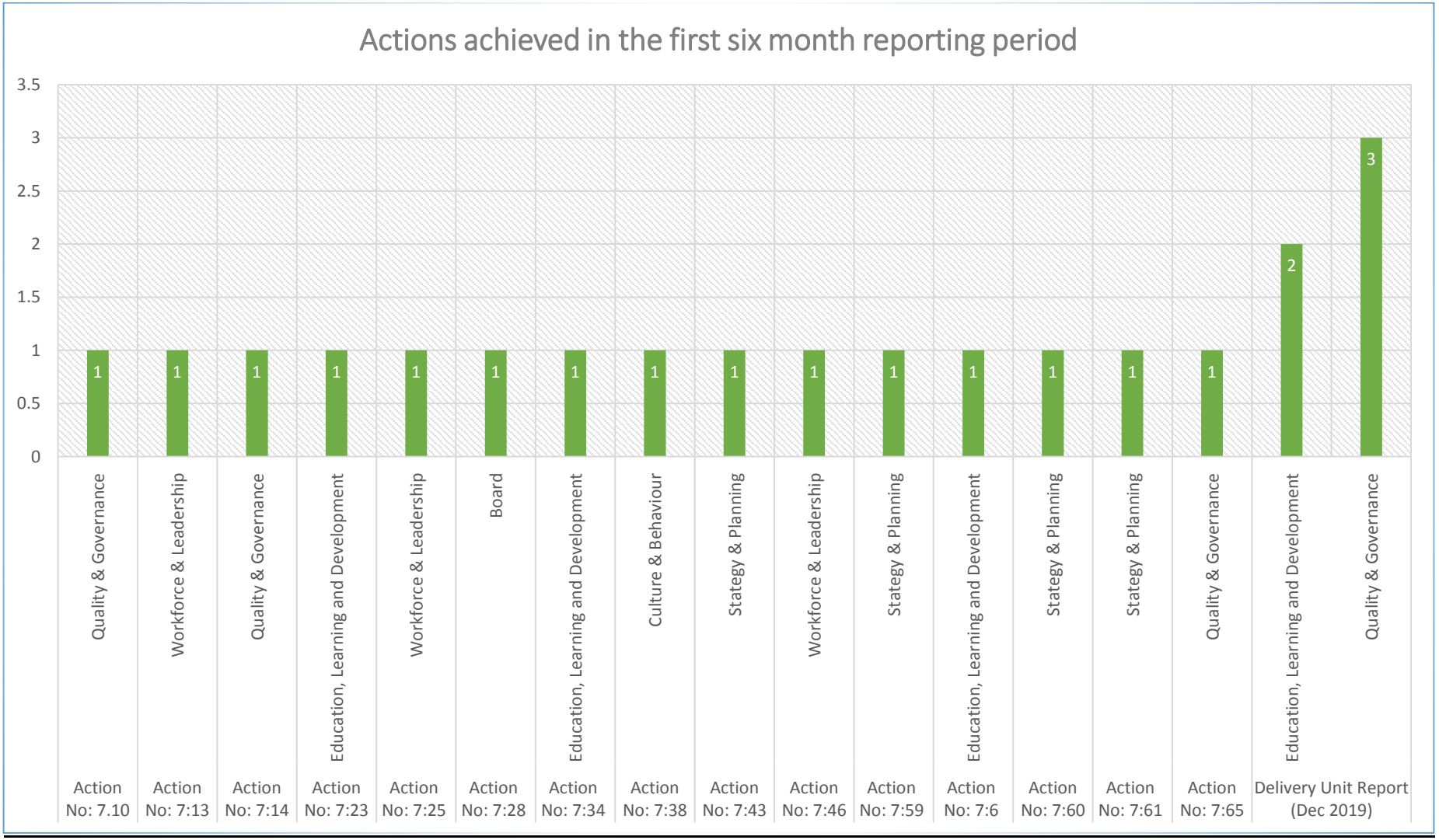
Actions achieved in the first six month reporting period
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Quality & Governance
Workforce & Leadership
Quality & Governance
Education, Learning and Development
Workforce & Leadership
Board
Education, Learning and Development
Culture & Behaviour
Stategy & Planning
Workforce & Leadership
Stategy & Planning
Education, Learning and Development
Stategy & Planning
Stategy & Planning
Quality & Governance
Education, Learning and Development
Quality & Governance
Action No: 7.10
Action No: 7:13
Action No: 7:14
Action No: 7:23
Action No: 7:25
Action No: 7:28
Action No: 7:34
Action No: 7:38
Action No: 7:43
Action No: 7:46
Action No: 7:59
Action No: 7:6
Action No: 7:60
Action No: 7:61
Action No: 7:65
Delivery Unit Report (Dec 2019)

Positive **action measures** in the area of **Quality & Governance** achieved in this reporting period

	Quality & Governance Action Measures		Outputs	Evidence
1	TOR 2	Action No: 7.10	Regular risk management meetings taking place, held at a time and place that allows for maximum attendance.	Update of weekly newsletter, monitoring of recurring themes.
2	TOR 2	Action No: 7:14	Regular consultant meetings with a starting agenda on governance. These meetings are joint with anaesthetics & paediatric colleagues.	Staff attendance lists, action and minutes from multidisciplinary meetings available.
3	TOR 10	Action No: 7:65	Criteria for the opening of the new FMU has been agreed by the multidisciplinary maternity guidelines group.	Minutes available for the governance meeting during Feb/March 2019.
4		Delivery Unit Report (Dec 2019)	RCA methodology utilised to review the 43 incidents and further peer review of the clinical outcomes complete.	Documented through the Action plan and aggregated learning plan.
5		Delivery Unit Report (Dec 2019)	Consistent governance processes within the Maternity Directorate in line with the HB's corporate process to ensure appropriate escalation.	Governance structure and framework now implemented and available.
6		Delivery Unit Report (Dec 2019)	Current incident reviews have been simplified to place 'patient safety' at the focus of the review.	Evidence through initial review, MDT meeting and incident review meetings.

Positive **action measures** in the area of **Workforce & Leadership** achieved in this reporting period

	Workforce & Leadership Action Measures		Outputs	Evidence
1	TOR: 2	Action No: 7:13	Clinical lead for governance from within the consultant body has now been identified.	Named individual responsible and attendance list at governance day available.
2	TOR: 4	Action No: 7:25	Consultant and Midwifery lead for Clinical audit/quality improvement now appointed.	Named individual responsible and attendance list at governance day available.
3	TOR: 7	Action No: 7:46	Clinical Leads in a structure that supports the service with defined role descriptions and job descriptions.	Named clinical leads in place - further actions to fully integrate with Princess of Wales in recent boundary change.

Positive **action measures** in the area of **Strategy & Planning** achieved in this reporting period

	Strategy & Planning Action Measures		Outputs	Evidence
1	TOR: 7	Action No: 7:43	In-depth assessment of the service has taken place as it moves into the future with its new ways of working and the likelihood of an increased demand for services.	Risk assessment at board level taken place and documented – further advise to be sought from the oversight panel.
2	TOR:7	Action No: 7:59	Full risk assessment taken place prior to the merger on the 9th 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 complete and documented at board level- further advise to be sought from oversight panel.
3	TOR: 7	Action No: 7:60	Monitoring the effects to the reduce inpatient capacity to avoid any adverse effects on the safety or quality of the service has undertaken.	Daily acuity reports, PCH operating regularly at full capacity. Monitoring in place.
4	TOR: 7	Action No: 7:61	Plan has been developed to increase capacity if this is seen to be required.	DATIX monitoring of use in place. Use of the overflow area also monitored.

Positive **action measures** in the area of **Education, Learning & Development** achieved in this reporting period

	Education, Learning & Development Action Measures		Outputs	Evidence
1	TOR: 1	Action No: 7:6	A standard induction programme for all new junior medical staff and a standard induction programme for all locum doctors is now in place.	Through the production of Internal feedback surveys. National feedback to Deanery and GMC.
2	TOR: 2	Action No: 7:23	Sharing outcomes from Sis on a regular basis and in an appropriate, regular and accessible format now taking place.	Minutes available from Governance day agenda items.
3	TOR: 5	Action No: 7:34	All trainees in post have a clinical and educational supervisor.	Named individuals provided at induction programme.
4		Delivery Unit Report (Dec 2019)	Development of a log of the aggregated action plans for monitoring of implementation complete.	Learning plan available.
5		Delivery Unit Report (Dec 2019)	Newly developing governance arrangements. The use of learning to inform improvements via these groups has been implemented.	Evidence from the measurement meetings which includes: Governance day established for the directorate – commenced April 2019 Risk newsletter developed 'Learning from incidents' – commenced April 2019 Immediate 'Make Safes' safety briefings – commenced Jan 2019 MDT debrief – commenced Dec 2018 Reflection meetings established – commenced June 2019 Joint Consultant meetings, weekly – commenced Jan 2019 Trainee voices forum – commenced 2018 Staff meetings – commenced April 2019 Management meeting for operational specialists and heads of midwifery – commenced May 2019 Integrated Directorate Business Meetings – commenced April 2019

Positive **action measures** in the area of **Board** achieved in this reporting period

	Board Action Measures		Outputs	Evidence
1	TOR: 4	Action No: 7:28	Appointment of executive level lead role for maternity.	Named individual responsible

Action measures which have been **partly achieved** and require **further improvement** as follows:

	Quality & Governance Action Measures partly achieved		Requirements	Outcomes and Evidence	Reasons not fully achieved
1	TOR: 4	Action No: 7:2	Consultant obstetric lead and senior midwife identified to ensure that all maternity unit guidelines are up to date. Readily available. Have a multi-disciplinary approach and adhered to in practice.	Consultant obstetric lead and senior midwife have now been identified.	Requires monthly report on lapsed guidelines – some have recently lapsed and need urgent review.
2	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 have now been identified.	Progression of audit plan via Governance structure required.
3	TOR: 1	Action No: 7.4	Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery. Personal Development Review Rates – To be >90%	Personal Development Reviews – current Midwifery Compliance: 71.06%	Personal Development Review Compliance Rates
4	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 completed. DATIX reporting on Dashboard. MITS upgrade has been completed.	Awaiting DATIX upgrade .
5	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 multi-disciplinary and including external assessors.	MDT panel in place and all SUI's reviewed by MDT. Safety briefings being circulated.	Training for RCA required. Further work is required to encourage a reporting and patient safety culture. Development of the Governance team capacity.
6	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 DATIX system to record clinical incidents. Monitor the usage of the incident reporting system.	DATIX training in place and mandatory. DATIX reports available to monitor progress.	Still some underreporting noted and mechanisms being sophisticated to monitor reporting. Development of the Governance team capacity. DATIX upgrade.
7	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.	Deanery training compliance and appraisal.	Monitoring of and receipt of annual reports required going forward.

8		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.	ICT currently working in MITS update for trigger list to be added to the programme, whereby midwives will not be able to complete episode without a DATIX link.	Awaiting role out of the update to MITS.

Partly achieved **action measures** in the area of **Workforce & Leadership** achieved in this reporting period which still require improvements

	Workforce & Leadership Action Measures partly achieved		Requirements	Outcomes/Evidence	Reasons not fully achieved
1	TOR: 2	Action No: 7.18	Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	Minutes and agendas available from meetings. Immediate post- merger, no difficulties reported.	Further reflection and review for rigour required.
2	TOR: 5	Action No: 7.32	Ensure obstetric consultant cover is achieved in all clinical areas when required.	Service established to achieve this.	Recruitment to workforce plan. 1 post vacant in the short term.
3	TOR: 7	Action No: 7.45	Provide mentoring and support to the Clinical Director.	Support provided to CD in situ.	Full requirement to be agreed.
4	TOR: 9	Action No: 7.57	Continue with efforts to recruit and retain permanent staff.	OD plan in support teams in place.	Requirement to develop leadership programme, now that leads are in place. Requires prioritisation.

Partly achieved **action measures** in the area of **Culture & Behaviour** achieved in this reporting period which still require improvements

	Culture & Behaviour Action Measures partly achieved		Requirements	Outcomes/evidence	Reasons not fully achieved
1	TOR: 2	Action No: 7.11	Ensure mandatory attendance for all appropriate staff at Governance meetings, Audit meetings.	All day Governance meetings implemented. Attendance register completed.	Requirement to embed into culture of services.
2	TOR: 2	Action No: 7.12	Undertake multi-disciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	Implementation of MDT meetings taking place and records of debriefs and attendance available.	Training and development of maternity team and benchmarking similar sessions going forward.
3	TOR:2	Action No: 7.16	Urgent steps must be taken to ensure that consultant obstetrics are immediately available when on call (max 30 minutes from call to being present)	Evidence through audits and Job Plans.	Further requirements to embed into service culture.
4	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.	Governance Infrastructure developed to support no blame culture.	Culture issues remain challenging. Creation of the capacity to reflect and learn being prioritised.

Partly achieved **action measures** in the area of **Strategy & Planning** achieved in this reporting period which still require improvements

	Strategy & Planning Action Measures partly achieved		Requirements	Outcomes/evidence	Reasons not fully achieved
1	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.	MIB established	Development programme via MIB required. Publication of Plan is also required.
2	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.	Strategy being developed.	Strategy requires wider engagement with stakeholders and families.
3	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: 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 the in hours role.	Directors of Nursing leading engagement with other providers to consider learning and good practice.	Further development required going forward.

Partly achieved **action measures** in the area of **Women's engagement & experience** achieved in this reporting period which still require improvements

	Women's engagement & experience Action Measures partly achieved		Requirements	Outcomes/evidence	Reasons not fully achieved
1	TOR: 5	Action No: 7.31	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit it undertaken. Ensure involvement of paediatric staff all future service design reviews and actions.	Review currently in place and numbers of anticipated births reviewed with other HB planning teams and HOM's.	Outcome expected shortly.
2	TOR: 8	Action No: 7.47	Develop and strengthen the role and capacity or 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 from women with MSLC group.	Still to be agreed.
3	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.	Women's experience midwife appointed. Compliance monitored. Women's stories utilised in the governance day.	Work needs to continue to improve the quality of accountability and partnership with women and their families. 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.
4	TOR:8	Action No: 7.52	Learn from the experience of women and families affected by events: 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	Appointment of Women's experience Midwife. Compliance with the Complaints and concerns process.	Learning, training and development day re-design.

			skills, expertise, communication, safety and quality of maternity care.		
5	TOR:8	Action No: 7.55	Review the level of effectiveness of the bereavement service: 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.	Midwife in post. Feedback surveys. All Wales Bereavement pathway in place.	Requires network action.

Partly achieved **action measures** in the area of **Education, Learning & Development** achieved in this reporting period which still require improvements

	Education, Learning & Development Action Measures partly achieved		Requirements	Outcomes/evidence	Reasons not fully achieved
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 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.
2	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. Midwifery staff induction. Locum staff induction and Annual mandatory training.	Documented on induction Agenda and training records.	Review to be undertaken
3	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. Compliant with training requirements.	Ongoing monitoring
4	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.	Key individuals are being released and supported to undertake leadership developments.	Due to new roles and responsibilities being developed this will be embedded in the short to medium term.

Partly achieved **action measures** in the area of **Board** achieved in this reporting period which still require improvements

	Board Action Measures partly achieved		Requirements	Outcomes/evidence	Reasons not fully achieved
1	TOR: 5	Action No: 7.30	Ensure the Medical Director has effective oversight and management of the consultant body.	To be agreed	Still to be agreed
2	TOR: 5	Action No: 7.33	Actively share the findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to: 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.	Framework in place needs embedding. Education committee revising quality of education.
3		Delivery Unit Report (Dec 2019)	Review the corporate process for the reporting and investigation of all incidents and concerns including the governance arrangements that provide board assurance. 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.	Further review undertaken by the Delivery Unit, report received April 2019. Quality and Patient Safety Governance Framework developed with wide range of key stakeholders. Draft improvement plan developed. Increased governance focused resource and reporting within directorates. Agreement between clinical executive Directors re leadership of newly agreed sub group structure for QSRC, meetings to be scheduled August 2019.	Ongoing review of corporate process.
4	TOR: 8	Delivery Unit Report (Dec 2019)	Investigate 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. Review the HB methodology for carrying out investigation including the monitoring and implementation of actions.	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 a (WSRC 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 of Nursing Midwifery & Patient Services, 11 June 2019.	

Action measures which have not been achieved and the reasons why?

	Quality & Governance Action Measures not met		Requirement	Reasons for non- compliance
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.	Awaiting audit plan from SHOM, No National audits carried out in 2018/19. Audit plan to be agreed with internal audit and CD.
2	TOR: 4	Action No: 7.26	Agree jointly owned neonatal and maternity service audits of neonatal service data.	Steps to ensure forums monitor audit performance going forward.
3	TOR: 10	Action No:7.66	Update the risk register and review regularly at Board level.	Risk register requires update and escalation (Target date 30/09/2019)

	Workforce & Leadership Action Measures not met		Requirement	Reasons for non- compliance
1	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.	Awaiting approval of request
2	TOR: 5	Action No: 7.29	Closely monitor bank hours undertaken by midwifes 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.	Workforce scorecard to be developed and agreed. Rota manager for Maternity Services.
3	TOR:10	Action No:7.69	Identify and nurture the local leadership talent.	Requires prioritisation, to be agreed.

	Women's engagement & experience Action Measures not met		Requirement	Reasons for non-compliance
1	TOR: 1	Action No: 7:7	Environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed National Standards of Care.	Dedicated area is now available for these patients with appropriately trained staff to support the women. Non-compliant with the standards for bereavement care in Wales as per the National bereavement pathway. Also non-compliant with SANDS.

	Culture & Behaviour Action Measures not met		Requirement	Reasons for non- compliance
1	TOR: 2	Action No: 7.8	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.	Yet to be agreed
2	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. Staff must be held to account for poor behaviours and understand how this impact's on women's safety and outcomes.	Accountability of culture needs to be developed

	Strategy & Planning Action Measures not met		Requirement	Reasons for non- compliance
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.	Yet to be agreed

2	TOR: 6	Action No: 7.41	Consider the impact pf the planned merger on the current culture of the organisation.	Cultural issues remain. Significant number of new staff in pipeline for recruitment which will support culture change.
3	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.	Yet to be agreed

	Women's engagement & experience Action Measures not met		Requirement	Reasons for non-compliance
1	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.	Yet to be agreed
2	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.	Yet to be agreed
3	TOR: 8	Action No: 7.50	Continue to work with and build on the community -based engagement approaches being suggested by the MSLC. Explore	Yet to be agreed

			working with external partners, including the CHC and community-based organisations.	
4	TOR: 8	Action No: 7.53	Review the communications, support and engagement approach and strategy. Ensure that the focus is not solely on management of key messages. Demonstrate openness, honesty and transparency, admission of fault and learning from this.	Yet to be agreed
5	TOR: 8	Action No: 7.54	Prioritise an engagement programme with families at its heart. Women and families affected by events should be part of the improvement, co-design and culture change of the new service.	Yet to be agreed