

Maternity Improvement Action Plan

Action Group	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
1 Quality and Governance Process and Outcome	33%																						
2 Workforce and Leadership	30%																						
3 Culture and Behaviour	14%																						
4 Strategy and Planning	40%																						
5 Womens Experience and Engagement	9%																						
6 Education, Learning and Development	36%																						
7 Board	13%																						
Overall	27%																						

RAG	
Compliance	■
Improvements required	■
Immediate action	■

TOR 1	To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.
TOR 2	Assess the prevalence and effectiveness of a patient safety culture within maternity services including: <ul style="list-style-type: none"> o The understanding of staff of their roles and responsibilities for delivery of that culture. o Identifying any concerns that may prevent staff raising patient safety concerns within the Trust. o Assessing that services are well led and the culture supports learning and improvement following incidents.
TOR 3	Review the RCA investigation process, how SIs are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event. Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.
TOR 4	Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.
TOR 5	Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.
TOR 6	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.
TOR 7	Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.
TOR 8	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.
TOR 9	Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board
TOR 10	To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms

Action No	RCOG Reference	Recommendation	Measurement	Evidence	Current Risk	Target Risk	Areas for Targeted Intervention for Improvement	Target Date	Action Lead (Initials)
1	TOR: 1 Action No: 7.1	Urgently review the systems in place for: •Data collection •Clinical validation •Checking the accuracy of data used to monitor clinical practice and outcomes •What information is supplied to national audits	Performance Scorecard devised and in use. Work stream to make changes to MITS to include DATIX number. Awaiting audit plan from SHOM. No national audits carried out 2018/19	Datix / MITS link and reporting Audit plan and achievement/progress of the plan			MITS upgrade Improved datix reporting and recording. Audit plan for 2019 to be agreed with Internal audit and CD.	17/06/2019 31/03/2021	Deputy HOM Audit & Effectiveness & Research Leads
2	TOR: 1 Action No: 7.2	Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines: •Are up to date and regularly reviewed •Are readily available to all staff, including locum staff and midwifery staff •Have a multi-disciplinary approach •Are adhered to in practice	Leads identified. Systematic guideline reviews in place for rolling programme Guidelines available Compliance requires monitoring through audit which is not fully operational	Governance within the Forums Publication of Guidelines			Requires monthly report on lapsed guidelines – some have recently lapsed and need urgent review – requested at assurance meeting 7 th May. Awaiting Audit Plan Awaiting approvals from Pharmacy	01/01/2020	Audit & Effectiveness & Research Leads Forum Leads
3	TOR: 1 Action No: 7.3	Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.	Leads identified Audit Plan	Lead nominated May 2019 and Audit Plan being agreed.			Progression of Audit plan via Governance structure	31/03/2021	Audit & Effectiveness & Research Leads Forum Leads
4	TOR: 1 Action No: 7.4	Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery: •To ensure compliance with guidelines •To ensure competency and consistency of performance is included in annual appraisal.	Incident reports and reviews Personal Development Review Rates - To be >90%	Personal Development Reviews - Current Midwifery Compliance: 71.06% Weekly risk newsletter			Personal Development Review Compliance Rates Datix Incident reporting	31/10/2019	HOM Governance Lead
5	TOR: 2 Action No: 7.9	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	Agreement of Trigger list Datix Reporting on Dashboard	Dashboard			MITS upgrade DATIX upgrade Dashboard reporting	17/06/2019 14/06/2019	Deputy HOM & Consultant Midwife
6	TOR: 2 Action No: 7.10	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	Meetings established and embedded	Update of weekly newsletter Monitoring of recurring themes			Sustaining and embedding into culture	01/04/2019	Governance Lead
7	TOR: 2 Action No: 7.14	Consultant meetings should: •Be regular in frequency •Have a starting agenda item on governance •Be joint meetings with anaesthetic and paediatric colleagues	Attendance at multi disciplinary team meeting	Staff attendance sheet and actions and minutes				01/05/2019	Governance Lead

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8	TOR: 3 Action No: 7.19	Ensure that a system for the identification, grading and investigation of SI's is embedded in practice through: •Appropriate training to key staff members •Making investigations multidisciplinary and including external assessors.	Training development Review process for incidents	Training records MDT panel in place and all SUI's reviewed by MDT. Further work is required to encourage a reporting and patient safety culture. Safety briefings being circulated.			Training for RCA Embed MDT review process Concern regarding under reporting, which is being audited and work to MITS being undertaken to make DATIX number mandatory field on MITS.	31/03/2020 01/04/2019	Governance Lead
9	TOR: 3 Action No: 7.21	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	Datix reporting	Datix training in place and mandatory. Datix reports and monitoring			Still some underreporting noted and mechanisms being sophisticated to monitor reporting. Development of the Governance team capacity Datix Upgrade	17/06/2019	Deputy HOM
10	TOR: 4 Action No: 7.26	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	Audit Plan and National Reporting	Audit Plan and National Reporting			Ensure forums monitor audit performance Setting a minimum target expected for performance UHB produced assurance report against national reporting	31/03/2021	Audit & Effectiveness & Research Leads Forum Leads Governance Lead
11	TOR: 5 Action No: 7.36	Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors.	Compliance against standards Incident reporting	Annual clinical summary of activity reporting for specialist midwifery Deanery training compliance and appraisal			Monitoring of and receipt of annual reports	31/03/2020	Deputy HOM Clinical Director
12	TOR: 10 Action No: 7.65	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.	SOP approval and escalation via the governance framework	Minutes of governance in Feb/March 2019				11/03/2019	Consultant Midwife
13	TOR: 10 Action No: 7.66	Update the risk register and review regularly at Board level	Risk register sign off through governance process and escalated through QS&R committee	Minutes from the forums and cooperate committee			Update Risk register and escalate	30/09/2019	HOM Clinical Director Directorate Manager
14	Delivery Unit Report (Dec 2019)	Complete the reviews of the 43 incidents in this cluster utilising the RCA methodology and including peer review of the clinical outcomes.	Action plan update	Action plan and aggregated learning plan				30/05/2019	Governance Lead

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15	Delivery Unit Report (Dec 2019)	Ensure the governance processes within the Maternity Directorate are consistent with the HBs corporate process to ensure appropriate escalation.	Governance structure and framework has b	Structure implemented				30/04/2019	Governance Lead
16	Delivery Unit Report (Dec 2019)	Simplify the current processes for review of an incident and make 'patient safety' the focus of the review (rather than grading for external reporting).	Structure and evidence	This is multifaceted via the following: <ul style="list-style-type: none"> Initial review MDT meeting Incident review meeting 				30/04/2019	Governance Lead
17	Delivery Unit Report (Dec 2019)	Ensure sustainable change in the Midwifery reporting process that provides assurance that incidents are being reported and investigated in line with the Putting Things Right requirements.	Audit of reporting	ICT currently working on MITS update for trigger list to be added to the programme, whereby midwives will not be able to complete episode without a DATIX link. This will ensure reporting of incidents.				30/06/2019	Deputy HOM
18	Internal action	Maternity Theatres to be managed by ACT, to national theatre standards	Theatre standards in ACT	Movment and Audit			Funding required for full roll out	31/03/2020	General Manager

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1	TOR: 2 Action No: 7.13	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	Appointment of Lead	Named individual responsible Attendance list at Governance day			Sustainability of leadership and monitoring attendance	01/05/2019	Medical Director
2	TOR: 2 Action No: 7.18	Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	MDT and joint consultant meetings	Work bedding in post move. Minutes and agendas of meetings Examples of engagement			Immediate post-merger, no difficulties reported but requires further reflection and review for rigour.	01/01/2020	Medical Director
3	TOR: 4 Action No: 7.25	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 each year to form part of their annual appraisal dataset • Sharing of the outcomes of clinical audits and the performance against national standards	Appointment of Leads	Named individual(s) responsible Attendance list at Governance day and forums			Embed within the culture	01/05/2019	Medical Director
4	TOR: 4 Action No: 7.27	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	Increase in workforce and capacity of team	Workforce dashboard and WTE numbers Agreement on Directorate patient safety paper			Approval of request	01/06/2019	Director of Nursing and Midwifery
5	TOR: 5 Action No: 7.29	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	Weekly score card monitoring	Weekly updates in assurance group			Workforce scorecard to be developed and agreed Rota manager for Maternity Services	01/08/2019	HR Business Partner
6	TOR: 5 Action No: 7.32	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • 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 been implemented • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other • Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	Service established to achieve this.	Handover attendance documents Spot checks by Senior Management Team Job plans and workforce			Recruitment to workforce plan Consultant cover in place. Gaps being managed through locums and additional shifts for existing team. Successful recruitment to consultant vacancies with only 1 post vacant in the short term.	01/01/2020	HOM Clinical Director

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7	TOR: 7 Action No: 7.45	Provide mentorship and support to the Clinical Director <ul style="list-style-type: none"> • 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 to cover the needs of the service • Consider buddying with a Clinical Director from a neighbouring Health Board. 	To be agreed	Support CD in situ Training supported			To be agreed	01/01/2020	To be agreed
8	TOR: 7 Action No: 7.46	Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to include an individual response for each of the following: <ul style="list-style-type: none"> •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 appointed within an agreed structure	Named clinical leads			To be fully integrated with Princess of Wales in recent boundary change	01/01/2020	CD HOM
9	TOR: 9 Action No: 7.57	Continue with efforts to recruit and retain permanent staff.	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
10	TOR: 10 Action No: 7.69	Identify and nurture the local leadership talent	OD plan to support teams in place. Requirement to develop leadership programme now leads are in place.	Requires prioritisation.			To be agreed	To be agreed	To be agreed

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1	TOR: 2 Action No: 7.8	Ensure external expert facilitation to allow a full review of working practice to ensure: <ul style="list-style-type: none"> • 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. 	to be agreed	to be agreed			to be agreed	to be agreed	to be agreed
2	TOR: 2 Action No: 7.11	Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at: <ul style="list-style-type: none"> •Governance meetings •Audit meetings •Perinatal mortality meetings 	Attendance at meetings	All day Governance meeting implemented Attendance register completed Attendance at Forums via governance structure			Embedded into culture of services	30/09/2019	HOM CD O&G CD C&YP
3	TOR: 2 Action No: 7.12	Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	Implementation of MDT debriefings	Records of debriefs and attendance			Training and development of maternity team and benchmarking similar sessions	to be agreed	CD HOM
4	TOR: 2 Action No: 7.16	Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	Job planning and spot check audit	Datix Job plans Audit			Embedded into service culture	01/09/2019	CD HOM
5	TOR: 3 Action No: 7.20	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Sis.	Increase the reporting Active involvement in MDT debriefs Reflection meeting attendance	Attendance and action logs Increased trend in reporting and accuracy of reports Governance infrastructure developed to support no blame culture. Require an impartial team to undertake debriefs.			Triangulation of evidence Cultural issues remain challenging. High levels of support and intervention being put in place. Creation of the capacity to reflect and learn being prioritised	Activated	Governance Lead
6	TOR: 5 Action No: 7.38	Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. <ul style="list-style-type: none"> • This must involve the antenatal ward round being performed by the consultant. 	Presence at MDT handovers	Documented attendance Spot check audits 40hrs to 60hrs on a single unit in place.			Embedding into service culture	Activated	CD HOM
7	TOR: 6 Action No: 7.42	In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. <ul style="list-style-type: none"> •Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes 	Cultural survey	Staff experience Women experience			Accountability culture needs to develop.	31/03/2021	to be agreed

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1	TOR: 5 Action No: 7.39	Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. •A risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
2	TOR: 6 Action No: 7.41	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.	To be agreed	Cultural issues remain. Significant numbers of new staff in pipeline for recruitment which will support culture change.			Concerns regarding lack of staff engagement with OD plan Mixed cultures initially difficult but reported to be settling. Patient safety culture and compassionate leaderships requires significant development.	To be agreed	To be agreed
3	TOR: 7 Action No: 7.43	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. • This can determine the structures and competencies of clinical leadership and governance that will support the service.	Risk assessment prior to move undertaken	Risk assessment at board level			Oversight panel to advise further	11/03/2019	COO
4	TOR: 7 Action No: 7.58	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.	Development of the CTMUHB Maternity Strategy	Development programme via MIB Publication of Plan				30/09/2019	Consultant Midwife
5	TOR: 7 Action No: 7.59	Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including: • Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.	Risk assessment prior to move undertaken	Risk assessment at board level			Oversight panel to advise further	11/03/2019	COO
6	TOR: 7 Action No: 7.60	Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.	Daily Acuity reports	PCH operating regularly to full capacity.			Monitoring in place.	11/03/2019	HOM
7	TOR: 7 Action No: 7.61	Develop a plan to increase inpatient capacity if that is seen to be required.	DATIX monitoring of use	Overflow area available.			Incident monitoring	11/03/2019	HOM
8	TOR: 10 Action No: 7.67	Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care.	Development of the CTMUHB Maternity Strategy	Development programme via MIB Publication of Plan			Strategy being developed but requires wider engagement with stakeholders and families.	30/09/2019	Consultant Midwife

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9	TOR: 10 Action No: 7.68	Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding: <ul style="list-style-type: none"> • 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 our of hours service delivery and developing their in hours role 	Directors of Nursing leading engagement with other providers to consider learning and good practice.	Feedback from site visits				01/01/2020	Director of Nursing and Midwifery
10	TOR: 10 Action No: 7.69	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. <ul style="list-style-type: none"> • 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 provision. 	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed

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1	TOR: 1 Action No: 7.7	Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care.	Dedicated area with appropriately trained staff to support the women	There is a private environment – suite on labour ward. Unclear what standard needs to be met			Meeting the standards for bereavement care in Wales as per the national bereavement pathway, but we are not SANDS compliant.	11/03/2019	HOM
2	TOR: 5 Action No: 7.31	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit undertaken •Ensure involvement of paediatric staff for all future service design reviews and actions.	Regional review presented	Review currently in place and numbers of anticipated births being reviewed with other HB planning teams and HOM's.			Meetings in place with a review of patient flows, activity and capacity. Outcome expected shortly.	01/01/2020	AD Planning & performance
3	TOR: 8 Action No: 7.47	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 appropriate support and resources • Support lay members to engage with women using services in the FMU and RGH and at PCH to assess satisfaction and to identify issues relating to choices. • Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.	Engagement form Women with MSLC group	To be agreed			To be agreed	To be agreed	Consultant Midwife
4	TOR: 8 Action No: 7.48	Utilising the role and strengths of the Community Health Council: •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 and families, 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 at RGH so they can be assured regarding the impact on access and satisfaction with maternity services.	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
5	TOR: 8 Action No: 7.49	Develop the range and scope of engagement with women and families: • Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback. • As a priority, review and address the monitoring of the outcomes of patient experience as a key part 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 patient stories, diaries, 'mystery shopper' or observation techniques.	To be agreed	To be agreed			To be agreed	To be agreed	HOM
6	TOR: 8 Action No: 7.50	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.	To be agreed	To be agreed			To be agreed	To be agreed	HOM

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7	TOR: 8 Action No: 7.51	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: <ul style="list-style-type: none"> Review and enhance staff training on the value of listening to women and families. Review the process of investigation of concerns, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes Priorities 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 patient experience, Sis, complaints and concerns and other data and ensure that there is a rigorous approach 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 and inappropriate patient discharge 	Appointment of Womens experience Midwife Compliance with the Complaints and concerns process Womens stories utilised in the Governance Day	Womens experience midwife appointed Compliance monitored Governance day agenda			Appointment of a Consultant Midwife and Intrapartum Midwife for improved standards and governance has been activated. Work needs to continue to improve the quality of accountability and partnership with women and their families. Linked to culture. There is an urgent need to develop capacity to investigate and respond to concerns. In light of current telephone helpline volume of concerns. Work is being done to engage other HB's to support with capacity to investigate concerns raised.	01/05/2019	HOM Governance Lead
8	TOR: 8 Action No: 7.52	Learn from the experience of women and families affected by events: <ul style="list-style-type: none"> Respond and work with families in the way they require. Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care. 	Appointment of Womens experience Midwife Compliance with the Complaints and concerns process Womens stories utilised in the Governance Day	Womens experience midwife appointed Compliance monitored Governance day agenda Learning and development forum design of Learning, training and development days			Learning, training and development day re-design	30/09/2019	Deputy HOM
9	TOR: 8 Action No: 7.53	Review the communications, support and engagement approach and strategy. <ul style="list-style-type: none"> Ensure that the focus is not solely on management of key messages Demonstrate openness, honesty and transparency, admission of fault and learning from this. 	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
10	TOR: 8 Action No: 7.54	Prioritise an engagement programme with families at its heart. <ul style="list-style-type: none"> Women and families affected by events should be part of the improvement, co-design and culture change of the new service. 	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
11	TOR: 8 Action No: 7.55	Review the level and effectiveness of the bereavement service <ul style="list-style-type: none"> Ensure that appropriate support and counselling is available for all families as required Consider implementing the National Bereavement Care Pathway that has been developed by SANDS in collaboration with stakeholders including women and their families, RCOG and RCM. 	Appointment of a Bereavement Midwife Womens feedback	Midwife in Post Feedback surveys			All Wales Bereavement pathway in place – needs Network action.	31/03/2020	Deputy HOM

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1	TOR: 1 Action No: 7.5	Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum	Appointment of fetal surveillance and wellbeing midwife Agreed CTG education and training programme Compliance against all wales fetal surveillance standards	CTG training in place but competency assessment element requires review. Medical staff: 100% Midwifery staff:94%			Review of competency assessment based on All-Wales agreement. We are in compliance with All-Wales standards	01/10/2020	HOM
2	TOR: 1 Action No: 7.6	O & G consultant staff must deliver: •A standard induction programme for all new junior medical staff •A standard induction programme for all locum doctors	Feed back from Junior medical staff Feedback from Locum staff	Internal feedback surveys National feedback to Deanery and GMC			Locum induction programme will require review	01/09/2019	CD
3	TOR: 2 Action No: 7.15	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	Induction programme	Induction Agenda Training records			Review to be undertaken	01/01/2020	HOM CD
4	TOR: 2 Action No: 7.17	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 outpatient sessions.	Training records	Training records Staff attendance			Staff assessment to be undertaken	01/01/2020	CD
5	TOR: 3 Action No: 7.22	Actively discuss the outcomes of Sis which individual consultants were involved in their appraisal.	Completion of appraisals	UHB comment on individuals appraisals for reflections and SI discussion				12/06/2020	Medical Director
6	TOR: 2 Action No: 7.23	Improve learning from incidents by sharing the outcomes from Sis on a regular basis and in appropriate, regular and accessible format.	Governance process to allow this	Governance day agenda				01/05/2019	Lead Governance midwife
7	TOR: 5 Action No: 7.34	Allocate all trainees currently in post a clinical and educational supervisor •The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education •The competency assessments for trainees must be provided in-house under the supervision of the RCOG	All the trainees have an educational supervisor and clinical supervisor.	Named individuals provided at induction programme				01/05/2019	Royal College lead
8	TOR: 5 Action No: 7.35	Undertake a training needs assessment for all staff to identify skills gaps and target additional training	Training needs assessment	Training records Staff attendance			Need to develop deeper review and broaden scope.	12/06/2020	HOM CD
9	TOR: 5 Action No: 7.37	Develop an effective department wide multi-disciplinary teaching programme. • This must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • Attendance must be monitored and reviewed at appraisal.	Established learning and development forum Agreed training programme Compliance with training requirements	Training records Staff attendance				12/06/2020	HOM CD

Action No	RCOG Reference	Recommendation	Measurement	Evidence	Current Risk	Target Risk	Areas for Targeted Intervention for Improvement	Target Date	Action Lead (Initials)
10	TOR: 5 Action No: 7.40	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.	Workforce development	Scope and practice review inline with workforce developments				01/01/2020	HOM CD DM
11	TOR: 7 Action No: 7.44	Support training in clinical leadership •The Health Board must allow adequate time and support for clinical leadership to function.	Development within the team	Key individuals are being released and supported to undertake leadership development.			Due to new roles and responsibilities being developed this will be embedded in the short to medium term.	12/06/2020	Medical Director Director of nursing and midwifery
12	TOR: 8 Action No: 7.56	Provide training for staff in communication skills, in particular on: • Empathy, compassion and kindness	Compliance with training and development	Training records Staff attendance				12/06/2020	HOM CD
13	Delivery Unit Report (Dec 2019)	Develop a log of the aggregated action plans for monitoring of implementation.	Aggregated learning plan	Learning pla				30/05/2019	Governance lead
14	Delivery Unit Report (Dec 2019)	Use learning to inform improvement via the newly developing governance arrangements i.e. incident data, investigation reports, Peri-Natal Mortality review.	<ul style="list-style-type: none"> • Governance day established for the Directorate. Commenced in April 2019. • Risk newsletter developed 'learning from incidents' – April 2019 • Immediate 'make safes' safety briefings – Jan 2019 • MDT debrief – Dec 2018 • Reflection meetings established – June 2019 • Joint Consultant meetings, weekly – Jan 2019 • Trainee voices forum – Established 2018 • Staff meetings – April 2019 • Management meeting for operational, specialists and heads of midwifery (MMOSH) – May 2019 • Integrated Directorate Business Meetings – April 2019 	Evidence from the measurement meetings				01/04/2019	CD HOM

Action No	RCOG Reference	Recommendation	Measurement	Evidence	Current Risk	Target Risk	Areas for Targeted Intervention for Improvement	Target Date	Action Lead (Initials)
1	TOR: 4 Action No: 7.28	Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should: <ul style="list-style-type: none"> •Have a direct progress reporting responsibility to the Board, in particular while the issues raised in this 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 pathway to ensure priorities remain focussed. 	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
2	TOR: 5 Action No: 7.30	Ensure the Medical Director has effective oversight and management of the consultant body by:	To be agreed	To be agreed			To be agreed	To be agreed	To be agreed
3	TOR: 5 Action No: 7.33	Actively share and findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to: <ul style="list-style-type: none"> • Reassess the quality of induction, training and supervision in obstetrics • Seek assurance on the suitability of this service for trainees • Appoint a named RCOG College tutor to provide support for the trainees currently on the RGH site with adequate time and resource to fulfil this function 		Medical Directors in discussion with Deanery with plans being put in place.			Education committee revising quality of education. College tutor link. Framework in place needs embedding.	Activated	Medical Director
4	TOR: 9 Action No: 7.62	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. <ul style="list-style-type: none"> • 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 planned improvements. 	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed
5	TOR: 9 Action No: 7.63	7.63 Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed
6	TOR: 9 Action No: 7.64	7.64 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 that the Board provides.	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed	To be agreed

Action No	RCOG Reference	Recommendation	Measurement	Evidence	Current Risk	Target Risk	Areas for Targeted Intervention for Improvement	Target Date	Action Lead (Initials)
7	Delivery Unit Report (Dec 2019)	<p>Review the corporate process for the reporting and investigation of all incidents and concerns including the governance arrangements that provide board assurance.</p> <p>Clarify the roles and responsibilities for incident management across the organisation that demonstrates the lines of accountability for the risk management of an incident and cross-organisational learning.</p>		<ul style="list-style-type: none"> • Further review undertaken by the Delivery Unit, final draft report received April 2019, recommendations cross referenced with Wales Audit Office and other reports, to help in implementation • Quality and Patient Safety Governance Framework developed with wide range of key stakeholders, approved by the Executive Board and endorsed by Quality Safety & Risk Committee • Draft improvement plan developed, requires further refining, meeting with COO to complete 14 June 2019. Paper identifying progress submitted to QSRC 6 June 2019 • Increasing governance focused resource and reporting within directorates (organisation wide audit of governance processes currently underway, led by COO & DPCMH) • 'Plan on a page' developed awaiting sign off for wider circulation • Agreement between clinical Executive Directors (5 June 2019) re leadership of newly agreed sub group structure for QSRC, meetings to be scheduled August 2019 onwards 				To be agreed	To be agreed

Action No	RCOG Reference	Recommendation	Measurement	Evidence	Current Risk	Target Risk	Areas for Targeted Intervention for Improvement	Target Date	Action Lead (Initials)
8	Delivery Unit Report (Dec 2019)	<p>Instigate rapid review of patient safety incidents where care or service delivery problems give rise to concern and implement make safe as actions across the HB.</p> <p>Review the HB methodology for carrying out investigation including the monitoring and implementation of actions.</p>		<ul style="list-style-type: none"> • Serious incident toolkit and standard operating procedure revised and implemented with leadership from Heads of Nursing • Refocus since Dec 2018 of patient safety improvement team and extra clinical resource to support more timely response, weekly scrutiny internally and via Quality & Safety Division • Revised approach significantly improved clinical leadership and ownership from initial report to closure, including better established multi-disciplinary review, family involvement, action planning and implementing learning • Datix enabled to share learning on closure, sharing learning across the organisation needs developing (QSRC infrastructure) – formal review of datix system to be instigated (agreement to proceed 10 June 2019) • Newly establishing clinically led SI team (good examples SI & HTARI recognised by HTA, practice and leadership in RGH) • Welcome further DU review and support – draft terms of reference received, terms of 90 day intervention to be finalised between DU & Executive Director Nursing Midwifery & Patient Services 11 June 2019 				To be agreed	To be agreed