Resources	R	to meet 100% of funded establishment, to provide a safe and quality service to service to women and their babies	Staffing score card being developed.	Consultant Midwife report	7.57
					2.1.2	Staffing position to be presented and monitored via weekly assurance meetings with senior midwives.	As above	17/10/2018	Programme Director Senior Midwives	G	To activily monitor staffing levels to ensure safe service provided to women and babies across all sites	Meetings in diaries and minutes produced		7.57
					2.1.3	When necessary releasing specialist midwives and community midwives to help in the acute setting.	When necessary midwives are requested to move between areas	17/10/2018	Senior Midwives	G	To ensure safe staffing levels to maintain a safe and quality service to women and their babies	Meetings in diaries and minutes produced		7.57
					2.1.4	Senior midwifery manager 'on call' rota to be implemented	This was implemeted in July 2018	02/07/2018	Directorate Manager/Chief operating officer Head of Miwifery	G	To ensure safety for women and babies. To provide prompt advice and support for clinical midwifery staff and medical staff	Meetings in diaries and minutes produced		7.57
			2.2	Closely monitor bank hours undertaken by midwives employed by Cwm Taf, to ensure: - the total number of hours is not excessive, - the Health Board complies with the European Working Time Directive, - these do not compromise safety.	2.2.1	Agreed that for an 8 week period midwives would be paid double time for extra shifts	Reviewed in Nov 18 and extended until end of Feb 19. Reviewed extended until May 19. Reviewed May extended until July 19	extended 01/07/2019 01/03/2019	Chief operating Officer Director of Nursing	G	To increase the staffing levels on both sites. To maintain a safe,efficient, effective and equitable service over the two sites	Meetings in diaries and minutes produced		7.29
					2.2.2	To be monitored reported weekly via internal assurance monitoring process		17/10/2018	Programme Director Senior Midwives	G	To ensure safe staffing levels to ensure a safe , efficient and effective service for women and babies	Meetings in diaries and minutes produced		7.29
			2.3	Sickness levels need will be in line with the Health board and Welsh average	2.3.1	Weekly planning sessions with lead midwives. To monitor the themes and trends regrading short term sickness levels.	Score card to be added	30/05/2019	Directorate Manger/HR Lead Head of Midwifery	R	Decrease as the establishment increases to national average Overtime target to reduce with sickness and recruitment maitain a safe, efficient and effective service for women and their babies	Score card being developed		
					2.3.2	HR & OD focussed support.	The position is slowly improving as staff who have short term sick leave return to work	01/02/2019	Assistant Director for HR & OD Clinical Director/ Head of Midwifery	G	Support staff to improve services and safety for women and babies		Consultant Midwife report	
			2.4	Maternity theatres need to adhere to national standards	2.4.1	Maternity theatres need to be managed by ACT Directorate	Paper written and requires investment Added to risk register	01/08/2019	Head of Nursing Surgical Head of Midwifery	A	Theatre teams mamanged by ACT		Consultant Midwife report	
			2.5	Clinical supervision	2.5.1	Need to adhere to national standards		01/08/2019	Clinical Director Head of Midwifery	B			Consultant Midwife report	
					3.1.1	Block locum usage for all three tiers as appropriate for planned cover On-going review via Medical Productivity Group and in CBM	Consultant Vacancies: RGH 2.00 consultant post covered by long term locums. 2.00 additional Consultant posts to be recruited for new workforce model. Specialist Vacancies: PCH 1 middle grade cover by LT locums SHO Vacancies: No vacancies - currently recruiting above establishment to support training needs	17/10/2018	Chief Operating Officer Directorate Manager	G	to meet 100% of funded establishment, to provide a safe and efficient and effective service to women and babies. To make sure there is a stable medical staff establishment which will receive mandatory and core traninng packages	Current position being maintained to mitigate risk will be reviewed at CBM.	Mention of Locums in RCOG **Immediate Concerns** table - but in an operational sense not a longer term strategic manner.	7.57
					3.1.2	Advert for fixed term locum posts to continue whilst permanent posts being developed and authorised do we need this or add above	1 wte appointed FT and has now been apponted substantivley commencing in July	17/10/2018	Chief Operating Officer Directorate Manager	G	to meet 100% of funded establishment, to provide a safe service to women	Advert on NHS Jobs		7.57

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SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY	3	Medical staffing needs to be safe, effective, efficient and sustainable	3.1	Robust recruitment and retention of medical staff ensuring a stable and skilled workforce	3.1.3	Recruitment of multiple Consultant posts (2 replacement and 2 new posts)	Appointment of 3wte commencing July - September 2019. 2 wte specific adverts currently being drafted	01/08/2019	Medical Director Clinical Director/ Directorate Manager	B	Recruitment of new full time Consultants to increase staffing numbers at sustainability of service provided. Decreasing the need for locum usage and sickness levels.	Fixed term locum interviews 27/02/19 Permanent appointments: April 2019	Consultant Midwife report	7.57
					3.1.4	RGH - 1.00 WTE additional SHO long term agency post agreed by Medical Director to increase core establishment to 6 WTE	Additional SHO at RGH in situ however 1 wte maternity leave in workforce	17/10/2018	Medical Director Directorate Manager	A	To ensure that training posts are able to attend sessions required to maintain a safe sustainable Tier 1 rota over night to ensure safety of service for women and babies	Finance overspend on establishment		7.57
					3.1.5	0.30 additional WTE consultant post agreed to cover SWP activities, but 1WTE locum in post.	0.30 additional WTE consultant post agreed to cover SWP activities, but 1WTE locum in post. This also supports the CD and consultant on call cover covering those staff not participating on the on-call	17/10/2018	Medical Director Directorate Manager	G	To allow Clinical Director time to undertake SWP activity To maintain a safe, efficient and effective service to women and their babies during the period of major change	Finance overspend on establishment		7.57
					3.1.6	Mitigation of risk of On call - mixture of challenges, noting a number of staff at tier 2&3 not participating in the on call	Additional ad hoc cover and locum coverage whilst occ health support is being sought	04/02/2019	HR Lead Directorate Manager	R	All staff fully assessed and supported to undertake activities that they are deemed competent to perform.			7.57
			3.3	Tier 1 workforce will be appropriate, safe and sustainable	3.3.1	Look at feasibility of training and non training medical posts to ensure a sustainable Tier 1 Model	Scoping exercise to commence Jan 2019	02/09/2019	Chief Operating Officer Directorate Manager	B	Appropriate Tier 1 model to provide a safe service, which is not reliant on locum/agency cover.			
					3.3.2	Benchmarking of other service provisions	As above	02/09/2019	Chief Operating Officer Directorate Manager	B	to maintain a safe sustainable Tier 1 rota over night to ensure safety of service for women and babies			
					3.3.3	Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: - their scope of practice is clearly defined, - the Health Board and the individuals are protected against litigation risk for their extended roles.	Review current roles and scope of practise. This is also being benchmarked against similar posts in other Health Boards	02/09/2019	Head of Midwifery Clinical Director	B	Safe & sustainable Tier 1 model Reduction in ADH/locum spend Reduced incidents			7.40
			3.4	Ensure obstetric consultant cover is achieved in all clinical areas	3.4.1	- reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved, - undertake a series of visits to units where extended consultant labour ward presence has beenimplemented. - considering working in teams to ensure a senior member of the team is available in clinics andprovide cross cover for each other, - considering the creative use of consultant time in regular hours and out of hours to limit the use oflocums. recruit to vacancy with new Job plans	Job planning currently being undertaken Site vists of chosen units being organised	01/07/2019	Medical Director Clinical Director	B		Job Plans		7.32
					3.4.2	Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. •this must involve the antenatal ward round being performed by the consultant.		01/07/2019	Medical Director Clinical Director	B				7.38
			3.5	Actively share the findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board	3.5.1	reassess the quality of induction, training and supervision in obstetrics,		01/07/2019	Medical Director Clinical Director	B				7.33
					3.5.2	seek assurance on the suitability of this service for trainees,	Trageted visit in July 2019	01/07/2019	Medical Director Clinical Director	B				7.33
					3.5.3	appoint a named RCOG College tutor to provide support for the trainees currently on the RGH sitewith adequate time and resource to fulfill this function.	Consultant with dedicated lead role	01/07/2019	Medical Director Clinical Director	G				7.33
			3.6	Allocate all trainees currently in post a clinical and educational supervisor	3.6.1	the role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education,		01/07/2019	Medical Director Clinical Director	B				7.34
					3.6.2	the competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor.		01/07/2019	Medical Director Clinical Director	B				7.34
					4.1.1	Review the recommendations of current and future arrangements to be undertaken and presented to assurance group A new structure for Governance needs to be implemented in the directorate to ensure the team has capacity and is fit for purpose Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues. Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in an appropriate, regular and accessible format.	Regular clinical Governance and Quality & Safety meetings with agreed membership and TOR. Draft structure to be agreed at the next assurance group. Action plan to be developed for implementation of governance arrangements.	08/03/2019	Director of Nursing/Midwifery (executive lead for maternity) Governance lead Midwife/ Head of Midwifery	G	Learning and escalation of incidents for non repetition	Insert structure	Value and importance of governance arrangements included in RT's **Immediate Concerns** paper - but with a strategic emphasis, not operational. Consultant Midwife report	7.18 7.23
					4.1.2	Assurance that all relevant staff (medical and midwifery) are able to attend including service leads	In line with staffing improvements and leads being appointed. New CD appointed, permanent job plans being completed.	28/06/2019	Medical DIrector Head of Mdiwifery Clinical Director/ Directorate Manager	R	All Job plans to be aligned to identified obstetric leads for antenatal and intrapartum care. Midwifery leads for these areas have already been identified.		Consultant Midwife report	

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○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SA	4	The service requires clinical governance arrangements fit for purpose	4.1	Review of arrangements to evaluate if clinical governance processes are fit for purpose	4.1.3	Consultant meetings should: - be regular in frequency, - have a standing agenda item on governance, - be joint meetings with anaesthetic and paediatric colleagues.	Consultant meetings to be held as part of monthly Consultant meetings Currently holding weekly catch up sessions	01/06/2019	Clinical Director	B	Full Multidisaplinary Consultant meeting with governance focus			7.14
					4.1.4	MITS - Need for all Wales Solution to information systems (variation between Cwm Taf & POW)	MITS in use at old CTUHB and Myrddin in use at POW	01/09/2019	Welsh Government	R	Use of one system all Wales, which allows for data collection, validation and in line with performance board.		Consultant Midwife report	7.1 / 7.3
					4.1.5	Adhere to HTA standards of post-mortem consent -		01/04/2019	Chief Operating Officer Head of Midwifery	G		Awaiting confirmation	HTA	
					4.1.6	Consider extra resource to the Maternity Governance and Risk team to ensure: - workload is manageable, - that Datix are reviewed, graded and actioned in an appropriate and timely manner.	Structure has been reviewed and requested resources to support.	01/05/2019	Chief Operating Officer Head of Midwifery	R	Structure fit for purpose To ensure that the Governance structure is fit for purpose	Timliness of review and reporting	Consultant Midwife report	7.27 7.18 7.23
					4.1.7	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.		01/09/2019	Medical Director Clinical Director	B				7.36
	5	Service to ensure robust DATIX reporting procedures	5.1	Improve incident reporting by: - delivering training on the use of the Datix system for all staff, - encouraging the use of the Datix system to record clinical incidents, - monitor the usage of the incident reporting system.	5.1.1	Review governance and reporting processes and training for appropriate staff.	Restructure of the governance and reporting, investigation and closure of incidents within Maternity Department Training provided to all Band 7 and Senior Team to ensure clear pathway	31/01/2019	Director of Nursing/Midwifery Governance Lead Midwife	G	Documented framework describing the reporting system including learning is taking place across all areas. Fully engaged obstetric and midwifery workforce	Updated at weekly assurance group. Minutes of meetings available	Consultant Midwife report	7.11 & 7.21
					5.1.2	Maternity investigation tool to be added to DATIX	Maternity investigation tool added to Datix for more comprehensive investigation process	29/11/2018	Director of Nursing/Midwifery Governance Lead Midwife	G	So that all staff are aware of process and contribute to a robust investigation	On DATIX		7.21
					5.1.3	Urgent review of any delayed investigations ensuring these are completed as soon as possible	External support in situ for reviews Benchmark national reporting data and comparable UHB's Ongoing on a weekly process monitored through assurance group	11/01/2019	Director of Nursing/ Midwifery Governance Lead Midwife	G	maintain a quality and safety service to women and babies. To enusre lessons have been learnt and repetition doesn't occur	Updated at weekly assurance group.	**HIW Report** (page 8) mentions the importance of ensuring that there is adequate training.	7.1 & 7.3 & 7.21
			5.2	Actively discuss the outcomes of SIs in which individual consultants were involved in their appraisal.	5.2.1	Process for all action plans from incidents to be shared for appraisals A list of all incidents with name allocated to be provided inline with appraisal date		01/09/2019	Head of midwifery Medical Director	A	All incidents to form part of the appraisal discussion			7.22
	6	Fragility of services at RGH	6.1	Maintaining a safe, efficient, effective, equitable service in RGH prior to the service change in March 2019	6.1.1	Weekly meetings with Senior and Executive team to discuss staffing levels.	Meetings happen weekly	17/10/2018	Director of Nursing/Midwifery Programme Director	G	Assurance of safety of services during transition Women's care transfers seamlessly	Meetings in diaries and minutes produced	Some reference to all of point 6 section of this document in RT's **Immediate Concerns** paper.	
					6.1.2	Movement of staff from PCH to RGH when the graduate and newly appointment midwives are ready to work clinically approximately mid November	New Graduates in staffing numbers from 19/11/18	19/11/2018	Senior Midwives	G	Maintain safe staffing levels across the two sites. Safe, efficient, effective and equitable service to women and their babies	Weekly and daily monitoring of all staffing and activity levels. Action taken when required to ensure safety of units		
					6.1.3	Preparation of all staff to work in the new service model	Shadow arrangements agreed to commence 7th Jan 2019	08/03/2019	Clinical Director Head of Midwifery	G	Ensuring a safe, efficient and effective service to women and their babies during the transitional period Ensuring womens care transfers seamlessly during the period of major change			
					6.1.4	A phased move of activity in February 2019 from RGH to PCH	Plan to be developed in January 2019	08/03/2019	Chief Operating Officer Head of Midwifery	G	Ensuring a safe, efficient and effective service to women and their babies during the transitional period			
	7	Environments of care	7.1	Ensure that there is an environment of dignity and privancy for women undergoing abortion or miscarriage	7.1.1	To agree gestation for women who can receive care on the maternity delivery suite and those who will require appropriate accomodation on a general female ward.	No formal agreed gestation agreed criteria for appropriate clinical environment	01/06/2019	Heads of midwifery and nursing	A	Appropriate care environments			7.7
			7.2	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken	7.2.1	ensure involvement of paediatric staff for all future service design reviews and actions	Ongoing monitoring of births in all environments and monitoring of flows of women to external units	01/04/2019	Head of midwifery	G	Safety of units Stabalisation of capacity issues	Monitored via dashboard Datix for escalation into overflow area		7.31
			7.3	Review the working practice for how consultant cover for gynaecology services will be delivered after the merger.	7.3.1	risk assessment must be performed to determine the case mix of planned surgery on the RoyalGlamorgan site when there is no resident gynaecology cover.		01/08/2019	Executive Lead Clinical Director	B				7.39
	8	Escalation for Labour Ward presence of Multi disaplinary team	8.1	Develop a trigger list for situations which require consultant presence on the labour ward which must be: - agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives, - audited and reported on the maternity dashboard.	8.1.1	Development of a trigger list	To be discussed in Governance day 10/05/2019	01/06/2019	Clinical Director Anaesthetic Lead Neonatal Lead	R	Culture of appropriate jump calling	Added to the monitoring on the maternity dashboard		7.9

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SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY ○ SAFETY	9	Risk Management	9.1	Introduce regular risk management meetings which must be: - open to all staff, - conducted in an open and transparent way, - held at a time and place to allow for maximum attendance	9.1	Embeding weekly risk management meetings	In place	01/04/2019	Interim Risk Midwife Lead Consultant for Risk	G	Improvements in the culture of learning and improvments. Increased reporting levels Reduction in level of incidents	Complaint levels Attendance at the meetings and Forums DATIX Incidents Risk News letter		7.10
			9.2	Maintain the risk register to ensure appropriate escalation	9.2	Update the risk register and review regularly at Board level.		03/06/2019	Head of Midwifery Clinical Director	R				7.66
	10	Executive Leads	10.1	Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported.	10.1.1	This individual should: - have a direct progress reporting responsibility to the Board, in particular while the issues raised inthis report are being resolved - understand and facilitate improvement in the reporting of safety issues and clinical risk, - provide a single point of reference for liaison with external agencies, - ensure all reports from external agencies and regulators are channelled through a single pathwayto ensure priorities remain focussed.	Director of Nursing and Midwifery appointed New structure and accountability is being agreed	01/06/2019	Director of Nursing & Midwifery	B	Escalation and assurance to board members	Minutes of meetings		7.28
			10.2	Ensure the Medical Director has effective oversight and management of the consultant body	10.2.1	making sure they are available and responsive to the needs of the service, urgently reviewing and agreeing job plans to ensure the service needs are met, clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, dataassurance, train more consultant obstetricians as appraisers), ensuring the most unwell women are seen initially by a consultant and all women are seen by aconsultant within 12 hour NCEPOD recommendation4 (national standard) - job planning		01/06/2019	Medical Director Clinical Director	B	Adherence to job plans and attendance at meetings	Minutes of meetings Audit to be undertaken		7.30
			10.3	Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board	10.3.1	Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working.		01/09/2019	Executive Lead	B				7.58
					10.3.2	Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018. Independent Board members must challenge the executive over the contents of this report, Independent Board members must ensure they are fully informed on the monitoring of plannedimprovements.		01/09/2019	Executive Lead	G				7.62
					10.3.3	Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.		01/09/2019	Executive Lead	B				7.63
					10.3.4	Independent Board members should receive training in the implications of The Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services which the Board provides.		01/09/2019	Executive Lead	B				7.64
			10.4	Develop a Strategic vision with the involvement	10.4.1	Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care.		01/09/2019	Executive Lead Head of Midwifery	B				7.67
			10.5	Consider examining other UK maternity services to seek out models for delivery which could better serve their population	10.5.1	review models to include: methods of service delivery, consultant delivered labour ward care, the role of and function of a resident consultant, achieving a balance between obstetrics and gynaecology commitments, reducing the use of SAS doctors for out of hours service delivery and developing their in hours role.		01/12/2019	Executive Lead	B				7.68
			10.6	Identify and nurture the local leadership talent.	10.6.1	Develop and embeded stratergies to encourange and sustain leadership within the service	Clinical leadership programmes being supported for the directorate. Additional CD support allocated Coaching and mentoring supported Organisational Development plan implemented	01/03/2019	Executive Lead	B				7.69
			10.7	Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users	10.7.1	Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision Consider an externally facilitated and supported process for review. Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions.		01/03/2019	Executive Lead	B				7.70

Safety Efficiency Effectiveness	Issue No	Identified Issue	Recommendation No	Recommendation	Action No	Action Required	Current Position (Where applicable)	Target Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence	Link to Action Plan	RCOG Recommendations
SAFETY o SAFETY	11	User Engagement and Involvement	11.1	Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.	11.1.1	Develop and strengthen the role and capacity of the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care: Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriatesupport and resources, Support lay members to engage with women using services in the FMU at RGH and at PCH to assesssatisfaction and to identify issues relating to choices, Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found andto ask for regular feedback on action taken.		01/10/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.47
					11.1.2	Continue to work with and build on the community based engagement approaches being suggested by the MSLC. explore working with external partners, including the CHC and community based organisations.		01/10/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.50
			11.2	Utilise the role and strengths of the Community Health Council:	11.2.1	Ensure appropriate resources to act effectively as an independent advocate, Ensure that information is available to families regarding its role and contact details, Explore provision of CHC to act as point of contact and provide direct support for women andfamilies, in addition to acting as a conduit referring to other agencies and support, Involve the CHC in the early implementation of the new maternity facilities at PCH and the FMU atRGH so they can be assured regarding the impact on access and satisfaction with maternityservices.		01/10/2019	Director of Nursing & Midwifery	B				7.48
			11.3	Develop the range and scope of engagement with women and families.	11.3.1	review the effectiveness of patient experience methodology and its impact on service change andimprovement as a result of feedback, as a priority, review and address the monitoring of the outcomes of patient experience as a keypart of the governance structure, feedback the outcomes of all engagement to women and families, explore methods to hear directly from women and families about their experience including patientstories, diaries, 'mystery shopper' or observation techniques.		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.49
			11.4	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety:	11.4.1	Review and enhance staff training on the value of listening to women and families, Review the process of investigation of concerns, compiling responses, handling 'on the spot' issuesand ensure that all responses and discussions are informed by comprehensive investigations andaccurate notes, Prioritise the key issues that women and families have highlighted to improve the response, Ensure that promises of sharing notes and providing reports to families are delivered, Clarify the process regarding the triangulation of the range of information sources on patientexperience, SIs, complaints and concerns and other data and ensure that there is a rigorousapproach to make sense of patterns of safety and quality issues, Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion andinappropriate patient discharge.		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.51
			11.5	Learn from the experience of women and families affected by events	11.5.1	Respond and work with families in the way they require, Feed the learning into the design of a comprehensive training and support programme that willgive women and families confidence in the skills, expertise, communication, safety and quality ofmaternity care.		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.52
			11.6	Review the communications, support and engagement approach and strategy.	11.6.1	Ensure that the focus is not solely on management of key messages, Demonstrate openness, honesty and transparency, admission of fault, and learning from this.		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.53
			11.7	Prioritise an engagement programme with families at its heart.	11.7.1	Women and families affected by events should be part of the improvement, co-design and culturechange of the new service,		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.54
			11.8	Review the level and effectiveness of the bereavement service	11.8.1	Ensure that appropriate support and counselling is available for all families as required, Consider implementing the National Bereavement Care Pathway5 which has been developed bySands in collaboration with stakeholders including women and their families, RCOG and RCM.		01/09/2019	Head of midwifery Womens Experience Midwife and Consultant Lead	B				7.55

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NESS O EFFECTIVENESS O EFFECTIVENESS O EFFECTIVENESS O EFFECTIVENESS O	12	Variable leadership throughout the service and succession planning	12.1	A compehensive workforce establishment for leadership role identification, development and succession planning	12.1.1	Leads and succession for all roles and responsibilities to be identified throughout the service Appoint clinical leads in a structure that supports the service with defined role descriptions and objectives to include an individual responsible for each of the following: - governance and clinical quality to include guideline updating, - data quality, - medical staff education and training, - multi-disciplinary training, - audit, - risk management, - incident review, - complaints handling.	Clinical leads have been allocated across Medical and Midwifery teams Womens Experience midwife has been appointed.	03/12/2018	Assistant Director of Hr & OD Clinical Director/ Head of Midwifery	G	to ensure that leads are identified and continuously improving and maintaining safe services.		Consultant Midwife report	7.46
					12.1.2	Supporting staff to undertake appropriate leadership courses, both external and internal education.	Courses and staff are being identified commencing with a team of 10 to a labour ward leadership programme. The team includes medical, midwifery and management staff. Leadership courses being supported both internally and externally.	31/12/2019	Director of Nursing/Midwifery Medical Director	G	All effective leaders to be identified and supported throughout the service.	Labour ward leadership - Attended December 2018.	Consultant Midwife report	
					12.1.3	Support training in clinical leadership. - The Health Board must allow adequate time and support for clinical leadership to function.	New Clinical Director has been appointed and supported Job planning process currently being undertaken to ensure time allocated for leadership roles RCM Personal change courses organised for June & July 2019	01/01/2020	Clinical Director Head of Midwifery	B	Roles and responsibilities through effective clinical leadership throughout the Directorate	RCM Personal Change course		7.44
					12.1.4	Provide mentorship and support to the Clinical Director - define the responsibilities of this role, - ensure there are measurable performance indicators, - ensure informed HR advice to consistently manage colleagues' absence and deployment of staff tocover the needs of the service, - consider buddying with a Clinical Director from a neighboring Health Board.	New CD appointed with a full support framework in place which includes, Management support, mentorship from an experienced clinical director and HR support. Directorate to agree measurable performance	01/07/2019	Medical Director Directorate Manager	B	Effective clinical leadership			7.45
		Ensure mandatory attendance at following meetings for all appropriate staff.	12.2	Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are to be scheduled or elective clinical activity modified to allow attendance at: - governance meetings, - audit meetings, - perinatal mortality meetings.	12.2	Agreement of dates, membership and terms of referance. Activity to be reduced Ask consultant for what each month yearly sechedule for attendance	Establishing the forums and Governance days	01/06/2019	Clinical Director Head of Midwifery	B	Effective governance structure in place	Governance report Recording of attendance at meetings		7.11
	13	Assurance of the in date policies, procedures and guidelines for maternity services	13.1	Maximise the number of guidelines and policies that are current and based on evidence and are in line with RCOG and NICE standards and guideance	13.1.1	Review all current policies, procedures and guidelines make sure they are fit for purpose, evidence based and in date Scoping Exercise against RCOG and NICE Guidance to ensure the library of procedures and policies is robust and comparable to other units.	Scoping exercise completed in compliance with RCOG & NICE Guidance with guidelines required. Current: 85% compliant	05/11/2018	Governance lead Midwife Clinical Director	G	100% Compliance To ensure that all policies, procedures and guidelines avaiable are being utilised within the service to ensure a safe, efficient and effective for women and babies	Guidelines published on sharpoint X:\Waiting_List\ SURGICAL DIRECTORATE\ Compliance monitored via weekly meetings	Consultant Midwife report	7.2
					13.1.2	Ensure that there is a robust process to review the policies and update when required so that no lapse	Audit plans need to be developed. Re. clinical practice to guidance	28/01/2019	Governance Lead Midwife Audit Lead Consultant	G	100% Complance To ensure that all policies, procedures and guidelines avaiable are being utilised within the service to ensure safety for women and babies	Spreadsheet available with dates for review, authors and forums to be discussed.	Consultant Midwife report	7.2
			14.1	Identification of any cultural issues so that they can be resolved to enable functional and cohesive multidisciplinary team working together	14.1.1	Developing further a culture of empowerment for all staff through robust clinical governance arrangements and multidisciplinary working and clinical supervision	OD developing a plan with the Directorate to present at Dec Maternity Board	30/10/2019	HR Lead Senior Midwives Governance Consultant Lead/ Governance Lead Midwife	R	A multidisciplinary team working in professional harmony. Incidents and sickness levels decrease Excellent recruitment and retention of all staff	Add Charter as evidence Assistant Director to request from Workforce and OD	Consultant Midwife report Mention of changes in culture in RT's Immediate Concerns document, and in HIW Report (pp10 - 11) mention of MDT training.	
					14.1.2	effective working across the multidisciplinary team through shared training and shared vision meetings	OD developing a plan with the Directorate to present at Dec Maternity Board	30/10/2019	HR Lead Senior Midwives	R	A full maternity team working in professional harmony. Incidents and sickness levels decrease Recruitment and retention of all staff are improved	E5F3A4ED.pub X:\Waiting_List\ SURGICAL DIRECTORATE\ X:\Waiting_List\ SURGICAL DIRECTORATE\	Consultant Midwife report	
					14.2.1	Developing a plan to support all staff after the change of the service model Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.	OD developing a plan with the Directorate to present at Dec Maternity Board 3 sessions undertaken by OD external expert around appriciative inquiry and positive change.	30/10/2019	Assistant Director of HR & OD Clinical Director/ Head of Midwifery	R	A full maternity team working in professional harmony. Incidents and sickness levels decrease Recruitment and retention of all staff are improved Staff reported experience via staff survey	See above		7.41

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EFFECTIVENESS ○ EFFECTIVENESS ○ EFFECTIVENESS ○ EFFECTIVENESS ○ EFFECTIVENESS ○ EFFECTIVEN	14	Variable team working and dynamics	14.2	Ensure a cohesive team working together to successfully implement the changes of the service model in March 2019	14.2.2	Successful merger of two teams and identify any culture issues after the move to the larger unit in PCH during March 2019	OD developing a plan with the Directorate to present at Dec Maternity Board	01/04/2019	Assistant Director of Hr & OD Clinical Director/ Head of Midwifery	R	A full maternity team working in professional harmony. Incidents and sickness levels decrease to within national standards. Recruitment and retention of all staff are improved	See above	Consultant Midwife report	
					14.2.3	Successfully implementation of the FMU in RGH	Policies and guidelines completed midwifery team will be selected in December 2018 agreed plans for the interim FMU	08/03/2019	Governance Consultant Lead/ Governance Lead Midwife	G	Successful FMU, confident and competent staff to work in the model. Maximise the number of appropriate women who give birth in the unit	weekly reflection sessions. Quarterly reports from Consultant Midwife		
					14.2.4	Development of core and mandatory training plan for 2019 to include any training required following the change of service model in March 2019. The plan to include any training which has been identified from themes and recommendations from incidences and external reports	Core and mandatory training has been agreed to March 2019. staff have been informed re the training they need to complete and where to submit the evidence	31/03/2019	Clinical Director Head of Midwifery	G	90% of all staff will have undertaken the core and mandatory training ensuring a competent and confident workforce to provide a safe, efficient and effective service to women and their babies	Staff database available/ ESR	Consultant Midwife report	
			14.3	RCM Caring for you charter	14.3.1	Adhere to RCM " caring for you " staff charter - Establishment of staff side working group		01/07/2019	Head of Midwifery	B			Consultant Midwife report	
			14.4	Strengthen handover and safety briefings	14.4.1	To work with clinical Quality and Improvement lead to develop handover and safety briefings		01/06/2019	Director of Nursing/ Midwifery Quality Improvement Lead	B	Robust handover and safety briefings	QI Lead to observe handovers spontaneously		
			14.5	Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	14.5.1	Embeding effective debrief sessions to include full multi disaplinary meeting after unexpected outcome	Adhoc sessions being held	01/08/2019	Director of Nursing/ Midwifery Quality Improvement Lead	B	Support staff Workforce matrix			7.12
			14.6	In conjunction with Organisation Development undertake work with all grades of staff around communication, mutual respect and professional behaviours	14.6.1	staff must be held to account for poor behaviours and understand how this impacts on women'ssafety and outcomes.	All requested to reflect and meet with clinical supervior to confirm learning from the report	01/09/2019	Clinical Director Head of Midwifery	A	Culture of learning and improvement of all staff.			7.42
	15	Interaction with Neonatology	15.1	Cohesive multidisciplinary team working together. In particular effective communication and collaboration with the neonatal service to ensure that the service to babies is safe, efficient and effective development of a neonatal forum	15.1.1	Close collaboration between Obstetricians, Midwives and Neonatologists to provide data through audit and themes or trends of why babies are unexpected admitted to the neonatal unit. Trends and themes and learning lessons from any unexpected intrapartum stillbirths and early neonatal deaths	Forum is in place to discuss expected admissions to the neonatal unit. Neonatal team have been contacted and a meeting has been arranged ASAP to discuss. Neonatal lead to be lead and organise future meetings	01/03/2019	Clinical Director obstetrics Lead Consultant Neonates Head of Midwifery	R	All lessons learnt to provide a safe, efficient and effective service to babies Reduction in intrapartum stillbirths and early neonatal deaths.	Updates from Consultant midwife and governance lead	Consultant Midwife report	
					15.1.2	scoping exercise to make sure that obstetric/midwifery and neonatal guidelines and pathways are current, evidence based and compliment each other and take into consideration national recommendations	Task and finish group which includes, midwives, neonatal nurses and neonatologist has commenced this work this is in danger of going red, need to explore what progress has been made regarding the neonatal guidelines and policies. Will discuss at the meeting with the neonatal team	08/03/2019	Governance Lead Midwife Lead Consultant Neonates	R	Care provided to babies is based on national guidelines and is safe and effective	Updates from Consultant midwife and governance lead	Consultant Midwife report	
					15.1.3	Further embed regular perinatal review meetings to ensure, obstetricians, neonatologist, neonatal nurses and midwives are present	Regular meetings but not all professionals are present	01/04/2019	Governance lead Midwife Clinical Directors Obstetrics and Neonates	G	Safe, effective efficient service to women and their babies	Mitigating action plan to be attached	Consultant Midwife report	
					15.1.4	HIE in neonates and MDT approach review of all babies admitted to NICU - Need to review all cases		01/07/2019	Lead Consultant Neonates Governance lead Midwife/ Head of Midwifery	A	monthly meetings, minutes and action logs demonstrating learning and feedback.		Consultant Midwife report	
	16	High intervention rates particularly the number of women who follow: Consultant led antenatal pathways, Caesarean section Induction of labour rates	16.1	Modernising how antenatal care is provided and working towards 45% women labouring outside Obstetric unit. (Welsh Government performance target)	16.1.1	Community midwifery review to establish how care is delivered. Review how care is delivered in the ANC Maximising the number of women booking under the midwife as the lead professional Proactive promotion of home and MLU's as the place of birth for all appropriate women	Current rates of women birthing outside the OU is 10% Guidelines for women's Antenatal care pathway have been ratified PGD for midwives to give prophylaxis aspirin has developed and awaiting ratification by MMC Appointment of a consultant midwife. Workforce for FMU and accommodation agreed	01/07/2019	Clinical Director Consultant Midwife	B	Maximising the number of women booking under the midwife as the lead professional. Efficient care provision in the ANC reducing the number of inappropriate appointments in the consultant antenatal clinics Working towards 45% women labouring outside Obstetric unit. Reducing unnecessary interventions, which potentially could cause harm to women and babies.	Evidenced on a weekly basis via the dashboard		
			16.2	Caesarean Section Rates should meet the Welsh Government target of less than 25%	16.2.1	Identified via the dashboard the Elective CS rate is approximately 5 to 10% higher than the Welsh Average. Workshop and audit to further understand the reasons for such high rates Revisit the CS workshops worked which was undertaken in Wales in 2009/10	Current rates 30% Emergency 13% Elective 18% Obstetric leads need to be identified through Job plan to develop this work	31/10/2019	Clinical Director Consultant Midwife	R	CS rates to meet Welsh Government performance target. Reducing unnecessary intervention and potential harm to women and babies	Mitigating action plan to be attached	Consultant Midwife report	
					16.2.2	Review the 'birth choices' clinics to ensure they are fit for purpose. Review the leadership support for these clinics from both an obstetric lead and from the consultant midwife. Regular audit and data collection re VBAC service	Midwifery led clinics are taken place in both RGH and PCH. Will go red. Permanent consultant midwife is in post April 2019, the interim consultant midwife to led on this issue and develop an action plan	31/07/2019	Clinical Director Consultant Midwife	R	Maximise the number of women who have a VBAC and therefore reducing potential harm to them and their babies	Mitigating action plan to be attached		
					16.2.3	Review the present ECV service to make sure its robust and fit for purpose. To collect and publish data regarding the ECV service	ECV service in PCH. Data isn't published. Will go red, permanent consultant midwife will be in post in April 2019, the interim consultant midwife will lead on this issue and develop an action plan	31/07/2019	Clinical Director Consultant Lead	R	Reduce the number of elective CS for a breech presentation	Mitigating action plan to be attached		

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EFFECTIVENESS o EFFECTIVENESS o EFFECTIVENESS o EFFECTIVENESS					16.2.4	Weekly review through reflection meetings on the reasons for Emergency CS and the labour ward forum	Reflection sessions and labour ward forum will be established in January 2019 Will be established after the move of the obstetric services on 9th march 2019.	31/07/2019	Labour Ward Lead Consultant Consultant Midwife	A	Reduce unnecessary interventions and potential harm to women and babies	Action Plan needed to be attached		
			16.3	Induction of Labour Rates of less than 25% (Welsh Government performance target)	16.3.1	Audit to establish whether all IOL are undertaken in line with national and health board guidelines Make recommendations on the changes needed to reduce the rates	Current rate 48% - Audit presented and discussed at the audit meeting RGH on 13/11/18	01/12/2018	Consultant midwife	G	Reducing the rates to meet Welsh Government performance targets. Reducing unnecessary interventions and potential harm to women and babies	Attach a copy of the Audit - ED		
					16.3.2	Through job plan identify obstetric lead to take IOL work further	Job plan currently being discussed with consultants. Advert out for new consultants NS and AS to be instructed by JmP to carry out ECV work.	08/03/2019	Clinical Director Directorate manager	G	Reducing the rates to meet Welsh Government performance targets. Reducing unnecessary interventions and potential harm to women and babies	JP		
	17	Variable compliance levels with core skills and mandatory / professional training	17.1	100% of staff currently at work to attain compliance with the strategic training plan. This is in keeping with the Welsh Government recommendations	17.1.1	CTG interpretation - inform staff that they need to attend a study or complete 5 online cases RCOG eFM		29/03/2019	Lead Midwife for Fetal Surveillance Practice Development Midwife	G	90% of staff compliant with core and mandatory training Skilled competent workforce that provides high quality care	Add weekly assurance update	Mandatory Training mentioned in the **HIW Report** at page 11.	7.5
					17.1.2	Agree a revised competency assessment programme for CTG , in line with the all Wales fetal surveillance standards.	All Wales decision needs to be made.	01/09/2019	PROMPT lead Practice development midwife	A		https://gweddill.gov.wales/docs/dhss/publications/whc2018-024en.pdf		7.5
					17.1.3	PROMPT - inform the staff that they need to attend the skills and drills day. Ensure there are enough dates for the staff to achieve compliance before 31st March 2019 and staff are released from clinical duties to attend		29/03/2019	Practice Development Midwife Consultant Lead for Training	G	90% of staff compliant with core and mandatory training Skilled competent workforce that provides high quality care	Include training update		
					17.1.4	Gap & Grow - inform the staff that they need to undertake the perinatal institute on line training appointment of a 'fetal surveillance midwife' January 2019 - Appointed		31/12/2019	Lead Midwife for Fetal Surveillance Consultant Midwife	A	90% of staff compliant with core and mandatory training by Skilled competent workforce that provides high quality care	Include training update	Consultant Midwife report	
					17.1.5	NLS - for appropriate staff (every 4 years) or annual neonatal resuscitation update identifying potential NLS trainers		29/03/2019	Practice Development Midwife	G	100% of appropriate staff compliant with core and mandatory training by . i.e.. FMU Skilled competent workforce that provides high quality care	Include training update		
					17.1.6	Communication Skills Training - inform the staff what is expected and to attend the PROMPT skills and drills where effective communication skills are discussed		29/03/2019	Practice Development Midwife	G	90% of staff compliant with core and mandatory training by Skilled competent workforce that provides high quality care	Include training update	Consultant Midwife report	
					17.1.7	Mandatory & Statutory - attendance and study days need to be protected	Currently directorate protecting time and ensuring attendance is available.	31/12/2019	Head of Midwifery Directorate Manager	A	90% of staff compliant with core and mandatory training Skilled competent workforce that provides high quality care		Consultant Midwife report	
					17.1.8	Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at: - junior doctor induction, - locum staff induction, - midwifery staff induction, - annual mandatory training.	To ensure included on induction and mandatory training days	01/06/2019	Head of Midwifery Clinical Director	B	All staff being aware of responsibilities and accountability for reporting and escalating Increase in DATIX	DATIX on dashboard monitoring Training records		7.15
					17.1.9	Ensure training is provided for all SAS staff to ensure that they are: - up to date with clinical competencies, - skilled in covering high risk antenatal clinics and out-patient sessions.		01/08/2019	Clinical Director	A	Evidence of training and competencies			7.17
			17.2	Roles and responsibilities identified to monitor, record and ensure and escalate compliance	17.2.1	Identification of lead to monitor and update	Task and finish group to look at a strategic training plan. Recording on ESR. Co-ordinator role to be supported and identified to support.	01/01/2019	Clinical Director Head of midwifery Directorate Manager	G	Full database of compliance of all staff	Maternity admin support has been identified as lead and maintains the database ESR being updated	Consultant Midwife report	
			17.3	Adhere to Core Skills frame work standards	17.3.1	To be highlighted via the appraisal and PDR process		01/09/2019	Medical Director Head of Midwifery	G			Consultant Midwife report	7.4
			17.4	Ensure thar all staff are trained to the standards required	17.4.1	Undertake a training needs assessment for all staff to identify skills gaps and target additional training.		01/10/2019	Clinical Director Head of midwifery	B				7.35
			17.5	Develop an effective department wide multi-disciplinary teaching programme.	17.5.1	•this must be adequately resourced and time allocated for attendance by all staff groups includingspecialist clinical midwives and SAS doctors. •attendance must be monitored and reviewed at appraisal		01/09/2019	Clinical Director Head of Midwifery	B				7.37
			17.6	Provide training for staff in communications skills	17.6.1	Training on Empathy, compassion and kindness		01/04/2020	Clinical Director Head of Midwifery Training Leads	B				7.56

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Safety ○ Efficiency ○ Effectiveness	18	Large organisational and service change	18.1	Successful merger of services re Bridgend boundary changes April 2019	18.1.1	To work with the HOM and team from ABMU to understand the changes to boundaries Communication of the boundaries changes to the women who it will affect.	preliminary discussions ready for new organisation in 2019.	01/04/2019	Head of Midwifery Directorate Manager Clinical Director	A	Successful transition to the new organisation with seamless care to women and babies			
			18.2	Assessment of the impact of service change	18.2.1	Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services.	Monioring via weekly and monthly assurance meetings post RGH PCH Merger. Working with Princess of Wales to ensure successful integration of teams.	01/03/2020	COO Executive Lead	B	Successful transition of services			7.43
			18.3	Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.	18.3.1	Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.		01/08/2019	Assistant Director of W&OD	A				7.41
			18.4	Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety	18.4.1	Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new mergedunit.		01/03/2019	General Manager Executive Lead	G				7.59
					18.4.2	Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.		01/03/2019	General Manager Executive Lead	G				7.65
			18.5	Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.	18.5	Develop daily aquity scoring	Daily aquity being recorded and escalation plan in use	01/05/2019	Head of midwifery	G				7.60
			18.6	Develop a plan to increase inpatient capacity if that is seen to be required.	18.6	Internal and external plan to be developed	Overflow capacity has been allocated Regional group established to monitor	01/05/2019	General Manager Head of Midwifery	G				7.61
	19	Variable data and performance data presented	19.1	Dashboard and monitoring process to be established	19.1.1	Development of a maternity dashboard - to include, data re risk, clinical activity, staffing levels and training compliance as well as progress re Welsh Government performance targets	Dashboard developed	03/12/2018	IT Programmer Deputy Head of Midwifery	G	Identifying hot spots flagged and action plans to be developed	http://ctuhb-intranet/dir/PI/PB/_layouts/15/WopiFrame.aspx?sourcedoc={C048CCBB-C5F0-45F7-90E3-4224E2ADA3AE}&file=J7087%20Maternity%20Dashboard.xlsx&action=default&DefaultItemOpen=1	Consultant Midwife report Importance of developing appropriate data mentioned in RT Immediate Concerns paper.	
					19.1.2	Implementation of a weekly monitoring process	Weekly analyse of the data provided	17/10/2018	Director of Nursing/Midwifery Programme Director	G	Identifying Hot spots flagged and action plans to be developed	http://ctuhb-intranet/dir/PI/PB/_layouts/15/WopiFrame.aspx?sourcedoc={C048CCBB-C5F0-45F7-90E3-4224E2ADA3AE}&file=J7087%20Maternity%20Dashboard.xlsx&action=default&DefaultItemOpen=1		
Initial Improvements ○ Initial Improv	20	Initial Improvements	20.1	Completion of action	20.1.1	Poor Deanery feedback in regards to education environment and experience for trainees	Out of special measures	01/02/2018	Medical DIrector Clinical Director/ Directorate Manager	G	Meeting deanery expectations	Action plan to be attached	Consultant Midwife report	
					20.1.2	Comprehensive induction programme to be introduced for all junior medical staff.	Induction programme introduced	01/04/2019	Medical DIrector Clinical Director/ Directorate Manager	G	Positive feedback for induction programme	Include evidence		7.6
					20.1.3	Comprehensive induction programme to be introduced for all locum staff	Induction programme introduced	01/03/2019	Medical DIrector Clinical Director/ Directorate Manager	G	Positive feedback for induction programme	Include evidence		7.6
					20.1.4	Appointment to the HOM post	Appointment made	01/03/2018	Director of Nursing/ Midwifery	G	Post filled	WTE = 1		
					20.1.5	Senior midwife guidance for development and service change. Highlighted in reports that CTUHB has no Consultant Midwife post	Appointment Made	01/07/2018	Director of Nursing/Midwifery Head of midwifery	G	Post filled	WTE = 1		
					20.1.6	Incident occurs where Consultants were unable to be contacted	Bleeps ordered for all Consultants at PCH	01/06/2018	Chief Operating Operator Directorate manager	G	Consultants contactable	Datix submissions		
					20.1.7	Support for midwives OOH needed	Implemented of Senior midwife on-call	01/07/2018	Director of Nursing/Midwifery Head of Midwifery	G	Support for escalation process, professional advice and staffing.	On call rota		
					20.1.8	Appointment of patient experience midwife	appointment made	01/10/2018	Directorate Manager Head of Midwifery	G	Response times to complaints in line with Health Board. Weekly real time collection of feedback from women experiencing our services, with feedback to staff.	WTE = 1		
					20.1.9	Support for Senior leadership team	Operational HOM Support 4 sessions for CD support Consultant Midwife 26hrs per week	01/10/2018	Director of Nursing/Midwifery Programme Director	G		Appointments agreed		

Safety Efficiency Effectiveness	Issue No	Identified Issue	Recommendation No	Recommendation	Action No	Action Required	Current Position (Where applicable)	Target Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence	Link to Action Plan	RCOG Recommendations
○ Initial Improvements ○					20.1.10	Revise and reinforce escalation process	Escalation process updated and communicated	31/03/2019	Director of Nursing/Midwifery Head of Midwifery	G		X:\Waiting_List\SURGICAL DIRECTORATE\		
					20.1.11	Identify a clinical lead for governance from within the consultant body. This individual must: - be accountable for good governance, - attend governance meetings to ensure leadership and engagement.	Governance Lead appointed	01/05/2019	Medical Director Clinical Director	G	Lead appointed to embed Governance culture			7.13
					20.1.12	Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	Accomodation provided for those Consultants that live > 30 minutes away	11/03/2019	Medical Director Clinical Director	G				7.16
					20.1.13	Identify a clinical lead from senior medical staff within the directorate to support the current midwifery governance lead.	Appointed Obstetric Risk Lead	01/05/2019	Medical Director Clinical Director	G				7.24
					20.1.14	Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: - that clinical audits are multidisciplinary, - that there is a clinically validated system for data collection, - that the lead encourages all medical staff to complete an audit/quality improvement project eachyear to form part of their annual appraisal dataset, - sharing of the outcomes of clinical audits and the performance against national standards.	Appointed lead consultant & Midwife	01/05/2019	Head of midwifery Clinical Director	G				7.25

RABG	Progress/indicator RAG status
R	Work is significantly behind schedule and no progress has been made, and/or Progress has been made but the timescale has not been achieved.
A	Progress is being made, progress is good and the action is likely to be achieved within timescale. Or the action has been completed but evidence is required to demonstrate achievement.
B	Progress being made and is on track and will be completed on timescale
G	The action has been completed and there is a record of evidence to support its completion.